

Women and Employer-Sponsored Insurance

Most women in the United States get their health insurance through an employer. In 2007, nearly two-thirds of women aged 18 to 64—over 61 million women in total—received health benefits through their own (61 percent) or a family member’s (39 percent) employer.¹ Employer-sponsored insurance (ESI) is viewed favorably by those who have it—when surveyed, most individuals with ESI rate their coverage as very good or excellent, and most believe that their employer does a good job selecting high-quality health plans.² ESI spreads health costs and risks among a group of people, and buying insurance through an employer makes it easy for employees to enroll, maintain coverage, and pay their premiums.³ Employer-provided coverage is also an important source of financing in the current health system—in 2005, private sector employers spent a collective \$370 billion on health insurance premiums.⁴

For all these reasons, ESI is likely to play a significant role in health reform. Employers represent a key health financing source, and employee groups offer a convenient way to pool risk. Most people covered through ESI want the option of keeping the health insurance they currently have. It is essential, then, that advocates recognize ESI’s importance for women and how this type of health coverage fits into health reform efforts. This includes understanding how health reform plans can make it easier for women to obtain ESI. In particular, health reform plans might target health coverage for small businesses, which are considerably less likely than large firms to offer health coverage to their workers—most often citing cost as the reason.⁵

Different Types of Employer-Sponsored Health Insurance

The regulations that apply to employer-sponsored health coverage depend on the size of the employer. As a result, two distinct “markets” have emerged:

- The **small group market** is generally defined to include employers with two to 50 employees.⁶ Due to their size, small groups are less able to spread risk and, thus, cost among employees, which makes insurance companies less inclined to sell them coverage. To counteract this, the federal and state governments subject the small group market to regulations generally designed to make it easier to access to health coverage. Still, the smaller an employer is, the less likely it is to offer health benefits to its employees.⁷
- The **large group market** is where employers with at least 51 employees purchase health insurance.⁸ Unlike the small group market, the large group market is subject to little regulation, because large employers are presumed to have more clout and thus more ability to negotiate favorable terms for coverage on their own. While this tends to be true for very large employers, such as those with 1,000 employees, it may not always be true

How Small is a ‘Small Business’?

Laws governing the small group insurance market vary from state to state, and some states use different definitions of “small business.” While the majority of states and the federal government define “small businesses” as those with two to 50 employees,¹⁰ twelve states allow self-employed people, or “groups of one,” to purchase coverage in the small group market.¹¹

for more moderate sized employers, such as those with 55 or 60 employees. Even so, large employers are the most likely to offer health benefits to their employees; over 95 percent of businesses with 50 or more employees offer health insurance.⁹

In addition to being distinguished by their size, employer-sponsored health plans are also characterized by the insurance arrangement of the employer: “fully-insured” or “self-insured.” Fully-insured firms buy coverage from an insurance company. But many very large employers opt to self-insure instead. Under a self-insured health plan, the employer assumes the financial risk of covering its employees and pays medical claims from its own resources. Fully-insured health plans are subject to state and federal regulations for group health plans. Importantly, self-insured employer health plans are not subject to state law or regulation but instead are regulated by Federal law known as ERISA, the Employment Retirement Income Security Act of 1974.¹² Thus, even if a state adopted a law governing what health services must be covered in a health insurance plan, or how insurers can set premiums to charge employers, self-insured plans would be exempt from such state laws. In 2006, 45 percent of workers with health insurance were covered by a fully insured group health plan sold in the small or large group market, and 55 percent were covered by a self-insured health plan.¹³ Because some self-insured employers may use a health insurance company to process paperwork for employees, many people often don’t realize that their employer is self-insured.

Characteristics of the Small Group Health Insurance Market

Existing federal law addresses the availability of health insurance for small businesses.

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA provisions extend rights and protections to workers of small businesses with two to 50 employees.¹⁴ The law requires small group insurance carriers to offer coverage on a “guaranteed issue” basis, which means that neither small employers nor their employees may be denied health insurance based on health status-related factors, such as medical history, claims experience, and health status.¹⁵ HIPAA also mandates “guaranteed renewability” of small employer policies, meaning that an insurer may not cancel coverage for a group that has experienced high-cost claims.¹⁶ Notably, while HIPAA does increase the availability of health insurance coverage in the small group market, it does not address another major barrier for small firms—the cost of that coverage.

In most states, insurance companies consider the characteristics of each employee when determining a small business’ overall premium rate.

