



**INSURING THE HEALTHY OR INSURING THE SICK?
THE DILEMMA OF REGULATING THE INDIVIDUAL
HEALTH INSURANCE MARKET**

FINDINGS FROM A STUDY OF SEVEN STATES

Nancy C. Turnbull and Nancy M. Kane
Harvard School of Public Health

February 2005

ABSTRACT: The market for people who buy their own coverage has long been a troubled segment of the health insurance industry. Individual policies frequently are unavailable to those with preexisting health conditions, premiums are expensive, and benefits are limited. Many states have attempted to reform their individual health insurance market by requiring carriers to sell coverage to all applicants regardless of age or health; creating high-risk pools for those with preexisting conditions; and placing limits on the extent to which premiums can vary by age, sex, or health status. This study assesses the effectiveness of such regulatory reforms in seven states. The authors endorse reforms that deal with availability and affordability, including requiring insurers to offer coverage to all with reasonable waiting periods for preexisting conditions; requiring standardized benefits; limiting permissible rating factors and rate variation; and most important, finding ways to insure individuals through the group market.

[Click here](#) to view the state case studies.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to The Commonwealth Fund or its directors, officers, or staff, or to members of the Task Force on the Future of Health Insurance.

Additional copies of this (#771) and other Commonwealth Fund publications are available online at www.cmwf.org. To learn about new Fund publications when they appear, visit the Fund's Web site and [register to receive e-mail alerts](#).

CONTENTS

List of Tables and Figures.....	iv
About the Authors.....	v
Acknowledgments.....	v
Executive Summary.....	vi
Background.....	1
Previous Research.....	4
Project Approach.....	6
Findings.....	11
Discussion and Recommendations.....	32
Conclusion.....	39
Notes.....	41

LIST OF TABLES AND FIGURES

Table ES-1	Medical Loss Ratios in the Individual Market Dominant Carriers Before and After Reform	ix
Table ES-2	Individual Health Insurance Premiums as a Percentage of 200% Federal Poverty Income Level, Product Close to a \$500 Deductible with 20% Coinsurance	x
Table 1	State Regulatory Approaches: Availability of Coverage.....	9
Table 2	State Regulatory Approaches: Affordability of Coverage.....	10
Table 3	State Regulatory Approaches: Product Standardization and Reinsurance	10
Table 4	Health Insurance Coverage of the Nonelderly, 2001–2002	11
Table 5	Percent of Applicants Rejected by Carriers in Weaker-Regulation States ...	13
Table 6	Coverage of Maternity, Behavioral Health, and Drugs in Individual Health Insurance Policies	14
Table 7	2003 Monthly Premium Rates, Three Sample Family Situations, Product Close to a \$500 Deductible with 20% Coinsurance	18
Table 8	2003 Monthly Premium Rates, Three Sample Family Situations, Least Expensive Product.....	19
Table 9	Individual Health Insurance Premiums as a Percentage of 200% Federal Poverty Level, Product Close to a \$500 Deductible with 20% Coinsurance	20
Table 10	Individual Health Insurance Premiums as a Percentage of 200% Federal Poverty Level, Least Expensive Product.....	21
Table 11	State High-Risk Pools.....	22
Table 12	Carrier Participation and Market Share of Dominant Carrier	24
Table 13	E-Health Insurance Web Site Carriers and Number of Plans Available in Each State	26
Table 14	Medical Loss Ratios in the Individual Market Dominant Carriers Before and After Reform	30
Table 15	Range of Monthly Premium Rates in Massachusetts for Standard HMO and PPO Products	31
Figure 1	Monthly Premium Rates by Health Risk Category, Single Coverage, 25-Year-Old Male	16
Figure 2	Monthly Premium Rates by Health Risk Category, Single Coverage, 60-Year-Old Male	16
Figure 3	Difference in Premium Rates for a 60-Year-Old Male vs. a 25-Year-Old Male.....	17

ABOUT THE AUTHORS

Nancy C. Turnbull, M.B.A., is lecturer in health policy at the Harvard School of Public Health. Her research interests include regulation of health insurers, access to health insurance, and Medicaid policy. She is a former first deputy commissioner of insurance in Massachusetts. Ms. Turnbull earned her master's degree in business administration from the Wharton School of the University of Pennsylvania.

Nancy M. Kane, D.B.A., is professor of management at the Harvard School of Public Health. Her research interests include measuring hospital financial performance, quantifying community benefits and the value of tax exemption, and global applications of managed care concepts. Dr. Kane earned her master's and doctoral degrees in business administration from Harvard Business School.

ACKNOWLEDGMENTS

The authors thank Claudia Rozas for her excellent assistance on this project. We hope the health insurance market in Peru will benefit from the lessons she learned in the United States. We also thank Margaret Koller and Amy Tiedemann of the Rutgers University Center for State Health Policy, who conducted interviews in New Jersey and shared many insights and data from their work.

EXECUTIVE SUMMARY

Federal and state policymakers are considering a variety of policy approaches—such as tax credits—to expand health insurance coverage through the individual health insurance market. For these policy approaches to succeed, there must be a well-functioning individual health insurance market where reasonably comprehensive coverage is both available and affordable.

The individual market currently is quite small, covering approximately 17 million nonelderly Americans, or about 6.7 percent of the population. This market historically has not worked well for many people seeking coverage, in particular for those who need coverage the most. Policies frequently have been unavailable to people with existing health conditions; premiums have been expensive and usually have risen faster than group insurance rates; and benefits have generally been far more limited than those in group policies.

In response to these problems over the past decade, most states have implemented some type of individual health insurance reform in an attempt to improve access to coverage in the individual health insurance market. The type of reforms has varied. But most states have included some combination of regulations that require carriers to sell coverage to all applicants regardless of age or health; create high-risk pools for individuals with preexisting medical problems; and place limits on the extent to which premiums can vary by age, sex, or health status.

Our project assessed these regulatory reforms by examining the individual health insurance markets in seven states that adopted different regulatory approaches. Three of the study states, Massachusetts, New Jersey, and New York, have enacted and maintained relatively strict regulation of this market. Two states, Kentucky and Washington, enacted strict regulations but subsequently rolled back many of their reforms. The other states, Iowa and Kansas, adopted much weaker regulation of the individual market. One of our goals was to analyze how well state regulatory policies created and maintained effective individual health insurance markets. A second goal was to assess the likely impact and implications of federal and state policies that would place a greater reliance on the individual market as a source of health insurance for working families.

Key Findings

- *Stricter regulation has made an important difference, but affordability is still a major problem.*
Three states adopted more stringent regulation and then had the political will and

regulatory resolve to stay the course. They have created individual health insurance markets where comprehensive coverage is available to all, there is some choice of product and carrier, and premiums are more affordable for higher-risk people at the expense of less-affordable coverage for younger and healthier individuals. For instance, in New York, a state with strict regulation, a standard individual product costs about \$5,200 per year regardless of age or health status. An older individual will pay much higher premiums than younger, healthier individuals in less-regulated states.

Participating carriers did not experience any significant selection spiral or other type of market meltdown. All three states were helped by pre-reform conditions and in particular by the presence of several local carriers that were mandated to stay in the local market.

- ***Older or less healthy consumers face a range of problems in the weaker-regulation states.*** In the four states with weaker regulations, a significant percentage of applicants—as many as 30 percent to 40 percent for some carriers—is rejected for coverage, leaving these people with no option except high-risk pools with very expensive premiums. Even for those who qualify for market plans, permanent exclusions can be imposed for preexisting medical conditions. Policies often lack coverage for such important benefits as maternity, mental health, or prescription drugs. Premiums vary widely by age, gender, and health status, with as much as a 14- to 17-fold difference in premium rates for the same product based on age and health status. In 2003, for example, a healthy 25-year-old male in Kentucky could buy a \$2,500 deductible policy covering prescription drugs and mental health for only \$624 per year. The same product for a 63-year-old cost \$2,736 per year, a roughly fourfold difference. If the 63-year-old were unhealthy and eligible for coverage in the high-risk pool, the cheapest premium for similar benefits (with an \$1,800 deductible) was \$10,800 per year, a more than 17-fold difference from the cost of the premium for the healthy 25-year-old. Carriers continue to compete through marketing and product design techniques that are designed to encourage favorable selection and discourage high-risk applicants.
- ***State high-risk pools are not an adequate alternative to stricter regulation.*** Despite being the only source of coverage for many older and less-healthy consumers, the high-risk pools in the less-regulated states cover very few people. They also offer coverage that is very expensive, generally from 125 percent to 150 percent of the rates charged by carriers in the individual market, and there is as much as a threefold variation in premiums for the same product based on age. In Washington, for example, high-risk pool monthly premiums for the least-expensive product vary from \$235 to \$710 per person (\$2,820 to

\$8,520 per year) based on age, which represents between 6 percent and 19 percent of *median* family income in the state. As a result, high-risk pool subsidies tend to go to relatively high-income people, including those who can afford premiums well above market rates.

- *A few carriers in each state dominate the individual health insurance market, a trend that has strengthened over time.* Carrier withdrawals occurred in every state after reforms were enacted. Despite these withdrawals, the basic structure of the individual market, including the dominance of a carrier, has been relatively unchanged regardless of the state's regulatory approach. Market shares of the dominant carrier range from 50 percent to 90 percent. The withdrawal of carriers suggests that reform has made the individual market less attractive for some insurers in some states. Yet the individual market has been profitable for the largest carriers in each of the study states, perhaps as a result of increased market consolidation and weak regulation of premiums. The dominant carriers in each state have medical loss ratios (MLRs)—the proportion of premium devoted to medical expenses—that generally stayed the same or improved since the 1990s. As of 2002, loss ratios in the individual market in the study states were in the 70 percent to 85 percent range, with the exception of one or two carriers that had been losing money throughout the decade (Table ES-1).

Table ES-1. Medical Loss Ratios in the Individual Market Dominant Carriers Before and After Reform

State	Carrier	Average before reform	1998	1999	2000	2001	2002
Weaker Regulation							
IA	Wellmark	84.3%	83.3%	84.3%	82.1%	81.0%	80.5%
KS	BCBS of Kansas	~80%	84.8%	81.8%	84.7%	82.6%	80.2%
KY	Anthem of KY	75.9%	92.1%	83.5%	80.6%	69.2%	69.1%
WA	Premera BC		80.0%	80.8%	79.8%	83.4%	83.5%
	Regence BS	130.8%	90.8%	78.4%	82.8%	81.7%	84.8%
	Group Health	123.3%	98.2%	90.8%	99.4%	97.6%	110.8%
Stronger Regulation							
MA	BCBS	90+%	87.7%	90.4%	83.0%	84.4%	79.8%
NJ	Horizon*	n/a	81.9%	74.5%	77.5%	76.0%	77.6%
NY	Empire	150+%	Files not available from regulators	Not reported by carrier	85.2%	Not reported	83.9%
	Oxford	Not offered	Files not available from regulators	Not reported by carrier	85.1%	89.1%	97.4%

Includes Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey.

Source: Authors' analysis of carrier financial statements and regulatory filings.

- *Carriers can sometimes exploit differences in regulation among states to evade regulatory requirements.* Regulators have struggled over policy issues related to associations that are exempt—or claim to be exempt—from individual market reform. Some associations have been able to medically underwrite and reject applicants even in highly regulated markets.
- *Regardless of regulatory approach, affordability of coverage is a major problem in every state.* In each study state, premiums are often unaffordable compared to the family income level of the country's uninsured population, even for the young and healthy. As shown in Table ES-2, at 200 percent of federal poverty income level, the most popular individual products in our seven state sample would represent a high percentage of income for both older adults and younger adults with health problems in all the states represented, regardless of regulations.

Table ES-2. Individual Health Insurance Premiums
as a Percentage of 200% Federal Poverty Income Level,
Product Close to a \$500 Deductible with 20% Coinsurance
(includes benefits for maternity, mental health, and prescription drugs)

State	25-year-old male	35-year-old couple with two children	63-year-old couple two-person contract
200% FPL (2003)	\$17,960	\$36,800	\$24,240
Stronger Regulation			
MA	25%	28%	64%
NJ	33%	48%	52%
NY	29%	42%	43%
Weaker Regulation			
IA			
Market	9%	18%	37%
High-risk pool	37%	54%	129%
KS			
Market	n/a	n/a	n/a
High-risk pool	37%	57%	116%
KY			
Market	5%	16%	35%
High-risk pool	22%	57%	116%
WA			
Market	15%	28%	58%
High-risk pool	20%	39%	96%

Source: Authors' analysis of state insurance department documents and interviews.

Policy Recommendations

While regulatory reforms cannot solve all of these problems, they can help improve the health of the individual health insurance market. We recommend that states adopt a minimum set of regulatory reforms that deal with the problems of availability and affordability. These reforms include:

- *Require carriers to offer coverage to all, with reasonable waiting periods for preexisting conditions for those who do not have continuous prior coverage.* Guaranteed-issue requirements function better than high-risk pools, which work only for a very few people with sufficient income to pay very high premiums.
- *Standardize benefits, but permit some variation in cost-sharing.* Unless a uniform scope of benefits is required, consumers will attempt to buy products based on their actual or

perceived health needs. Carriers will try to guard against this adverse selection by limiting or eliminating benefits for certain services.

- ***Limit permissible rating factors and rate variation.*** States that have not imposed stringent restrictions on permissible rating factors have extremely large variations in premium rates. These variations undermine the purpose of insurance—having the healthy help pay for the sick—and make coverage unaffordable for people who are older and at higher risk.
- ***Impose clear standards for market conduct, including permissible marketing practices.*** In each of the study states, carriers have employed a variety of techniques to sell coverage to lower-risk consumers or to attempt to avoid higher-risk individuals. Problematic market conduct will always occur, even in the most well regulated markets. But clear and strict rules about permissible and impermissible practices would give regulators the legal authority they need to take action when needed and have a strong deterrent effect on some carriers.
- ***Undertake more active monitoring of the individual health insurance market.*** In the seven states we studied, there is very little active monitoring of the individual health insurance market, in part because there is very little information available to allow monitoring. Inadequate reporting systems and limited analytical capacity of regulatory agencies make it difficult, if not impossible, for policymakers to get an accurate and comprehensive picture of the individual health insurance market, or to fully understand the impact of regulatory reforms. These limitations make policy discussions particularly susceptible to anecdotes and unsupported assertions. They also make it difficult for regulators to fully enforce the provisions of the individual health insurance laws.
- ***Adopt a strict and consistent definition of who is eligible to purchase individual health insurance.*** States have adopted different definitions of who is eligible for individual insurance. Without clear rules about eligibility, there is too much opportunity for gaming and risk selection across carriers or among markets: between the individual and small-group markets, for example, or between the self-employed and groups of one.
- ***Clarify the link between the individual and small-group markets.*** There must be coherent boundaries and consistent rules between the small-group and individual markets. In certain areas, such as guaranteed issue, rules must be identical to prevent adverse selection between the markets. In other areas, such as product design, there is room

for different requirements, provided careful consideration is given to the potential consequences of the differences.

- ***Make associations play by the same rules.*** Associations and other group arrangements have been used to evade or undermine regulatory reforms in many states, creating market disruption and leaving consumers without important protections. Rather than endorsing proposals to preempt any meaningful oversight of associations, policymakers should impose stricter regulation on associations. The lack of uniform national rules that govern associations creates cherry-picking opportunities for carriers.
- ***Find ways to keep as many people as possible in the group market.*** The group market has many inherent advantages over the individual insurance market: risk pools are larger, buyers have more purchasing power, carriers and consumers have less opportunity for risk selection, administrative costs are lower, and coverage is generally less expensive. Policymakers should therefore support approaches that make group coverage available to as many people as possible. Such methods include requiring the self-employed to purchase coverage in the group market, extending the federal COBRA law, and requiring carriers (and employers) to allow dependents to remain eligible for coverage under their parents' policy until the age of 25.
- ***Promote mechanisms to make individual health insurance more affordable by spreading costs of the individual market more broadly.*** Affordability is a major barrier to the expansion of the individual health insurance market. Several states have tried to address this problem by spreading the costs of this market more broadly by using such techniques as reinsurance pools, assessments on group health insurers, and sliding-scale premium subsidies funded with public funds. These approaches have been somewhat successful. Still, policymakers also need to address the underlying medical expenses that drive much of the cost of individual health insurance. Otherwise, tax credits and other policy approaches are unlikely to have much success because many uninsured people have relatively low incomes.

A stronger approach to regulating the individual insurance market would be for the federal government to set model, minimum standards in key areas. This approach is desirable for several reasons. States vary considerably in their political environment, resources, and capabilities. Their ability to adopt and enforce reasonable regulatory standards varies according to the size and attractiveness of their markets to insurers. Smaller states often are unable to enact and implement strong protections because of their vulnerability to carrier withdrawals and to other “divide and conquer” strategies by

regional and national insurers. Carriers also are able to capitalize on the weak regulations in some states as a way to avoid and undermine stricter requirements in other states. This strategy is illustrated in many states by the disruptive effect on the individual market of association plans and other group trusts. In addition, the individual market in many states is too small to be credible for rating purposes, and too small to spread risk and costs broadly across enrollees, particularly if many carriers sell insurance in the state.

A complete federal takeover of health insurance regulation is risky because it might reflect the lowest common denominator level of the 50 states. But the adoption of a set of minimum federal regulatory standards would ensure a base of protection in every state, while permitting states to adopt more stringent approaches based on their own market conditions and philosophies.

Conclusion

The individual health insurance market can be improved somewhat with better and more consistent regulation, particularly if the stricter regulatory approaches we outline are adopted voluntarily by states or imposed on all states through the adoption of minimum federal standards. Even with these reforms, however, the individual market will continue to present a trade-off between availability to those with health conditions and affordability for healthy and low-risk individuals. In a system where purchasing health insurance continues to be voluntary, insurers and consumers are locked into a dance of avoiding the high-risk population. Policymakers must be realistic about the potential for using the individual health insurance market to make a significant dent in the growing problem of the uninsured. In particular, they should carefully consider if the individual health insurance market is the most efficient and affordable means to promote increased health coverage for the rising number of people without insurance. Other approaches—including permitting lower-income consumers to buy into public programs—are more promising means of reducing the number of uninsured Americans.

INSURING THE HEALTHY OR INSURING THE SICK? THE DILEMMA OF REGULATING THE INDIVIDUAL HEALTH INSURANCE MARKET

BACKGROUND

In 2003, approximately 17 million nonelderly Americans were covered by individual insurance policies.¹ An individual policy is obtained directly from an insurer, rather than through a group policy offered by an employer or other group policyholder. Although the individual market currently is quite small, covering approximately 17 million nonelderly Americans, or about 6.7 percent of the population, it is a very important market for populations that do not have access to employer-based health insurance. These groups include the self-employed, early retirees, young adults who have aged off their parents' coverage, and people who are between jobs.² One study concluded that one in four working-age adults had sought coverage in the individual health insurance market over a three-year period.³

In addition, the size and importance of the individual insurance market may grow in the future. According to the Census Bureau, the number of uninsured rose to 45 million in 2003, an increase of 5 million people or 14 percent since 2000.⁴ The proportion of the working age population covered by employer-group insurance has been falling for several years due to a decline in offer rates among smaller firms, changes in eligibility, and declines in the number of eligible workers enrolling in employer-sponsored plans, especially among smaller employers.⁵ These trends make the individual market more important as a potential source of coverage for a growing number of consumers.

Other trends may also increase the size of the individual market. Employers are considering new options for containing rising insurance costs, including medical savings accounts and defined contribution plans, that give employees money to purchase insurance on their own. New federal tax provisions also encourage purchase of high-deductible, individual insurance policies.⁶ At the federal level, there is active debate about proposals to expand coverage of the uninsured by subsidizing the cost of individual health insurance through tax credits. Other proposals under consideration at the federal level include expanding eligibility for public insurance programs, and encouraging association health plans for small businesses.^{7,8}

Conventional wisdom based on experience and evidence holds that the individual insurance market is challenging for both consumers and insurers. Insurers fear adverse selection: the likelihood in a voluntary individual insurance market that people who are in poorer health will seek coverage more often than those who are healthy. Health insurers

have historically adopted a variety of medical underwriting, product design, and rating approaches to protect against adverse selection and maintain the affordability of individual health insurance for healthier, lower-risk consumers. These corporate practices had the effect of making individual health insurance unavailable for many people seeking coverage, particularly people who needed health insurance the most because of existing health conditions or risk factors that could lead to higher health care costs, such as smoking or obesity. Regardless of health status, premiums were considerably more expensive and usually rose faster than group insurance rates, and benefits were generally far more limited than in group policies.⁹

In response to these problems, in the past decade, most states have implemented individual health insurance reforms. States enact regulatory reform of the individual health insurance market in order to achieve one or more of the following policy goals:

- ***Portability of coverage:*** To ensure that people who have health insurance can continue to be covered with no interruption or limitation of benefits when they encounter life events that threaten coverage (including loss of a job, divorce, relocation, or change of insurance carrier).¹⁰
- ***Availability of coverage:*** To ensure that anyone who wants individual health insurance coverage can obtain it, regardless of health status or other risk factors, while maintaining sufficient participation by insurance carriers.
- ***Affordability of coverage:*** To maintain premium rates at a level that is affordable for higher-risk individuals but not so high as to discourage healthier individuals from purchasing coverage.