When a small business applies for health insurance, the majority of states allow insurance companies to determine the premium that will be charged using a process known as “medical underwriting.” During the underwriting process, employees provide information such as their health status, prior medical claims, age, gender, and smoking status. Insurers use the information about each member of the group to determine the overall premium to charge a small group.¹⁷

Medical underwriting occurs in the large group health insurance market as well, but insurers underwrite the group as a whole rather than considering the health-related factors of each employee.¹⁸ Underwriting in a large group considers the entire group’s claims history, age distribution, industry, and geographic location, but employees are not required to complete medical questionnaires as they are in the small group insurance market.¹⁹

Small group insurance companies tend to set premiums based on the gender, age, and health status make-up of a small business's workforce.

If a majority of a small firm's workers are women, are older, or have prior health insurance claims or a history of health problems, the small business and its employees may not be able to afford health coverage. Indeed, the following insurance industry practices may make it more difficult for businesses to find affordable coverage in the small group insurance market:

- **Gender Rating.** Insurance companies in most states are allowed to use the gender make-up of a small business as a rating factor when determining how much to charge for health coverage. Under the premise that women have higher hospital and physicians' costs than men, insurers may charge small firms more for health coverage if they have a predominantly female workforce. From the employee's perspective, this disparity may not be apparent, since employment discrimination laws prohibit an employer from charging male and female employees within a firm different rates for their ESI.²⁰

While state and federal anti-discrimination laws prohibit most small businesses from charging male and female employees different premiums, gender rating in the small group insurance market can be an insurmountable obstacle to affording health coverage for a small firm with a disproportionately female workforce. If the overall premium is not affordable, a small business may forgo offering coverage to workers altogether, or shift a greater share of health insurance costs to employees.

- **Age Rating.** Insurers often base a small business's overall health insurance premium on the age make-up of its employees. Unless prohibited by state law, insurance companies tend to charge higher rates to small groups with older workforces, since older people are more likely to need and use health care services.²¹ Age rating serves as a financial barrier to health coverage to a small business with an older workforce.
- **Health Status Rating.** Although the federal HIPAA law prohibits insurers from rejecting small group insurance applications due to health status of its employees (known as "guaranteed issue"), it does not restrict insurers from using health status as a factor upon which to base premiums. Insurance companies often charge small groups higher premiums if their employee members have pre-existing health conditions. As a result, a small business employing even just a single worker with a history of health problems—such as breast cancer or diabetes—may find it difficult to afford health insurance coverage.

Addressing Affordability in the Small Group Health Insurance Market

Because the regulation of insurance has traditionally been a state responsibility²² there is no existing federal law regulating the premiums charged to small businesses for health coverage. A handful of states, however, have taken steps to increase the affordability of health insurance in the small group market. States have:

- Prohibited the use of certain rating factors through an outright ban;
- Limited the amount a particular rating factor (such as gender, health status or age) may be used through a "rate band," which sets limits between the lowest and highest premium that a health insurer may charge for the same coverage based on certain rating factors,²³ and

- Prohibited the use of rating factors through the imposition of “community rating.” Community rating is a method of calculating health insurance premiums based on the average or anticipated health costs of the entire community rather than the particular costs of one small firm.²⁴ Under “pure community rating,” an insurer must set the same premium for all small groups with the same coverage regardless of their employees’ gender, age, health status, or occupation.²⁵ Under “modified community rating,” an insurer is prohibited from setting premiums based on employees’ health status or claims history but allows variation based on limited demographic characteristics, which can include gender, age, and geographic location.²⁶

Protections Against Gender Rating

Unless prohibited by state law, insurers generally charge higher premiums to small groups consisting of more female than male employees. As demonstrated in Table 1, 34 states and the District of Columbia permit the use of gender as a rating factor in the small group insurance market. Of the remaining states:

- Twelve have banned gender rating in the small group market. The majority of these have adopted community rating; New York imposes pure community rating in its small group market, while Maine, Maryland, Massachusetts, New Hampshire, Oregon, and Washington ban gender rating under modified community rating. California, Colorado, Michigan, Minnesota, and Montana specifically prohibit insurers from considering gender when setting health insurance rates in the small group market.²⁷
- One state, Iowa, prohibits gender rating unless a small group insurance carrier secures prior approval from the state insurance commissioner.
- Three states—Delaware, New Jersey, and Vermont—limit the extent to which insurers may vary premium rates based on gender through a rate band.

The SHOP Act: Proposed Federal Legislation Could Ban Gender Rating for Small Groups

Introduced in Congress in 2008, the Small Business Health Options Program, or SHOP Act,²⁸ aims to make health insurance more affordable by:

- Allowing small employers to join purchasing pools designed to lower employee premiums,
- Providing tax credits to help offset the cost of health coverage, and
- Outlawing the use of rating based on health status and claims experience beginning in 2011.