These policy goals conflict. For instance, reforms that make coverage more widely available to higher-cost individuals can result in higher premiums. States have made different decisions about how to balance these competing priorities in their regulatory schemes.¹¹

The policy and regulatory tools available to states to reform the individual health insurance market fall into several categories:

- ***Insurance rules:***
 - Requiring certain carriers to participate in the individual market.

- Requiring participating carriers to issue coverage to eligible individuals regardless of health status or other characteristics (so-called guaranteed-issue requirements).
 - Limiting the ability of carriers to impose exclusions or waiting periods for preexisting medical conditions.
 - Requiring carriers to renew coverage regardless of an individual's medical costs or other factors (so-called guaranteed-renewability).
 - Limiting or eliminating the ability of carriers to vary premium rates by individual characteristics—such as age, gender, or health status—with the least discriminatory rating being “community rating,” which usually reflects only the geographic cost differences of enrollees.
 - Standardizing products to ensure an adequate level of benefits, to allow consumers to compare products more easily, and to reduce the ability of carriers to use benefit design as a means to attract or deter certain types of people from applying for coverage.
- ***State-created or state-sanctioned purchasing pools or alliances:*** These are designed to increase the purchasing “clout” of consumers in the individual market, create more stable risk pools, and achieve economies of scale to reduce administrative and distribution costs.
 - ***High-risk pools:*** Some states establish these as a way of guaranteeing the availability of insurance to individuals who are unable to obtain coverage in the individual health insurance market.
 - ***Subsidy mechanisms:*** These make individual health insurance more affordable and can take a variety of forms, including:
 - Reinsurance or assessment mechanisms to spread the costs of those with individual coverage more evenly across all carriers in the individual market.
 - Assessments on all health insurers in the state in order to cross-subsidize some of the cost of those with individual health insurance.
 - State-supported premium discounts or subsidies to make individual health insurance more affordable to some group of eligible people.

PREVIOUS RESEARCH

Prior research on the individual health insurance market has focused on a wide range of topics. These issues include the availability of coverage for those with health conditions, the affordability of coverage, the effect of market reforms in specific states, and the potential impact of tax credits as a mechanism to increase coverage. Different researchers have come to various conclusions about how well the individual health insurance market functions under reforms, depending on what they considered to be the objective of the reform. As a society, we lack consensus on our basic expectations of the individual health insurance market. For whom does the market need to work? The healthy? People in poorer health? What standards should be used to assess whether premiums are affordable? What benefits must be included in an individual health plan for it to be adequate? When is cost-sharing so high as to be unreasonable? How many health insurers are enough to ensure adequate choice and availability for consumers? What is the purpose of insurance: to have the healthy help pay for the sick, or is it a means of enforced saving for medical expenses?

Another consideration is that states have very different market structures and political climates. Many states have experienced considerable turmoil in their individual markets over the last decade, with frequent legal and regulatory revisions and in some cases rollbacks or repeals of reforms. In addition, reform of the individual health insurance market has occurred simultaneously with other health insurance reforms (such as small-group health insurance reform, the enactment of HIPAA, Medicaid expansions) and with other changes in the health care systems (rising health care costs and the managed care backlash). These factors make it difficult to draw causal inferences about the impact of individual reform alone. Finally, in many states even the most basic data about the individual health insurance market are often incomplete or lacking entirely, especially data about what markets looked like before and after the passage of individual market reforms.

Despite these challenges, several consistent themes emerge in previous research about the individual health insurance market.

Characteristics of Consumers Who Purchase Individual Coverage

The people who buy individual health insurance fall mainly into two groups. In the first group most people work full-time and year-round, are adults aged 45 or younger, and have incomes greater than 300 percent of the federal poverty level.^{12,13} Individuals in the second group are older, work part-time and/or part of the year, are self-employed or work for smaller firms, live in smaller cities or rural areas, and are poor or on the edge of poverty.

Characteristics of Products Offered

- Individual health insurance is often unavailable to people with health problems or is issued with exclusions, restrictions, and/or higher premiums.^{14,15}
- Premium costs are high, particularly when compared to the group market.¹⁶
- Administrative costs are generally much higher than in group policies so that a smaller proportion of premiums is paid out for medical costs.¹⁷
- Premiums vary widely by age, increasing steeply for older people.^{18,19,20,21}
- Holding premiums constant, benefits are less comprehensive and cost-sharing is higher for individual policyholders than those with group coverage.²²
- Managed care products have been much less common in the individual market than among groups, even in states with significant managed care penetration.²³

Characteristics of Markets

- The market has always been very concentrated, with a dominant carrier or two in most markets, although many other carriers sell coverage in at least some states. Blues plans have been the dominant carrier in most states.²⁴
- There is considerable turnover in the individual health insurance market. For most participants, the market is a source of short-term coverage (average of one or two years) while they are between jobs or have otherwise temporarily lost group coverage.²⁵

Outcomes of Regulatory Reforms

- State reforms have had little, if any, significant effect on increasing the number of people with coverage and might have slightly reduced coverage in some states.^{26,27,28,29,30}
- Reforms in many states have created winners and losers. Guarantee issue requirements, for example, have made coverage more available to those in high-risk groups, including people who are older or in poorer health. Yet community rating has dramatically increased coverage costs for younger, healthier people.^{31,32,33,34,35,36,37,38}
- In most states, market reforms have reduced the number of carriers in the individual market, thereby reducing choices for better-risk consumers.^{39,40}

- The adoption of standardized benefits has increased the scope of coverage available to some consumers, while reducing the availability of less comprehensive, lower cost products.
- Reform in most states has also caused the individual market to shift away from indemnity products to managed care.⁴¹

Projected Impact of Tax Credit Proposals

Due to the growing interest in federal tax credits as a way to increase health coverage, several recent studies have examined the potential effects of such credits on the purchase of individual health insurance.

- The estimated impact varies widely, ranging from a 10 percent increase in coverage among the uninsured to an increase of 85 percent.^{42,43,44} These estimates are highly sensitive to assumptions about the size and structure of the credit and the cost of premiums that consumers must pay.
- While several studies assert that tax credits will make individual insurance less costly by bringing younger and healthier people into the individual market and by increasing the availability of innovative, lower-cost products, there seems to be little empirical evidence on these issues.^{45,46,47,48}

PROJECT APPROACH

The regulatory approaches taken by certain states have been studied extensively. Much of this research, however, is several years old and has focused mainly on states that enacted significant reforms. Relatively less is known about states that enacted less comprehensive or minimal reforms. Little is known about the relative strengths and weaknesses of different regulatory approaches.

Our project had three goals:

- To assess how different state regulatory approaches affected the availability and affordability of individual health insurance.
- To analyze the political and practical feasibility of state regulatory approaches, with a particular emphasis on industry responses to regulation.
- To identify regulatory approaches, such as tax credits, that might enhance the potential effectiveness of federal policies that rely on the individual market as a source of health insurance for working families.

Selection of States to Study

We selected the seven study states based on regulatory approach, geographic diversity, the relative size of the individual market, and paucity of previous research. Among the fifty states, only a few states have enacted stronger reforms that include community rating for the individual market. As of 2004, approximately five to seven states have some form of community rating. Among the other states, regulations range from very weak to modest and have varied over time.⁴⁹

To explore a range of states and approaches, we included three states that instituted strong reforms in the mid-1990s, two states that instituted strong reforms but subsequently rolled them back, and two states that did not significantly reform the individual market over the last decade.

Based on these criteria, the seven states we selected were:

Stronger Regulation: Community-Rated States

1. **Massachusetts:** Enacted fairly strict reforms in 1996; revised somewhat in 2000.
2. **New Jersey:** Enacted strict reforms in 1993, at the same time as major reforms of its small-group health insurance market.
3. **New York:** Enacted strict regulations in 1993 at the same time as major reforms of the small-group market. Individual reforms were revised significantly in 1996 and slightly in 2000.

Weaker Regulation

Minor reforms

4. **Iowa:** Relatively little regulation; adopted some rating and portability reforms in the individual market in 1996; some revisions in 1997, mainly to comply with HIPAA. The individual insurance market is very important in the state.
5. **Kansas:** Little regulation; individual market important in the state.

Rollback of major reforms

6. **Kentucky:** Major reforms adopted in 1994, rolled back in 1996, 1998, and 2000.
7. **Washington:** Enacted major reforms in 1993, rolled back in 2000.

The stronger-regulation states are unique in their regulatory approach. Most states' regulatory schemes are similar to those in the weaker-regulation states.

Data Collection

In each study state we collected available information from two major types of sources:

- publicly available data such as regulations, regulatory filings, consumer guides, carrier financial reports, published industry analyses, and relevant research literature on each state; and
- interviews with “key informants” who understand the workings of the individual insurance market in each state. These key informants included insurance regulators, key legislators and staff, representatives of insurance carriers operating in the state, insurance agents and brokers, consumer advocates, and other individuals who are knowledgeable about that state’s individual insurance market. On average, we interviewed eight to ten people in each state.⁵⁰

Tables 1–3 compare the most important features of the regulatory schemes in the seven states, grouping the states into those that have adopted “stronger regulation” and those that have adopted “weaker regulation.”

The stronger-regulation states—Massachusetts, New Jersey, and New York—have taken similar approaches, although Massachusetts has adopted modified community rating, with a 2:1 rate band. This means that the rates for the oldest age category, for example, cannot be more than twice the rates for the youngest age category for the same benefit package and geographic area. Meanwhile, New Jersey and New York require full community rating. In all three states carriers must accept all applicants for coverage, regardless of health status. Regulations also prohibit permanent exclusion of any health condition.

The weaker regulation states, Iowa, Kansas, Kentucky, and Washington, also have generally similar regulatory schemes. Each of these states allows carriers to accept or reject applicants for coverage based on medical underwriting criteria and uses a state high-risk pool as the mechanism to ensure availability of coverage. Washington requires the use of a uniform health questionnaire to determine whether an applicant can be rejected by carriers. Kansas and Kentucky permit carriers to impose permanent exclusions for preexisting medical conditions. All of the weaker-regulation states also allow carriers much more rating latitude than in the three community-rated states. All four allow rates to vary by age and health status, and Iowa and Kansas also permit gender-based rating. As discussed below, while prior review of rates is required in four of the states, actuarial standards are weak and rates are actually subject to very little scrutiny.

As illustrated in Table 3, the three states with stronger regulations also specify a range of standardized benefit packages. These prescribe a range of benefits that must be included in individual health products plans but also allow variation in cost-sharing. The standardized range of benefit structures and variations facilitates comparisons across carriers participating in the market.

Table 1. State Regulatory Approaches: Availability of Coverage

	Stronger Regulation			Weaker Regulation			
	MA	NJ	NY	IA	KS	KY	WA
May carriers reject applicant because of health history?	No	No	No	Yes, unless 12 months prior coverage	Yes	Yes	Yes, uniform health screener
% applicants rejected by largest carrier	0	0	0	~30%	~20%	10%–15%	<8%
Permanent exclusions allowed?	No	No	No	No	Yes	Yes	No
Preexisting condition waiting period?	6 months	12 months	12 months	12 months	24 months	12 months	9 months
High-risk pool?	No	No	No	Yes	Yes	Yes	Yes

Source: Authors' analysis of state insurance department documents and interviews.

Table 2. State Regulatory Approaches: Affordability of Coverage

	Stronger Regulation			Weaker Regulation			
	MA	NJ	NY	IA	KS	KY	WA
Rating by:							
Health status	No	No	No	Yes	Yes	Yes	Yes
Age	Yes	No	No	Yes	Yes	Yes	Yes
Gender	No	No	No	Yes	No	Yes	No
Limit on rate variations	Yes (2:1 band for age)	Yes (community rating)	Yes (community rating)	No	No	No	No
Minimum loss ratio	75%	75%	80%	60%	55%	70%	72%
Prior approval of rates and rate increases	No (unless rates exceed average by two standard deviations)	No (unless rate increase >10%)	Yes	Yes	De facto yes	Yes	No
Financial results on individual line	Profitable		Profitable	Profitable	Very profitable	Profitable	Very profitable

Source: Authors' analysis of state insurance department documents and interviews.

Table 3. State Regulatory Approaches: Product Standardization and Reinsurance

	Stronger Regulation			Weaker Regulation			
	MA	NJ	NY	IA	KS	KY	WA
Standardized products?	Yes	Yes	Yes	No	No	No	No
Number and type of standard products	3 •HMO •PPO •Indemnity	5 •4 indemnity •1 HMO	2 •HMO •PPO				
Reinsurance pool among carriers?	Yes Funded by carriers	Yes	Yes Funded by state (\$39M in 2002)	No	No	No	No
Type of reinsurance mechanism	Carriers may cede individuals to pool		Individual stop-loss for 90% of claims between \$20K–\$100K				

Source: Authors' analysis of state insurance department documents and interviews.

Table 4 shows the percent of the nonelderly population in each state covered by individual health insurance and the percent uninsured. The importance of the individual market as a source of coverage varies: it is comparable to the national average in Massachusetts and Washington, somewhat less important in Kentucky, New Jersey, and New York, and more important in Iowa and Kansas.⁵¹ A higher proportion of the population in each state is uninsured than covered by individual health insurance.

Table 4. Health Insurance Coverage of the Nonelderly, 2001–2002

State	% Individual	% Employer	% Medicaid	% Uninsured	Nonelderly population (thousands)	Population with individual coverage (thousands)
Stronger Regulation						
MA	4.4	70.5	13.3	10.4	5,548	244
NJ	3.0	71.4	8.9	15.5	7,353	221
NY	3.9	61.4	15.7	17.8	16,609	648
Weaker Regulation						
IA	8.4	71.2	9.1	9.8	2,498	210
KS	7.1	68	8.5	12.8	2,265	161
KY	4.2	64.3	11.9	14.9	3,483	146
WA	6.1	63.8	12.6	15.3	5,295	323

Source: Kaiser Commission on Medicaid and the Uninsured and state data (www.statehealthfacts.kff.org).

FINDINGS

Data Issues

The information available publicly in each state varied considerably. Pre- and post-reform enrollment was not readily available. Financial information available on nonlocal carriers was incomplete; states generally do not require national carriers to report state-specific enrollment information or state-specific financial results by line of business. States generally had state-specific financial information on local health carriers, particularly Blue Cross Blue Shield plans and HMOs, but carriers did not often report information on the profitability of their individual line of business, even when required on regulatory filings. When results for the individual health insurance line of business were provided, the data included disability, Medicare supplement, and often other types of “health” business. On occasion we could disaggregate results for different types of individual health insurance, but most often we could not.

Interaction between the individual and small-group markets is also difficult to assess from the available data. All of the study states enacted regulatory reform of the small-group market, either before or concurrent with individual market reform. The information on small-group enrollment and carrier financial results in the small group market is usually even spottier than the data for the individual market. For example, the number of covered lives in the individual market seems to have declined in most, if not all, of the study states after individual market reforms were enacted. But it is probable that small-group market reform enabled many individuals previously covered in the individual market to obtain coverage in the small-group market instead. Medicaid expansions in some states may also have made public coverage available to some people who had previously had individual policies. In addition, states generally do not collect information on the number of people insured through association plans or through other types of quasi-group arrangements by which many self-employed people obtain health insurance coverage.

As we discuss later in this paper, these data limitations make it difficult, if not impossible, for policymakers (and researchers) to get an accurate and comprehensive picture of the individual health insurance market, or to understand fully the impact of regulatory reforms on the individual market. This makes policy discussions particularly susceptible to anecdotes and unsupported assertions. It also makes it difficult for regulators to fully enforce the provisions of the individual health insurance laws.

Availability and Uptake of Individual Coverage

Coverage is theoretically “available” to anyone who can afford it. Despite different regulatory approaches, each state has created a system in which individual health insurance is offered to anyone who seeks it, either from a limited choice of carriers or from a high-risk pool. In every state this has led to a widespread perception that the market is “working well enough,” although in some market areas there may be only one choice available.

Often, in the weaker-regulation states, a significant proportion of applicants is rejected by carriers, leaving the high-risk pool as the only source of coverage. In interviews in the weaker-regulation states, we asked carriers and brokers for information on the percentage of applicants for individual health insurance that are rejected for coverage because of medical conditions or health status. As shown in Table 5, rejection rates for the dominant carrier varied from approximately 8 percent in Washington to 30 percent in Iowa. In our interviews, brokers reported rejection rates as high as 40 percent for some carriers. In addition, these figures likely understate the true impact of medical underwriting on the availability of coverage since there is significant “field underwriting,” where brokers or carriers recommend that

no application be completed because of the likelihood it will be rejected based on the consumer’s health history. In two of the states with weaker regulation, carriers can also impose permanent exclusions for preexisting medical conditions. In all the weaker-regulation states, carriers can use health status as a rating factor.

Table 5. Percent of Applicants Rejected by Carriers in Weaker-Regulation States

	IA	KS	KY	WA
Percent of applicants rejected by dominant carrier	~30%	~20%	~10%–15%	~8%

Source: Authors’ interviews with key informants.

In the weaker-regulation states, consumers may be unable to obtain coverage for such important benefits as maternity, mental health services, and prescription drugs. Benefits also can vary widely or be excluded altogether in the weaker regulation states. In the four states without standardized benefit packages, coverage is often limited for certain types of services (including maternity, mental health and substance abuse services, and prescription drugs), and can be unavailable or offered only as a rider (Table 6). Mental health benefits, for example, are not offered by carriers in Washington. While these benefits are sometimes available as riders or in certain products, their exclusion from some plans creates an opportunity for carriers for significant risk segmentation and positive risk selection. If products with and without these benefits are treated separately for rating purposes, as is permissible in each of the four states without standardized benefits, the cost of these services is spread over only a subset of individual health insurance policyholders. These people are likely to be those with higher medical needs and costs, resulting in rider premiums that are very expensive.

In addition to these benefit gaps, consumers in two of the less-regulated states, Kansas and Kentucky, may face permanent exclusions for preexisting medical conditions (Table 1).

Table 6. Coverage of Maternity, Behavioral Health, and Drugs in Individual Health Insurance Policies

State		Maternity included in all policies?	Mental health and substance abuse coverage included in all policies?	Prescription drugs included in all policies?
Stronger Regulation				
MA		Yes	Yes	Yes
NJ		Yes	Yes	Yes
NY		Yes	Yes	Yes
Weaker Regulation				
IA	Market plans	No	No	No
	High-risk pool	No	Yes	Yes
KS	Market plans	No	Yes	No
	High-risk pool	No	No	Yes
KY	Market plans	No	Yes	No
	High-risk pool	Yes	Yes	No (available as a rider)
WA	Market plans	No	No	Yes (as of 2000)
	High-risk pool	Yes	Yes	Yes

Source: Authors' analysis of state insurance department documents and interviews with key informants.

It is interesting that three of the four states that lack standardized benefit packages (Iowa, Kentucky, and Washington) have mandated a broader range of benefits for the high-risk pool than is generally available in the individual market. This condition can create adverse selection into the risk pool. It also can raise high-risk pool premiums even higher than they would be otherwise, based solely on the differences in health status between those in the risk pool and those in the regular individual market. Mental health coverage, for example, is unavailable in products sold in the individual market in Washington, but it is provided to people in the state's high-risk pool. According to our interviews, individuals with behavioral health needs often try to get into the high-risk pool in order to obtain more comprehensive benefits.

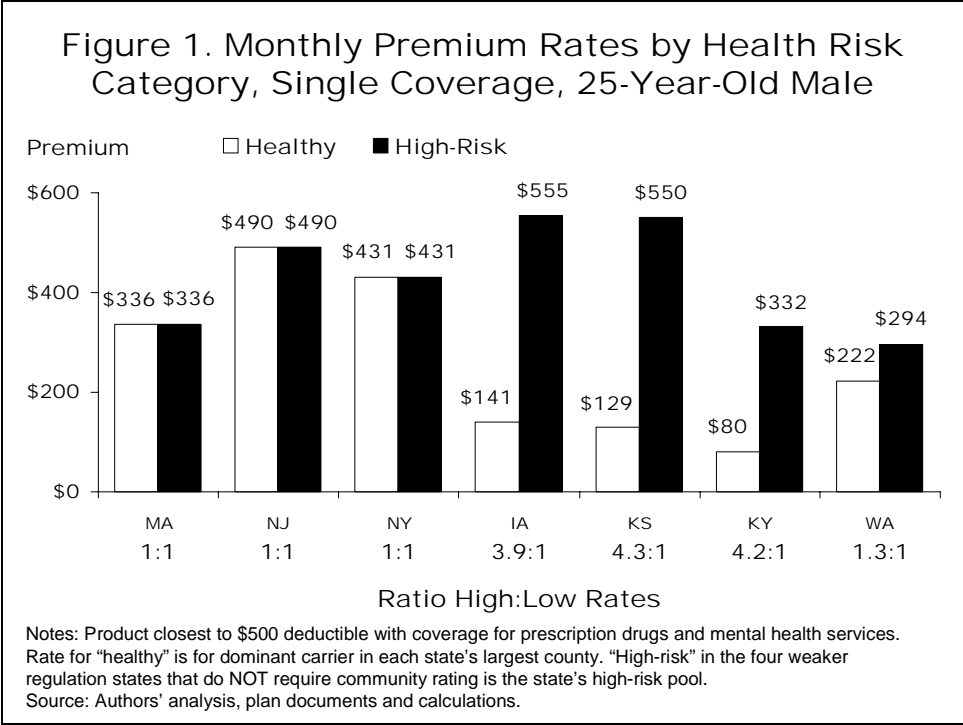
Affordability of Coverage

In less-regulated states, premiums vary significantly by individual demographic and health characteristics. The study states made different policy decisions about the degree of rate variation that they permitted in the individual health insurance market. New Jersey and New York require community rating: a carrier must charge the same premium for the