As part of the a nationwide small employer purchasing pool, the SHOP Act proposes default rating rules for all insurance plans offered through the pool, which includes modified community rating that would prohibit gender rating and give states incentives to adopt similar small group rules.

Protections Against Age Rating

Overall, 49 states and the District of Columbia allow insurers to use age as a rating factor in the small group market. (See Table 1.) Only one—New York—bans the use of age as a rating factor through pure community rating rules for small groups. Six additional states limit the use of age rating in the small group market through a rate band.

Protections Against Health Status Rating

The federal HIPAA law states that an employer may not charge individual employees higher premiums based on health status.²⁹ For instance, an employee with a chronic health condition like arthritis cannot be charged more for ESI than a “similarly situated” coworker (e.g. they are both full-time workers) without arthritis.³⁰

However, HIPAA does not address how much a small business may be charged for its overall health insurance premium. Unless prohibited by state law, insurers tend to charge higher premiums to small groups whose employees have poor health status. As shown in Table 1, 40 states and the District of Columbia permit health status rating in the small group market. However, ten states prohibit health status rating through community rating rules and virtually every other state imposes a rate band to limit how much insurers can vary rates due to health status in the small group market.³¹



What Can Women’s Advocates Do?

Women’s advocates can learn about the importance of employer-sponsored coverage for women, and identify the different types of employer-sponsored health insurance.

Most people in the United States obtain their health insurance from an employer. ESI is rated favorably by those who have it, and employers represent an important source of funding for health benefits. Considering these factors, ESI is likely to play a key role in health reform plans, and advocates must be informed about this type of coverage. Specifically, it is important for women’s advocates to understand characteristics of large and small group insurance markets, as well as the difference between fully-insured and self-insured health plans.

Women’s advocates can support regulations in the small group insurance market that will make coverage easier and more affordable to obtain, namely prohibitions on gender rating.

Despite the important role that ESI currently plays in the United States health care system and the role it is likely to play in future health reform, women who own and work for small businesses may encounter particular barriers to obtaining high-quality and affordable health coverage in the small group insurance market. While affordability is a problem facing all small businesses, for instance, gender rating makes it even more expensive for small employers with predominantly female workforces. Already, those small businesses that do not offer health coverage tend to have larger proportions of female workers.³²

Gender rating serves as a financial barrier to health coverage for small businesses with a predominantly female workforce. All but 13 states allow gender rating by small group insurance carriers—the remaining states and the District of Columbia should enact laws prohibiting the use of gender as a rating factor, through outright bans on the practice or community rating requirements.

Women’s advocates can learn about and promote other efforts that will make it easier for women and their families to obtain and afford ESI, in general.

There are many other ways that health reform plans can improve the availability and affordability of employer-provided health benefits, regardless of whether they are offered by a large or small business. Health reform plans might, for example, require that employers contribute to health care for their workers through a “pay or play” mandate. Or, health reform might create new tax incentives that make it easier for employers to offer—and employees to purchase—health coverage. These reforms are discussed elsewhere in the *Reform Matters*

Toolkit, namely the “Women and Employer Mandates” and “Women, Tax Policy, and Health Reform” sections.



For further reading, see:

Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), <http://www.kff.org/insurance/upload/7766.pdf>.

Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* (Sept. 2006), <http://familiesusa.org/assets/pdfs/rate-regulation.pdf>.

Community Catalyst, *Access to Affordable Insurance for Individuals and Small Businesses: Barriers and Potential Solutions* (June 2005), http://www.communitycatalyst.org/doc_store/publications/access_to_affordable_insurance_for_individuals_and_small_businesses_jun05.pdf.

Dawn M. Gencarelli, National Health Policy Forum, *Background Paper: Health Insurance Coverage for Small Employers* (Apr. 2005), www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.

Paul Fronstin & Ruth Helman, Employee Benefit Research Institute, *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey 3* (Jan. 2003), http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.

References

- 1 National Women’s Law Center analysis of 2007 data on health coverage from the 2008 Current Population Survey’s Annual Social and Economic Supplement, using CPS Table Creator, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.
- 2 Sara R. Collins, et al., The Commonwealth Fund, (Sept. 2006), *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families*, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=402531
- 3 Cathy Schoen et al., *Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance*, *Health Affairs* 27(3): 646-57 (May/June 2008).
- 4 Employee Benefits Research Institute, *EBRI Databook on Employee Benefits, Chapter 34: Employer Spending on Health Insurance* (Sept. 2007), <http://ebri.org/pdf/publications/books/databook/DB.Chapter%2034.pdf>
- 5 Health reform plans might require that employers contribute to health care for their workers through a “pay or play” mandate, or plans might create new tax incentives that make it easier for employers to offer—and employees to purchase—health coverage. See the *Reform Matters Toolkit* sections on the “Women and Employer Mandates” and “Women, Tax Policy, and Health Reform” sections of the *Reform Matters Toolkit* for further discussion of these types of health reform.
- 6 *See, e.g.*, 42 U.S.C. § 300gg-91(e)(4) (2008).
- 7 Dawn M. Gencarelli, Nat’l Health Policy Forum, *Background Paper: Health Insurance Coverage for Small Employers* 3 (Apr. 2005), www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf; Paul Fronstin & Ruth Helman, Employee Benefit Research Inst., *Issue Brief No. 253, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey* 11 (Jan. 2003), http://www.nhpf.org/pdfs_bp/BP_SmallBusiness_04-19-05.pdf.
- 8 *See, e.g.*, 42 U.S.C. § 300gg-91(e)(2) (2008).
- 9 Kaiser Family Found. & Health Research and Educ. Trust, *Employer Health Benefits 2007 Annual Survey* 5 (2007), <http://www.kff.org/insurance/7672/upload/76723.pdf>.
- 10 42 U.S.C. § 300gg-91(e)(4) (2008).
- 11 Colorado, Connecticut, Delaware, Florida, Hawaii, Maine, Massachusetts, Mississippi, New Hampshire, North Carolina, Rhode Island, and Vermont allow self-employed people to purchase small group insurance coverage. *See* COLO. REV. STAT. § 10-16-102(40)(a) (2008); CONN. GEN. STAT. § 38a-564(4)(A) (2008); DEL. CODE ANN. tit. 18, §§ 7202(34), 7207(3) (2008); FLA. STAT. § 627.6699(3)(v) (2008); HAW. REV. STAT. § 431:2-201.5(b) (2008); ME. REV. STAT. ANN. tit. 24-A, § 2808-B(1)(D) (2008); MASS. GEN. LAWS ch. 176J, § 1 (2008); MISS. CODE ANN. §§ 83-63-3(m), 83-63-6 (West 2008); N.H. REV. STAT. ANN. § 420-G:2(XVI)(a); N.C. GEN. STAT. § 58-50-110(22) (West 2008); R.I. GEN. LAWS § 27-50-3(kk), (m) (2008); VT. STAT. ANN. tit. 8, § 4080a(a)(1) (2008).
- 12 Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. and 29 U.S.C.).

- 13 William Pierron & Paul Fronstin, Employee Benefit Research Inst., *Issue Brief No. 314, ERISA Pre-emption: Implications for Health Reform and Coverage 1* (Feb. 2008), http://www.ebri.org/pdf/briefspdf/EBRI_IB_02a-20082.pdf.
- 14 Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C. § 300gg-91(e)(4) (2008)).
- 15 42 U.S.C. §§ 300gg-11(a)(11), 300gg-1(a)(1) (2008) (“health status-related factors” include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability).
- 16 42 U.S.C. §§ 300gg-12 (2008).
- 17 Nat’l Ass’n of Health Underwriters, *Consumer Guide to Group Health Insurance 1*, <http://www.nahu.org/consumer/groupinsurance.cfm> (last visited July 16, 2008).
- 18 *Id.*; Henry J. Kaiser Family Foundation, *How Private Health Coverage Works: A Primer, 2008 Update* (Apr. 2008), <http://www.kff.org/insurance/upload/7766.pdf>.
- 19 *Id.*
- 20 42 U.S.C. § 2000e-2(a)(1) (2008) (Title VII of the Civil Rights Act of 1964 makes it an unlawful employment practice “to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s race, color, religion, sex or national origin”). See also *Ariz. Governing Comm. for Tax Deferred Annuity & Deferred Compensation Plans v. Norris*, 463 U.S. 1073 (1983) (holding that the use of sex-based actuarial tables, which resulted in the employer providing lower annuity payments to women who contributed the same amount as men violated Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e); U.S. EQUAL EMPLOYMENT OPPORTUNITY COMM’N, DIRECTIVES TRANSMITTAL No. 915.003 EEOC COMPLIANCE MANUAL SECTION 3: EMPLOYEE BENEFITS (Oct. 3, 2000), available at <http://www.eeoc.gov/policy/docs/benefits.html> (“health insurance benefits must be provided without regard to the race, color, sex, national origin, or religion of the insured. An employer must non-discriminatorily provide to all similarly situated employees the same opportunity to enroll in any health plans it offers. An employer must also ensure that the terms of its health benefits are non-discriminatory”).
- 21 *Id.* at 6.
- 22 McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (2008).
- 23 Typically, an insurer will establish an average premium, or “index rate,” and the rate band will set a floor below and a ceiling above that index rate to designate the amount by which an insurer can vary premiums based on the specified factor(s). For example, State X’s rate band allows an insurer to vary premiums from the index rate by plus or minus 25 percent. If an insurer’s index rate is \$400, then the lowest premium allowed under the rate band would be \$300 and the highest allowable premium would be \$500. See: Deborah J. Chollett & Adele M. Kirk, The Henry J. Kaiser Family Foundation, *Understanding Individual Health Insurance Markets* 43-44 (Mar. 1998).
- 24 Mila Kofman & Karen Pollitz, Georgetown University Health Policy Institute, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Chance 3* (Apr. 2006), <http://www.pbs.org/now/politics/Healthinsurancereportfinalkofmanpollitz.pdf>.
- 25 N.Y. Ins. Law § 3231(a) (McKinney 2008).
- 26 Connecticut, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Oregon, Vermont, and Washington impose modified community rating. For statutory citations, please see each state’s notes accompanying Table 1.
- 27 Montana’s “unisex insurance law” is not limited to health insurance; it prohibits insurers from using gender as a rating factor in any type of insurance policy issued within the state. See MONT. CODE ANN. § 49-2-309(1) (2008).
- 28 S. 2796, H.R. 5918, 110th Cong. (2d Sess. 2008).
- 29 42 U.S.C. § 300gg-1(b) (2008); 26 C.F.R. § 54.9802-1 (2008).
- 30 Families USA, *Issue Brief: Understanding How Health Insurance Premiums Are Regulated* (Sept. 2006), <http://familiesusa.org/assets/pdfs/rate-regulation.pdf>.
- 31 Thirty-eight states impose rate bands limiting health status as a rating factor, while the remaining three states—the District of Columbia, Hawaii, and Pennsylvania—allow the use of health status as a rating factor because they impose no rating restrictions at all in the small group market.
- 32 Fronstin & Helman, *supra* note 7, at 10-11.