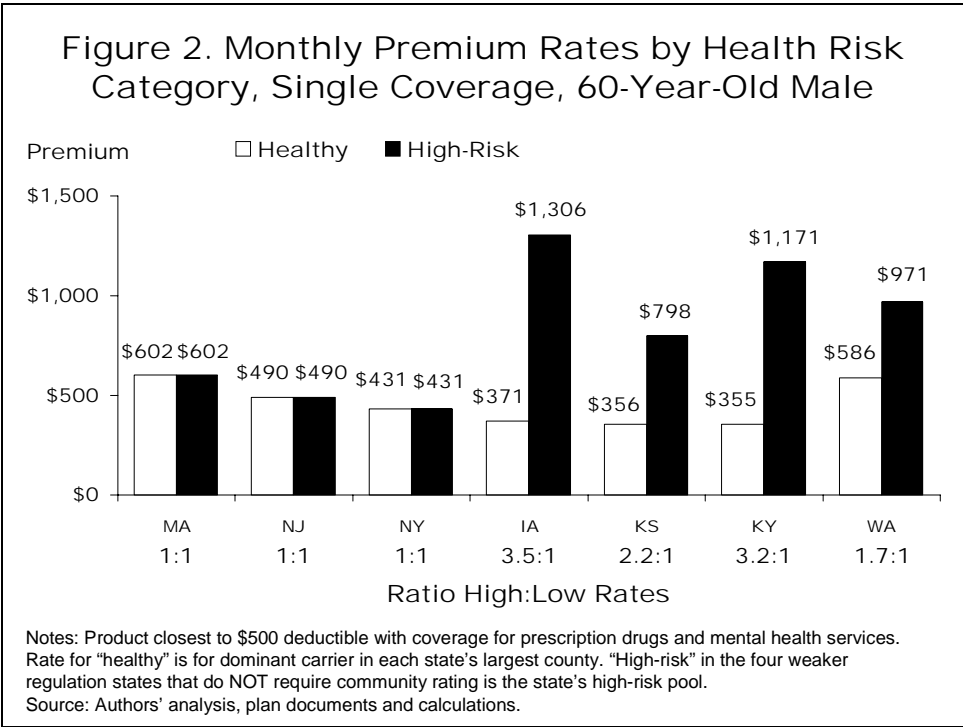
same plan to a consumer regardless of age, gender, health status, or any other personal characteristic; only geographic cost variations may be reflected in rates. Iowa, Kansas, Kentucky, and Washington permit rating based on personal demographic and health factors. Massachusetts is in the middle, prohibiting rating based on health status, but allowing age to be used as a rating factor within a 2:1 range. This means that the rates for the oldest age category, for example, cannot be more than twice the rates for the youngest age category for the same benefit package and geographic area.

Figures 1 through 3 show the implications of these rating differences by comparing market premiums faced by two male consumers, one a 25-year-old and the other a 60-year-old. The premiums are for the same product offered by the dominant carrier in each state, and for the most similar product offered by the state's high-risk pool. (The premium rates across states vary both because of differences in benefit packages and health care costs in each state, as well as possible differences such as the demographics of the risk pool for each carrier.)

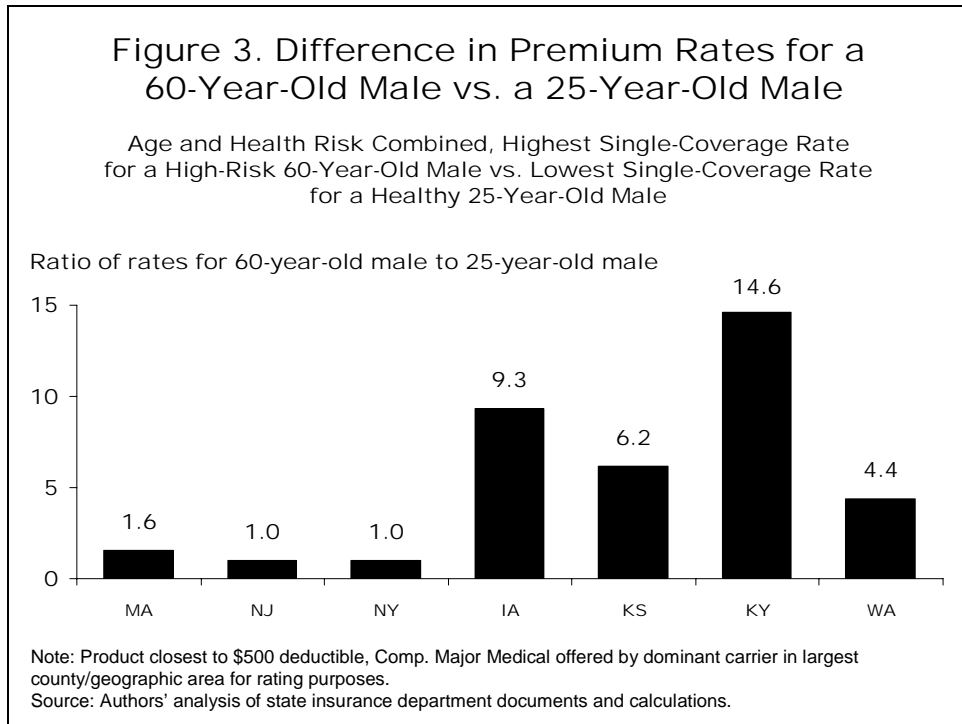
As shown in Figure 1, in the weaker-regulation states, which permit medical underwriting and demographic rating, a 25-year-old male who is unable to pass the medical underwriting process pays a premium that is between 1.3 and four times higher than a "healthy" 25-year-old. In Iowa, for example, the monthly rate for a 25-year-old male who passes medical underwriting is \$133, while the monthly rate for a 25-year-old male who must obtain coverage in the state's high-risk pool is \$555 per month. These premium rates, in general, are much higher than what employees who are covered through employer-sponsored plans typically pay. Workers in these plans benefit from the lower, pool group rates of the employer-sponsored plans and from employer contributions. For the purpose of comparison, in 2003, the average, single employee contribution to such plans was approximately \$42 per month and did not vary by age or health status.



As shown in Figure 2, in these states a similar magnitude of rate variation occurs for a 60-year-old but at a much higher premium level. In contrast, in the stronger-regulation states, consumers of the same age pay the same premium rate regardless of their health status. In the states that also permit gender rating, women pay significantly higher premiums than do men.



The combined effect of age and health status rating is shown in Figure 3. In the weaker-regulation states, there is a fourfold to almost 15-fold difference in premium rates between a high-risk 60-year-old male and a healthy 25-year-old male. In Massachusetts, which permits some age rating, there is almost a twofold difference. Consumers in New Jersey and New York pay the same rates regardless of age or health status because of community rating.



In less-regulated states, some carriers use a variety of rating, new product design, and marketing techniques to “clean up” their individual business, causing huge premium increases for older and sicker consumers. In our interviews we heard about a wide range of approaches adopted by some carriers to “clean up” or “freshen up” their books of individual business. Some raise premiums dramatically and encourage healthier enrollees to move into new medically underwritten products (referred to by one observer as “Whack-a-Mole”). Carriers also close blocks of business to new applicants, which leads to rising medical costs and higher premiums for those whose health status prevents them from obtaining other coverage. In one case, a carrier established an entirely new company to write new medically underwritten business after guaranteed-issue regulation was relaxed, and closed the guaranteed-issue, non-medically underwritten business to new applicants.

Regardless of regulatory approaches, high premiums are a barrier to coverage for many residents of each state, including people who are healthy and relatively young. Premium rates are lower for younger and healthier individuals in states that permit demographic and health status

rating. However, individual insurance is generally very expensive, especially when compared to the average amount that employees pay for employer-sponsored health insurance. Tables 7 and 8 show the range of monthly premiums in each state for three sample family structures: a 25-year-old single male, a 35-year-old couple with children, and a 63-year-old couple. Table 7 shows the rates for the product most similar to a major medical or PPO product that has a \$500 deductible and 20 percent coinsurance, while Table 8 shows premiums for the least expensive product. Both tables show products that include coverage for maternity, drugs, and mental health coverage.⁵² For all but the youngest and healthiest, premiums for individual health insurance in most cases would far exceed 10 percent of median state income, even for the least expensive product that includes a comprehensive scope of benefits.

Table 7. 2003 Monthly Premium Rates, Three Sample Family Situations, Product Close to a \$500 Deductible with 20% Coinsurance

State	Monthly median state income, 2002	25-year-old male	35-year-old couple with two young children	63-year-old couple, two-person contract
Stronger Regulation				
MA: Market	\$4,200	\$369	\$873	\$1,302
NJ: Market (HMO plan)	\$4,400	\$490	\$1483	\$1,048
NY: Market	\$3,500	\$431	\$1,294	\$863
Weaker Regulation				
IA	\$3,500			
Market		\$141	\$539	\$742
High-risk pool		\$555	\$1,656	\$2,612
KS	\$3,500			
Market		n/a	n/a	n/a
High-risk pool		\$550	\$1,763	\$1,596
KY	\$3,200			
Market		\$80	\$477	\$709
High-risk pool		\$332	\$1,744	\$2,343
WA	\$3,700			
Market		\$222	\$870	\$1,172
High-risk pool		\$294	\$1,184	\$1,942

Note: Market means individuals can pass medical underwriting in IA, KS, KY, and WA. Rates are for largest county or geographic area, dominant carrier. Product closest to \$500 deductible, 20% coinsurance product. Rates are not publicly available in Kansas.

Source: Authors' analysis of state insurance department documents, 2002 Current Population Survey, U.S. Census Bureau (median income rounded to nearest hundred dollars).

Table 8. 2003 Monthly Premium Rates, Three Sample Family Situations,
Least Expensive Product
(includes benefits for maternity, mental health, and prescription drugs)

State	Key features of product	25-year-old male	35-year-old couple with two children	63-year-old couple, two-person contract
Stronger Regulation				
MA: Market	\$5,000 deductible, PPO plan	\$226	\$533	\$806
NJ: Market	\$10,000 deductible, 50% coinsurance	\$198	\$502	\$478
NY: Market	Standard HMO Product	\$431	\$1,294	\$863
Weaker Regulation				
IA				
Market	\$1,750 deductible	\$120	\$459	\$632
High-risk pool	\$2,000 deductible, 20% coinsurance	\$450	\$1,196	\$1,688
KS				
Market	n/a	n/a	n/a	n/a
High-risk pool	\$10,000 deductible, 30% coinsurance	\$124	\$531	\$480
KY				
Market	\$2,500 deductible	\$52	\$307	\$456
High-risk pool	\$1,500 deductible (Very expensive rider for mental health and drugs)	\$270	\$1,342	\$1,800
WA				
Market	\$10,000 deductible (Maternity and mental health coverage is not available)	\$84	\$332	\$554
High-risk pool	\$1,500 deductible	\$235	\$908	\$1,420

Note: Market means individuals can pass medical underwriting in IA, KS, KY, and WA. Rates are for largest county or geographic area, dominant carrier. Least expensive product available from dominant carrier that includes drugs, maternity, and mental health benefits. (Maternity and mental health excluded in market product for Washington.) Rates are not publicly available in Kansas.

Source: Authors' analysis of state insurance department documents.

Purchasing individual insurance consumes a large portion of annual income, particularly for most of the uninsured, even for those who are young and healthy. One way to gauge the affordability of individual health insurance is to compare premiums with the family income of people who are uninsured. Nearly two-thirds of the uninsured have annual family income of less than 200 percent of the federal poverty level.⁵³ Tables 9 and 10 compare premiums in

each state to 200 percent of the federal poverty level in 2003, using the premium information from Tables 7 and 8. Table 9 uses premiums for a \$500 deductible policy, while Table 10 uses premiums for the least expensive product available in each state that include maternity, mental health, and drug benefits.

Table 9. Individual Health Insurance Premiums
as a Percentage of 200% Federal Poverty Level,
Product Close to a \$500 Deductible with 20% Coinsurance
(includes benefits for maternity, mental health, and prescription drugs)

State	25-year-old male	35-year-old couple with two children	63-year-old couple two-person contract
200% FPL (2003)	\$17,960	\$36,800	\$24,240
Stronger Regulation			
MA	25%	28%	64%
NJ	33%	48%	52%
NY	29%	42%	43%
Weaker Regulation			
IA			
Market	9%	18%	37%
High-risk pool	37%	54%	129%
KS			
Market	n/a	n/a	n/a
High-risk pool	37%	57%	116%
KY			
Market	5%	16%	35%
High-risk pool	22%	57%	116%
WA			
Market	15%	28%	58%
High-risk pool	20%	39%	96%

Source: Authors' analysis of state insurance department documents.

Table 10. Individual Health Insurance Premiums
as a Percentage of 200% Federal Poverty Level, Least Expensive Product
(includes benefits for maternity, mental health, and prescription drugs)

State	25-year-old male	35-year-old couple with two children	63-year-old couple two-person contract
200% FPL (2003)	\$17,960	\$36,800	\$24,240
Stronger Regulation			
MA	15%	17%	40%
NJ	13%	16%	24%
NY	29%	43%	43%
Weaker Regulation			
IA			
Market	8%	15%	31%
High-risk pool	30%	39%	84%
KS			
Market	n/a	n/a	n/a
High-risk pool	8%	17%	24%
KY			
Market	3%	10%	23%
High-risk pool	18%	44%	89%
WA			
Market	6%	11%	27%
High-risk pool	16%	30%	70%

Source: Authors' analysis of state insurance department documents.

Depending on family composition and health status, annual premiums represent anywhere from 9 percent to 129 percent of income for the \$500 deductible-type product, and from 3 percent to 89 percent for the least expensive product available. Premiums are most affordable for low-risk young males and families in the states that permit demographic rating, and most expensive for older people and for those who cannot pass medical underwriting and must purchase through the high-risk pool.⁵⁴

These estimates are based on premiums for benefit packages that are comparable in scope to the health insurance provided to most people with group coverage, which generally includes benefits for drugs, maternity, and mental health services. In the states with weaker regulatory structures, less expensive benefit packages are available. Premiums in these states consume a lower proportion of family income, at least for consumers who could pass the underwriting required to qualify for these products. New Jersey also permits products designed to provide more “bare bones” coverage, although enrollment in these

plans has been a very modest 500 people. Of course, any product with lower levels of coverage would expose policyholders to potentially higher out-of-pocket expenses. For example, as illustrated in Table 8, deductibles would likely be very high relative to incomes.

State high-risk pools cover very few people, coverage is very expensive, and older people pay much higher premiums. The four states that permit medical underwriting have created high-risk pools as a mechanism to make coverage available to those who are rejected by carriers (Table 11). The states with stronger regulation do not have high-risk pools because carriers must issue coverage to any individual who applies.

Although carriers in less-regulated states report rejecting as many as 30 percent of applicants for individual health insurance, the number of people covered by the state high-risk pools is very small. The low rates of coverage are likely related to the expense of premiums, which range from 125 percent to 150 percent of the rates charged by carriers in the individual market.⁵⁵ There is as much as a threefold variation in premiums for the same product, based on age. Notably, high risk pools also impose waiting periods for those that qualify for participation. In the four study states, the waiting period ranged from 90 days to 12 months.

Table 11. State High-Risk Pools

	IA	KS	KY	WA
Number covered	200	1,700	~1,000	2,500
Product choices	1 (4 deductibles) \$500, \$1,000, \$1,500, \$2,000	1 (6 deductibles) \$500, \$1,000, \$1,500, \$2,500 (Medical Savings Account), \$5,000	3 FFS: \$400 PPO: \$700, \$1,500, 2,250 PPO: \$750, \$1,500	2 (3 deductibles) \$500, \$1,000, \$1,500
Benefits compared to market	Worse	Much worse	Similar	Often much better
Premium rates	150% of average rate	130%–150% of market rates	150% of market rates	125%–150% of average rates of top five individual carriers
Preexisting condition exclusions	6 months	90 days	12 months	6 months
Lowest-priced option				
Deductible	\$2,000	\$5,000	\$1,500/3,000	\$1,500

	IA	KS	KY	WA
Monthly Premium rates				
25-year-old	\$371	\$229	\$442 (f) \$160 (m)	\$236
60-year-old	\$1,026	\$369	\$525 (f) \$571 (m)	\$710
Most comprehensive option				
Deductible	\$500	\$500	\$400/800	\$500
Monthly Premium rates				
25-year-old	\$500	\$595	\$733 (f) \$266 (m)	\$295
60-year-old	\$1,589	\$958	\$872 (f) 949 (m)	\$971
Eligibility	State resident	State resident	State resident	State resident
	Rejection by one insurer, premium increase or reduction in benefits	Rejection by one insurer or if charged more than the Kansas High-Risk Pool	Rejection by at least two private insurers for individual coverage similar to that of Kentucky Access	Rejection by one insurer or if county does not provide insurance
	Cannot be eligible for other individual or group coverage	Cannot be eligible for other individual or group coverage		Cannot be eligible for Medicare
Rating factor	Age	Age	Age and sex	Age
Lifetime maximum benefit	\$1 million	\$1 million	FFS: unlimited; PPO: \$2 million	\$1 million
Subsidy mechanism	Assessment on all carriers and certain self-funded employers	Assessment on all carriers	Tobacco settlement funds; assessment on all carriers	Subsidy from individual market; carriers and assessment on all carriers
Annual subsidy	\$2.5 million	\$3 million	\$2 million	\$30 million

Source: Authors' analysis of state insurance department documents and interviews.

High-risk pool subsidies go to relatively high-income people (those who can afford premiums well above market rates). The source of pool subsidies generally is assessments on all carriers in specific markets (individual, or all health insurance). On a per-person basis the subsidy is about \$12,000 per person in Iowa and Washington, but only \$2,000 per person in Kansas and Kentucky. Given the high premium rates in the high-risk pools, it seems fair to conclude that the risk pools represent a relatively expensive subsidy to a small number of higher-income individuals.

Market Structure and Industry Behavior

The market is highly concentrated among a few insurers, and growing more so over time. The number of carriers writing individual coverage in each state varied from six in Kentucky to more than 20 in New York (Table 12). On a per-population basis, the states with the greatest number of carriers are Kansas and Iowa, which have the weakest regulation, and

Massachusetts, which requires carriers in the small-group market to participate in the individual market. The other four states have roughly the same ratio of carriers per population.⁵⁶

Table 12. Carrier Participation and Market Share of Dominant Carrier

	Stronger Regulation			Weaker Regulation			
	MA*	NY**	NJ	IA	KS	KY	WA
Number of carriers	17	20+	15	7	11	7	8
State population (millions)	6.3	18.8	8.4	2.9	2.6	4	5.9
Carriers per million population	2.7	1.1	1.8	2.4	2.6	1.8	1.4
Market share of largest carrier	70%	50% +	60%	60%+	60%	90%	66%

* Carriers that have more than 5,000 lives in small group market must participate in the individual market.

** All HMOs must participate in the individual market. Number of carriers varies by county.

Source: U.S. Census Bureau and authors' analysis of state insurance department documents.

The number of carriers participating in the individual market has shrunk in most markets over the last decade for two reasons: an exodus of national carriers, and mergers among those that remain in the market. The withdrawal of national carriers has been caused by several factors: an inability to compete with locally domiciled HMO plans that have deep provider discounts, an inability to compete in markets that prohibit various forms of medical underwriting, the loss of large group customers due to mergers and corporate relocations, and political factors. The number of locally domiciled carriers also has fallen, largely because of financial instability and growth through acquisition. In Washington, for instance, we identified at least 18 carriers that provided products in the individual market in 1993; by 1999, the number of plans that provided individual products was down to one, largely because of mergers. In New York, of 11 carriers identified as providing individual insurance in 1996, after several mergers only six remained in 2002.

Some national carriers appear to have exploited state legislatures' concerns over limited choice markets by withdrawing or threatening to withdraw from state markets, even though the carriers' individual business was insignificant to the market. Concerns about carrier withdrawals were a major factor in the reform rollbacks in Kentucky and Washington. Many observers, however, believe that the reaction of carriers was out of proportion to the reforms and was intended in part to discourage similar reform efforts in other states. In general the carriers that withdrew in each state were relatively small in terms of covered lives. These carriers tended to be regional or national insurers that withdrew from many if not most states, regardless of the type of

regulatory reform enacted by the individual states. Many of these same carriers also withdrew in Kansas, Massachusetts, New York, and New Jersey.

The number of carriers in New Jersey, for example, fell from a high of 28 in the initial post-reform years to 15 carriers in 2003. All carriers in New Jersey that sell health insurance are required to “play” in the individual market, either by actively selling individual coverage or by “paying” to cover the losses incurred by the other carriers that do participate.