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Table 1: State Laws Protecting Against the Use of Gender, Age, and Health Status as Rating Factors in the Small Group Market

See Table 1 notes for statutory citations.

State	Gender	Age	Health Status
Alabama	X	X	⊖
Alaska	X	X	⊖
Arizona	X	X	⊖
Arkansas	X	X	⊖
California	●	X	⊖
Colorado	●	X	⊖
Connecticut (modified community rating)	X	X	●
Delaware	⊖	X	⊖
District of Columbia	X	X	X
Florida	X	X	⊖
Georgia	X	X	⊖
Hawaii	X	X	X
Idaho	X	X	⊖
Illinois	X	X	⊖
Indiana	X	X	⊖
Iowa	●	X	⊖
Kansas	X	X	⊖
Kentucky	X	X	⊖
Louisiana	X	X	⊖
Maine (modified community rating)	●	⊖	●
Maryland (modified community rating)	●	X	●
Massachusetts (modified community rating)	●	X	●
Michigan	●	X	⊖
Minnesota	●	⊖	⊖
Mississippi	X	X	⊖
Missouri	X	X	⊖
Montana	●	X	⊖
Nebraska	X	X	⊖
Nevada	X	X	⊖
New Hampshire (modified community rating)	●	X	●
New Jersey (modified community rating)	⊖	⊖	●
New Mexico	X	X	⊖
New York (pure community rating)	●	●	●
North Carolina	X	X	⊖
North Dakota	X	X	⊖
Ohio	X	X	⊖
Oklahoma	X	X	⊖
Oregon (modified community rating)	●	⊖	●
Pennsylvania	X	X	X
Rhode Island	X	X	⊖
South Carolina	X	X	⊖
South Dakota	X	⊖	⊖
Tennessee	X	X	⊖
Texas	X	X	⊖
Utah	X	X	⊖
Vermont (modified community rating)	⊖	⊖	●
Virginia	X	X	⊖
Washington (modified community rating)	●	X	●
West Virginia	X	X	⊖
Wisconsin	X	X	⊖
Wyoming	X	X	⊖

Key
 ● Protections exist
 ⊖ Limited protections exist (use limited through rate band)
 X No protections exist

Notes to Table 1

- Alabama:** Gender and age: ALA. ADMIN. CODE r. 482-1-116-.05(a)(1) (2008). Health status: ALA. ADMIN. CODE r. 482-1-116-.05(a)(5)(b). Health Status Rate Band: $\pm 20\%$
- Alaska:** Gender and age: ALASKA STAT. \S 21.56.120(a)(9) (2008). Health status: ALASKA STAT. \S 21.56.120(a)(1) (2008). Health Status Rate Band: $\pm 35\%$
- Arizona:** Gender and age: ARIZ. REV. STAT. ANN. $\S\S$ 20-2311(B)(1), 20-2301(A)(8) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: ARIZ. REV. STAT. ANN. \S 20-2311(A) (2008). Health Status Rate Band: $\pm 60\%$
- Arkansas:** Gender: ARK. CODE INS. R. 19(8) (Weil 2008) (allowing small employer insurance carriers to use gender as a rating factor, provided that the rate differential is based on actuarial statistics). Age: ARK. CODE ANN. $\S\S$ 23-86-204(b), 23-86-202(4) (West 2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: ARK. CODE ANN. \S 23-86-204(a)(2) (West 2008). Health Status Rate Band: $\pm 35\%$
- California:** Gender: CAL. INS. CODE $\S\S$ 10714(a)(2), 10700(t)-(v) (West 2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, and family size, in addition to the benefit plan selected by the employee). Age: CAL. INS. CODE \S 10700(v) (West 2008). Health Status: CAL. INS. CODE \S 10714(a)(1) (West 2008). Health Status Rate Band: $\pm 10\%$
- Colorado:** Gender and age: COLO. REV. STAT. $\S\S$ 10-16-105(8)(a), 10-16-102(10)(b) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics other than age, geographic region, family size, smoking status, claims experience, and health status). Health status: COLO. REV. STAT. \S 10-16-105(8.5)(a)(III) (2008). Health Status Rate Band: $+10\%$, -25%
- Connecticut:** Gender and age: CONN. GEN. STAT. \S 38a-567(5)(A) (2008) (allowing small employer insurance carriers to vary the community rate based on age and gender). Health status: CONN. GEN. STAT. $\S\S$ 38a-567(5)(A) (2008), -564(27) (requiring community rating that excludes the use of claim experience, health status, and duration of coverage as rating factors).
- Delaware:** Gender: DEL. CODE ANN. tit. 18, \S 7205(2)(a) (2008) (allowing small employer insurance carriers to vary premium rates based on gender and geography combined by up to 10 percent). Age: DEL. CODE ANN. tit. 18, \S 7202(9), 7205 (2008) (allowing the use of age as a rating factor if actuarially justified). Health status: DEL. CODE ANN. tit. 18, \S 7205 (2008). Health Status Rate Band: $\pm 35\%$
- District of Columbia:** D.C. CODE $\S\S$ 31-2801 to -3851.13 (2008), D.C. CODE MUN. REGS. tit. 26, $\S\S$ 100-8899 (2008) (no statute or regulation imposes any rating restrictions on the small group market).
- Florida:** Gender and age: FLA. STAT. \S 627.6699(6)(b)(1) (2008). Health status: FLA. STAT. \S 627.6699(6)(b)(5) (2008). Health Status Rate Band: $\pm 15\%$
- Georgia:** GA. CODE ANN. \S 33-30-12(b), (d) (West 2008). Health Status Rate Band: $\pm 25\%$
- Hawaii:** HAW. REV. STAT. $\S\S$ 43:1-100 to 435E-46 (2008), HAW. CODE R. $\S\S$ 16-1-1 to 16-304-3 (2008) (no statute or regulation imposes any rating restrictions on the small group market).
- Idaho:** Gender and age: IDAHO CODE ANN. \S 41-4706(1)(h) (2008). Health status: IDAHO CODE ANN. \S 41-4706(1)(b) (2008). Health Status Rate Band: $\pm 50\%$
- Illinois:** Gender and age: 215 ILL. COMP. STAT. 93/25(a)(6), 93/10 (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: 215 ILL. COMP. STAT. 93/25(a)(2) (2008). Health Status Rate Band: $\pm 25\%$
- Indiana:** Gender and age: IND. CODE $\S\S$ 27-8-15-17, 27-8-15-6 (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: IND. CODE \S 27-8-15-16(1) (2008) Health Status Rate Band: $\pm 35\%$
- Iowa:** Gender and age: IOWA CODE \S 513B.4(2) (2008) (prohibiting the use of rating factors other than age, geographic area, family composition, and group size without prior approval of the insurance commissioner). Health status: IOWA CODE \S 513B.4(1)(b) (2008). Health Status Rate Band: $\pm 25\%$
- Kansas:** Gender and age: KAN. STAT. ANN. $\S\S$ 40-2209h(7)(A), 40-2209h(a)(9) (2008). Health status: KAN. STAT. ANN. \S 40-2209h(2) (2008). Health Status Rate Band: $\pm 25\%$
- Kentucky:** Gender and age: KY. REV. STAT. ANN. \S 304.17A-0952(6) (West 2008). Health status: KY. REV. STAT. ANN. \S 304.17A-0952(4) (West 2008). Health Status Rate Band: $\pm 50\%$
- Louisiana:** Gender and age: LA. REV. STAT. ANN. \S 22:228.6(B)(3) (2008). Health status: LA. REV. STAT. ANN. \S 22:228.6(B)(2)(b) (2008). Health Status Rate Band: $\pm 33\%$
- Maine:** Gender and health status: ME. REV. STAT. ANN. tit. 24-A, \S 2808-B(2)(B) (2008) (prohibiting small employer insurance carriers from varying the community rate based on gender, health status, claims experience or policy duration of the group or group members). Age: ME. REV. STAT. ANN. tit. 24-A, \S 2808-B(2)(D), (D-1) (2008). Age Rate Band: $\pm 20\%$
- Maryland:** MD. CODE ANN., Ins. \S 15-1205(a)(1)-(3) (West 2008) (allowing small employer insurance carriers to adjust the community rate only for age and geography).
- Massachusetts:** MASS. GEN. LAWS ch. 176J, \S 3(a)(1), (2) (2008) (allowing small employer insurance carriers to adjust the community rate only for age, industry, participation-rate, wellness program, and tobacco use).
- Michigan:** Gender and age: MICH. COMP. LAWS \S 500.3705(2)(a) (2008) (prohibiting commercial small employer insurance carriers from setting premium rates based on characteristics of the small employer other than industry, age, group size, and health status). Health status: MICH. COMP. LAWS \S 500.3705(2) (c) (2008). Health Status Rate Band: $\pm 45\%$
- Minnesota:** Gender: MINN. STAT. \S 62L.08(5) (2008) (prohibiting the use of gender as a rating factor for small employer insurance carriers). Age: MINN. STAT. \S 62L.08(3) (2008). Health status: MINN. STAT. \S 62L.08(2) (2008). Age Rate Band: $\pm 50\%$, Health Status Rate Band: $\pm 25\%$
- Mississippi:** Gender and age: MISS. CODE ANN. $\S\S$ 83-63-7(1)(g), -3(d) (West 2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: MISS. CODE ANN. \S 83-63-7(1)(b) (West 2008). Health Status Rate Band: $\pm 25\%$
- Missouri:** Gender and age: MO. REV. STAT. \S 379.936(1)(10) (2008). Health status: MO. REV. STAT. \S 379.936(2) (2008). Health Status Rate Band: $\pm 35\%$