Having many carriers compete does little to ensure available and affordable coverage, although it may provide more product choices to lower-risk consumers. Despite carrier withdrawals, the basic structure of the individual market is relatively unchanged in the study states. A single carrier accounts for most of the individual health insurance market in each state. As shown in Table 12, the market share of the dominant carrier ranges from approximately 50 percent in New York to 90 percent in Kentucky. The dominant carrier in each state is a Blue Cross Blue Shield (BCBS) plan, as was the case even before market reform. The BCBS plan is also the dominant carrier in the group market in each state, although the BCBS share of the group market is lower than its share of the individual market.⁵⁷

Information on individual health insurance products is less broadly available in states with stronger regulation. In the four states with weaker regulation where medical underwriting is permitted, carriers are actively marketing individual health insurance through captive marketing representatives, independent brokers, active telemarketing sales efforts, and health insurance Web sites.

In contrast, there appears to be no active marketing of individual health insurance in Massachusetts, New Jersey, and New York. The carriers do not use agents or brokers to sell the policies. Instead, consumers are expected to call carriers directly.

In the past, direct calls to carriers in Massachusetts led to access problems. During the first post-reform, two-month open enrollment period, sales agents often gave wrong or misleading information to people who telephoned carriers. This misinformation included telling people the carrier did not offer individual insurance; telling sick individuals they would be denied coverage; and saying that the open enrollment period would not begin until a date after the period had actually ended. Some insurers referred callers to a recording that provided no options if they were seeking individual health coverage. The Massachusetts Attorney General’s office had to intervene to stop the practices.

Interviews indicate that in New Jersey only two of the fifteen current carriers in the market engage the services of brokers or “producers,” as they are known in the state. The producer payment mechanism differs between the two carriers, with one paying commission based on a small percent of premium, and the other paying a flat fee per member, per month. A veteran in the broker community noted that there is little opportunity for brokers to make significant compensation selling in the individual market alone, and so individual coverage is generally just one of a number of products brokers will sell for a carrier or brokerage firm.

As shown in Table 13, there is also very little use of e-health Web sites as a means of marketing individual coverage. Instead, carriers and regulators in these states reported that consumers generally obtain information on individual health insurance directly from the carriers or from Web sites and state consumer guides. A recent survey of individual insurance market members conducted by Rutgers Center for State Health Policy found that the materials available on the New Jersey Department of Banking and Insurance’s Web site—including rate sheets and a Buyer’s Guide—were used extensively by consumers in their purchasing decisions.⁵⁸

Table 13. E-Health Insurance Web Site Carriers and Number of Plans Available in Each State

	Stronger Regulation			Weaker Regulation			
	MA	NJ	NY	IA	KS	KY	WA
Carriers	None	Group Health Insurance	Horizon	Celtic Golden Rule	Celtic	Anthem BCBS	Regence BS Group Health Lifewise
Number of plans available	0	1 plan	15 plans	36 plans	8 plans	11 plans	20 plans
Lowest-priced option		GHI	Horizon-FFS	Golden Rule-PPO	Celtic-PPO	Anthem BCBS-PPO	Group Health-HMO
Deductible		\$0	\$10,000	\$5,000	\$5,000	\$5,000	\$5,000
Monthly premium rates							
25 years old		\$253	\$235	\$31 (m) \$39 (f)	\$58 (m) \$62 (f)	\$31 (m) \$40 (f)	\$44
60 years old			\$235	\$165 (m) \$134 (f)	\$212 (m) \$206 (f)	\$126 (m) \$123 (f)	\$97

	Stronger Regulation			Weaker Regulation			
	MA	NJ	NY	IA	KS	KY	WA
Most comprehensive option		GHI	Horizon-FFS	Celtic-FFS	Celtic-FFS	Anthem BCBS-PPO	Group HMO/Lifewise PPO
Deductible		\$0	\$1,000	\$250	\$250	\$250	\$500
Monthly premium rates							
25 years old		\$253	\$1,030	\$176 (m) \$187 (f)	\$194 (m) \$206 (f)	\$97 (m) \$295 (f)	\$140
60 years old		\$253	\$1,030	\$702 (m) \$687 (f)	\$708 (m) \$688 (f)	\$393 (m) \$384 (f)	\$410
Medical underwriting		No	No	Yes	Yes	Yes	No
Exclusion period		n/a	12 months	12 months	12 months	12 months	9–12 months

Source: Authors' review of information available on Ehealthinsurance.com. Accessed May 2004.

The basis of competition among carriers continues to include creative risk selection through selective incentives to agents and brokers. After the Iowa legislature passed reforms creating uniform basic and standard products for the individual market, most carriers paid 0 to 3 percent commissions to agents selling these products, compared with 20 percent for new business and 5 to 6 percent for renewal business of nonuniform individual products. Individuals who asked for the uniform products were told by agents to buy it from the local Blue Cross plan. Field agents in Iowa also “pre-screen” individuals for carriers. As one carrier representative explained, “Many agents know our underwriting guidelines and they won’t even go through the application process for our product.”⁵⁹

During the period of community rating in Kentucky, one insurance company reduced broker commissions for the individual business to \$5 per policy, except for those sold through the Farm Bureau association scheme described below. But now that community rating no longer is in place in Kentucky, field sales agents and general agent brokers get 6 to 8 percent of premium from the company for selling individual policies.

There are other marketing and outreach practices that could positively influence selection into a carrier’s products. They include requiring the completion of a six-page health questionnaire before issuing coverage, even though the state does not allow medical underwriting; increasing deductibles to very high levels before standardized benefits are covered; and rating by ZIP code (offering lower rates in higher-income ZIP codes). These practices occur in markets that do not allow medical underwriting.

Associations that are exempt from individual market reform have enabled carriers to medically underwrite and reject applicants even in highly regulated markets. In Kentucky, one company subverted the individual reforms—community rating in particular—by encouraging healthy individuals to purchase individual coverage through the Farm Bureau, with which the company had a “special” marketing relationship. The Farm Bureau sponsored an association known as Metro Senior Association (MSA) until 1998. The MSA was allowed to medically underwrite and therefore could keep its individual premiums below what the company could offer individuals directly. The Farm Bureau arrangement helped the company keep roughly 30,000 healthy individuals as customers at premiums below those of community rated (not medically underwritten) individuals. The company was concerned these customers would drop coverage rather than pay rates that doubled after reforms required community rating. When the reforms were rolled back and medical underwriting again was permitted, the MSA dissolved.

Other insurers formed associations domiciled in less-regulated states through which they used such mass marketing techniques as targeted direct mail and telemarketing to sell products to individuals in more highly regulated states. These products require medical underwriting or cancellation provisions that would not be allowed under the laws of the customer’s residence state. For instance, one company sells medical insurance products to individuals through 27,000 agents in 32 states. In February 2000, the court found against two of the company’s subsidiaries for churning (discontinuing old blocks of business and offering new ones) through products offered in associations domiciled in another state.⁶⁰

The use of associations to avoid individual market reform appears to be an essential part of the business strategy of several national carriers based on corporate documents. This is an excerpt from the SEC filings of a national carrier writing in its 2002 report to shareholders:

To remain profitable and competitive in this changing and unpredictable market, (the Company) is concentrating on select niches that offer the greatest potential for profitability. . . . With increasingly stringent federal and state restrictions on small group insurance, we emphasize the sale of individual and association products, which offer greater flexibility in both underwriting and design compared to small group products. . . . Some states have enacted small-group insurance and rating reforms, which generally limit the ability of the insurers to use risk selection as a method of controlling costs. We have discontinued selling certain policies in states where, due to these healthcare reform measures, we cannot function profitably.⁶¹

The National Association of Insurance Commissioners has convened a special task force for reviewing association group coverage.⁶² The inability to develop nationally uniform regulations creates these cherry-picking—or risk avoidance—opportunities for carriers. The association problem is impossible to overcome without federal intervention.

In a trend perhaps related to market consolidation and other industry-wide behaviors noted above, most insurers in the individual market have not suffered financial losses despite regulatory reforms. In fact, individual health insurance appears to be a profitable line of business for most carriers. One of the oft-cited concerns about potential market reforms was that it would make the individual insurance market unprofitable and financially risky for carriers. While carrier withdrawals suggest that reform has made the individual market less attractive for some carriers in some states, the individual market has been profitable for the largest carriers in each of the study states. Table 14 shows that medical loss ratios have generally fallen in each state since reform, suggesting higher profit margins on this line of business. The medical loss ratio is the percent of total premiums that is paid out for medical expenses. The lower the medical loss ratio, the higher the share of premiums retained by the insurance carrier.

We were unable to assess profit margins on the individual line of business for most carriers because state regulatory filing regulations do not require carriers to break down administrative expenses by line of business. Based on our interviews and a review of overall carrier costs structures, we estimate that the administrative costs of the individual line of business are approximately 10 percent to 15 percent. Using this estimate with the data in Table 14, all but one carrier would have had positive financial results—or positive margins—on its individual line of business. Our interviews confirmed this estimate of carriers' financial performance. Most carriers reported that the individual line of business was profitable, and in some cases it was significantly more profitable than their group business.

Table 14. Medical Loss Ratios in the Individual Market Dominant Carriers Before and After Reform

State	Carrier	Average before reform	1998	1999	2000	2001	2002
Weaker Regulation							
IA	Wellmark	84.3%	83.3%	84.3%	82.1%	81.0%	80.5%
KS	BCBS of Kansas	~80%	84.8%	81.8%	84.7%	82.6%	80.2%
KY	Anthem of KY	75.9%	92.1%	83.5%	80.6%	69.2%	69.1%
WA	Premera BC		80.0%	80.8%	79.8%	83.4%	83.5%
	Regence BS	130.8%	90.8%	78.4%	82.8%	81.7%	84.8%
	Group Health	123.3%	98.2%	90.8%	99.4%	97.6%	110.8%
Stronger Regulation							
MA	BCBS	90+%	87.7%	90.4%	83.0%	84.4%	79.8%
NJ	Horizon*	n/a	81.9%	74.5%	77.5%	76.0%	77.6%
NY	Empire	150+%	Files not available from regulators	Not reported by carrier	85.2%	Not reported	83.9%
	Oxford	Not offered	Files not available from regulators	Not reported by carrier	85.1%	89.1%	97.4%

Includes Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey.

Source: Authors' analysis of carrier financial statements and regulatory filings.

Capacity to Regulate Effectively at the State Level

Rate regulation is weak and easily subject to actuarial manipulation. Six of the seven states have adopted little if any regulation of premium rates in the individual health insurance market. In addition, as shown in Table 2, minimum medical expense ratios for individual products are quite low and range from 55 percent in Kansas to 80 percent in New York.

One of the best examples of the impact of weak rate regulation occurs in Massachusetts. The state's carriers are required to participate in the individual health insurance market if they insure 5,000 or more lives in the state's small-group market. Certain carriers—including some of the largest carriers in the group market—have used the absence of effective rate regulation to undermine this mandatory participation requirement. A carrier's individual health insurance rates in Massachusetts are subject to regulatory review only if they are more than two standard deviations above the average rates in the individual market. As shown in Table 15, this weak regulatory standard

permits rates for some carriers to be almost double the rates of other carriers for exactly the same standardized benefit package. The predictable result is that carriers with high premium rates have few or no individual enrollees, thereby allowing them to finesse the requirement to participate in the individual market.