Montana: Gender: MONT. CODE ANN. § 49-2-309(1) (2008) (“It is an unlawful discriminatory practice for a financial institution or person to discriminate solely on the basis of sex or marital status in the issuance or operation of any type of insurance policy, plan, or coverage or in any pension or retirement plan, program, or coverage, including discrimination in regard to rates or premiums and payments or benefits”). Age: MONT. CODE ANN. §§ 33-22-1809(1) (f), -1803(9) (2008) (allowing all rating factors except gender, claims experience, health status, and duration of coverage). Health status: MONT. CODE ANN. §§ 33-22-1809(1)(b) (2008). Health Status Rate Band: ± 25%

Nebraska: Gender and age: NEB. REV. STAT. § 44-5258(1)(j) (2008). Health status: NEB. REV. STAT. § 44-5258(1)(b) (2008). Health Status Rate Band: ± 25%

Nevada: Gender and age: NEV. REV. STAT. § 689C.145 (2008). Health status: NEV. REV. STAT. § 689C.230(2) (2008). Health Status Rate Band: ± 30%

New Hampshire: N.H. REV. STAT. ANN. § 420-G:4(1)(e)(1) (2008) (prohibiting small employer insurance carriers from setting premium rates based on characteristics of the small employer other than age, group size, and industry classification).

New Jersey: N.J. STAT. ANN. § 17B:27A-25(a)(3) (West 2008) (providing that the premium rate charged by a small employer insurance carrier to the highest rated small group shall not be greater than 200% of the premium rate charged to the lowest rated small group purchasing the same plan, “provided, however, that the only factors upon which the rate differential may be based are age, gender and geography”). Rate Band for Age, Gender & Geography: ± 200%

New Mexico: Gender and age: N.M. STAT. § 59A-23C-5.1(A) (2008). Health status: N.M. STAT. § 59A-23C-5(A)(2) (2008). Health Status Rate Band: ± 20%

New York: N.Y. INS. LAW § 3231(a) (McKinney 2008) (requiring all small employer insurance plans to be community rated and defining “community rating” as “a rating methodology in which the premium for all persons covered by a policy or contract form is the same based on the experience of the entire pool of risks covered by that policy or contract form without regard to age, sex, health status or occupation”).

North Carolina: N.C. GEN. STAT. ANN. § 58-50-130(b)(1) (West 2008). Health Status Rate Band: ± 25%

North Dakota: Gender and age: N.D. CENT. CODE §§ 26.1-36.3-04(2)(g), 26.1-36.3-01(6) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: N.D. CENT. CODE § 26.1-36.3-04(2)(b) (2008). Health Status Rate Band: ± 20%

Ohio: Gender and age: OHIO REV. CODE ANN. § 3924.01(E) (West 2008). Health status: OHIO REV. CODE ANN. § 3924.01(A)(1) (West 2008). Health Status Rate Band: ± 40%

Oklahoma: Gender and age: OKLA. STAT. tit. 36, § 6512(7) (2008). Health status: OKLA. STAT. tit. 36, § 6515(A)(4) (2008). Health Status Rate Band: ± 25%

Oregon: OR. REV. STAT. § 743.737(8)(b)(B) (2008) (providing that small employer insurance carriers may only vary the community rate by ± 50% based on age, employer contribution level, employee participation level, the level of employee engagement in wellness programs, the length of time during which the small employer retains uninterrupted coverage with the same carrier, and adjustments based on level of benefits).

Pennsylvania: 40 PA. CONS. STAT. §§ 1-6701 (2008), 31 Pa. Code §§ 11.2-303.1 (2008) (no statute or regulation imposes any rating restrictions on the small group market).

Rhode Island: Gender and age: R.I. GEN. LAWS § 27-50-5(a)(1) (2008). Health status: R.I. GEN. LAWS § 27-50-5(2) (2008). Health Status Rate Band: ± 10%

South Carolina: Gender and age: S.C. CODE ANN. §§ 38-71-940(B), 38-71-920(5) (2008). Health status: S.C. CODE ANN. § 38-71-940(A)(2) (2008). Health Status Rate Band: ± 25%

South Dakota: Gender: S.D. CODIFIED LAWS §§ 58-18B-3, 58-18B-1(4) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Age: S.D. CODIFIED LAWS § 58-18B-17 (2008). Health status: S.D. CODIFIED LAWS § 58-18B-3(2) (2008). Age Rate Band: 3:1, Health Status Rate Band: ± 25%

Tennessee: Gender and age: TENN. CODE ANN. §§ 56-7-2207(b)(7), 56-7-2203(6) (West 2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: TENN. CODE ANN. § 56-7-2209(b)(2) (West 2008). Health Status Rate Band: ± 35%

Texas: Gender and age: TX. INS. CODE ANN. §§ 1501.210(a), 1501.210(c) (Vernon 2008). Health status: TX. INS. CODE ANN. § 1501.204(2) (Vernon 2008). Health Status Rate Band: ± 25%

Utah: Gender and age: UTAH CODE ANN. §§ 31A-30-106(1)(h), 31A-30-103(6) (West 2008). Health status: UTAH CODE ANN. § 31A-30-106(b)(i) (West 2008). Health Status Rate Band: ± 30%

Vermont: VT. STAT. ANN. tit. 8, § 4080a(h)(1) (2008) (prohibiting the use of the following rating factors when establishing the community rate: demographics including age and gender, geographic area, industry, medical underwriting and screening, experience, tier, or duration); VT. STAT. ANN. tit. 8, § 4080a(h)(2) (2008) (providing that upon approval by the insurance commissioner, insurers may adjust the community rate by a maximum of 20% for demographic rating including age and gender rating, geographic area rating, industry rating, experience rating, tier rating, and durational rating).

Virginia: Gender and age: VA. CODE ANN. § 38.2-3433(A)(1) (West 2008) (allowing insurance carriers offering essential and standard plans in the small employer market to use age, gender, and geography as rating factors). Health status: VA. CODE ANN. § 38.2-3433(A)(2) (West 2008). Health Status Rate Band: ± 20%

Washington: WASH. REV. CODE § 48.21.045(3)(a) (2008) (providing that small employer insurance carriers may only vary the community rate based on geographic area, family size, age, and wellness activities).

West Virginia: Gender and age: W. VA. CODE §§ 33-16D-5(b), 33-16D-2(d) (2008) (allowing small employer insurance carriers to set premium rates based on demographic characteristics of the small employer). Health status: W. VA. CODE § 33-16D-5(a)(2) (2008). Health Status Rate Band: ± 30%

Wisconsin: Gender and age: WIS. STAT. § 635.02(2) (2008). Health status: WIS. STAT. § 635.05(1) (2008). Health Status Rate Band: ± 35%

Wyoming: Gender and age: WYO. STAT. ANN. § 26-19-304(a)(xi) (2008). Health status: WYO. STAT. ANN. § 26-19-304(a)(iii) (2008). Health Status Rate Band: ± 35%