Table 15. Range of Monthly Premium Rates in Massachusetts for Standard HMO and PPO Products

Boston region	25-year-old single	35-year-old family	63-year-old couple	Carrier's enrollment
Lowest HMO	\$351	\$873	\$1,320	22,000 (64% of HMO members)
Highest HMO	\$462	\$1,410	\$1,600	1,474 (3% of HMO members)
Ratio High:Low	32% higher	61% higher	21% higher	
Lowest PPO	\$466	\$1,101	\$1,665	3,287 (98% of PPO members)
Highest PPO	\$765	\$2,461	\$3,037	0
Ratio High:Low	64% higher	124% higher	82% higher	

Source: Massachusetts Division of Insurance, rates as of January 2003.

Our interviews with state regulators revealed that rate regulation is perceived to be one of the most challenging issues of health insurance reform. Regulators often believe they have insufficient authority over premium rates and are sometimes reluctant to use the authority they have. In three of the study states (New York, New Jersey, and Massachusetts) one of the *quid pro quos* of regulatory reform was to relax or eliminate rules that had required prior approval of individual health insurance rates, sometimes including a public hearing process. The elimination of rate review was also one of the key features of the rollback of reforms in Washington.

Interviews with several carriers in these states suggested that rating flexibility and assurances of “adequate” and timely premium increases was in many ways more important than the imposition of stricter rating requirements or guaranteed issue. In the words of one carrier, “Loosening up rate regulation was a real relief valve. . . . We knew that if rate regulation was eliminated, we could always make up the effects of other reforms by raising prices. . . . Limits on premium rates are the big issue for us with guaranteed issue.”

Regulators said they were reluctant to scrutinize rates carefully for a variety of reasons: concerns about carrier solvency, fears that carriers will withdraw from the

individual market if rate review is viewed as too “onerous,” a belief that minimum loss ratio standards are adequate to ensure reasonable rates, lack of actuarial expertise within state insurance departments, and an attitude of resignation about the inevitability of high premiums and large premium increases in the individual market. In the words of one regulator, “We try to approve rates quickly so there is no basis for carrier dismay . . . we have only had three rate hearings in the past 35 years.” A regulator in another state said, “We don’t really have the expertise to know if carriers are playing with their rates in order to avoid complying fully with our reform law, but we suspect that they are.”

DISCUSSION AND RECOMMENDATIONS

The states in our study have made very different decisions about how to regulate their individual health insurance markets, reflecting varying values, political climates, and expectations. Three states adopted more stringent regulation and then had the political will and regulatory resolve to stay the course. They created markets where comprehensive coverage is available to all, there is some choice of product and carrier, and premiums have been made more affordable for higher-risk people at the expense of less affordable coverage for younger and healthier individuals. Participating carriers did not experience any significant selection spiral or other type of market meltdown. All three states were helped by pre-reform conditions, and particularly by the presence of a number of local carriers that could not withdraw from the states.

In the weaker-regulation states, older or less-healthy consumers face a range of problems. A significant percentage of applicants are rejected for coverage, leaving them with no option but expensive high-risk pools. Even for those who qualify for market plans, permanent exclusions can be imposed for preexisting medical conditions. Products often lack coverage for such important benefits as maternity, mental health, or prescription drugs. Premiums vary widely by age, gender, and health status, with as much as a 15-fold difference in premium rates for the same product based on age and health status. Carriers continue to compete through marketing and product design techniques that are designed to encourage favorable selection and discourage high-risk applicants.

Carriers can sometimes exploit differences in regulation among states to evade regulatory requirements. Regulators often lack the tools and resources to deal with these problems. State legislators have become reluctant to enact stronger reforms for fear that regional and national carriers will decide to leave their states.

In all states, regardless of regulatory posture, premiums are unaffordable compared to family income, especially at the income level of most of the country's uninsured, even for the young and healthy.

While regulatory reforms cannot solve all of these problems, they can help improve the condition of the individual health insurance market. We recommend that states adopt the following minimum set of regulatory reforms.

Problem #1—Older and Less-Healthy Consumers Often Cannot Obtain Coverage Except Through Expensive and Costly High-Risk Pools

Recommendations:

Require carriers to offer coverage to everyone. Guaranteed-issue requirements work better than high-risk pools, which benefit few people who have sufficient income to pay very high premiums.

Permit a reasonable waiting period for preexisting conditions for those who have not had continuous prior coverage. A necessary corollary of requiring carriers to take everyone in a voluntary insurance system is that there must be some protections against adverse selection. A 12-month waiting period seems reasonable based on the experience of the study states, in combination with a clear definition of what constitutes a “preexisting condition.”

The experience of Washington is instructive on this issue. The state's original reform law had a 90-day waiting period for preexisting conditions. While this law was in effect, one large carrier in the individual market had 330 deliveries per 1,000 pregnancy-age females, more than ten times the rate in its group business. Some 80 percent of these deliveries occurred within nine months of enrollment in the plan. Nearly three-quarters of these women canceled their coverage shortly after having their babies, 60 percent within three months after delivery. (One employee told us that the company received letters from some of the members who canceled coverage thanking them for the excellent coverage and promising to re-enroll if they became pregnant again.)

Problem #2—Individual Products Often Lack Coverage for Important Benefits, and Carriers Use Product Design as a Means of Risk Selection

Recommendation:

Standardize benefits, but permit some variation in cost-sharing. Unless a uniform scope of benefits is required, consumers will attempt to buy products based on their actual or perceived health needs. Carriers will try to guard against this adverse selection by limiting

or eliminating benefits for certain services. Standardized products also are more comprehensible to consumers, and make it much easier for them to comparison shop. The federal experience with regulating Medigap coverage demonstrates the value of standardized benefit packages.

Developing standardized products is challenging; it requires achieving a political consensus about benefits, as well as addressing the issue of affordability. The experiences of Massachusetts, New York, and New Jersey, however, demonstrate that this can be done.

While requiring the same scope of benefits in all individual health plans is desirable, consumers also need some product choice. This can best be achieved by allowing products to have different, specified levels of consumer cost-sharing, such as deductibles, coinsurance, and copayments. The potentially negative impact of product choice in terms of risk segmentation can be addressed. Each carrier can be required to pool all its products for rating purposes. Premium rates can be allowed to vary only by the actuarial value of the differences in cost-sharing, and not by any differences in the health care costs of people who select different levels of cost-sharing.

Problem #3—Older and Less-Healthy Consumers Pay Much Higher Premiums than Younger and Healthier Individuals

Recommendation:

Limit permissible rating factors and rate variation. There is a trade-off between permissible rating methods and affordability for certain groups. Rating methods that result in lower premiums for younger and lower-risk individuals come at the direct expense of higher premiums for older and higher-risk individuals. States that have not imposed stringent restrictions on permissible rating factors have extremely large variations in premium rates. These variations undermine the purpose of insurance (having the healthy pay for the sick, and vice versa) and make coverage unaffordable for people who are older and higher risk.

Community rating seems, on balance, to have been quite successful in New Jersey and New York, although premiums are very expensive. Modified community rating (allowing an age factor) has worked well in Massachusetts. While we believe states should be permitted to require community rating, imposing this requirement on all states might be extremely disruptive to younger, healthier enrollees, since most states now permit extremely large rate variations. A more reasonable policy would be to permit some limited rate variation based on age only, such as a rate band of 1.5 to 1, or 2 to 1, which would limit the permissible variation in rates between the oldest and youngest age groups. No rate variations should be permitted for gender, health status, or other demographic factors.

Allowing some variation for age would take into account the reality of current market conditions in most states and acknowledge the challenge of attracting and keeping younger people in the individual market. Any rate limitation must be phased in over several years to avoid rate shock for younger people.

Problem #4—Carriers Engage in “Creative Risk Selection” Through Marketing and Other Practices

Recommendations:

Impose clear standards for market conduct, including standards for permissible marketing practices. In each of the study states, carriers have employed a variety of techniques to sell coverage to lower-risk consumers and to avoid higher-risk individuals. In most cases, regulators were aware of these practices but did little to stop them because of a lack of legal authority, resources, regulatory resolve, or a combination of these factors.

Problematic market conduct always will occur, even in the most well regulated markets. But clear and strict rules about permissible and impermissible practices would give regulators the legal authority they need to take action when needed, and would have a strong effect on some carriers.

One area of market conduct that needs attention is agent and broker commissions. Standards are needed both to protect consumers from broker incentives to sell them the product that pays the highest commission, as well as to shield them from carrier policies that dissuade agents and brokers from informing consumers about all the available product options. One approach that might help address these problems is to require carriers to file commission schedules with state insurance departments, which would review them and address any problematic practices and post them on the departments' Web site. Agents and brokers could also be required to disclose commission structures to consumers, including posting commission structures in a public place and on any agency Web site. Similarly, in markets where consumers must seek information directly from carriers, insurance departments can closely supervise the quality and format of the information, and can impose significant penalties for misleading information.

States might also encourage the federal government to consider creating a health insurance information and counseling program for the individual health insurance market. One model could be the federally funded State Health Insurance Assistance Program in each state that helps elders and their families navigate the health insurance system and deal with problems that arise.

Undertake more active monitoring of the individual health insurance market. There is very little active monitoring of the individual health insurance market in the seven states we studied, at least in part because there is very little information available to allow monitoring. Even when information was required on regulatory filings, it often was not provided. The information on national carriers was particularly sparse.

Data limitations make it difficult, if not impossible, for policymakers to get an accurate and comprehensive picture of the individual health insurance market or to fully understand the impact of regulatory reforms on the individual market. These limitations make policy discussions particularly susceptible to anecdotes and unsupported assertions. The lack of data also makes it difficult for regulators to fully enforce the provisions of the individual health insurance laws.

State reforms could be better understood if there were efforts to improve the breadth and quality of the information collected on the individual and small-group markets, as well as efforts to make this information more easily available for and from state regulators. Such information is critical if federal policymakers want to assess the impact of any policy approaches that are adopted, such as federal tax credits. Some states have begun to put carrier filings on Web sites that can be downloaded by the public, a trend that should be encouraged and possibly given financial assistance at the federal level.

In addition, there must be clear expectations about the information carriers must provide, and sanctions when carriers do not provide it. One way to address the consistent failure of carriers to provide required information is to mandate that carriers attest to the completeness and accuracy of the information they submit to state insurance departments, as ascertained by a signature of the CEO and CFO. Penalties for false, misleading, or incomplete information could be imposed along the lines of the Sarbanes–Oxley penalties for false or misleading financial statements of publicly held companies.

Problem #5—Carriers Can Undermine or Evade Regulation in the Individual Market by Exploiting Different Rules for Individual, Small-Group, and Association Markets

Recommendations:

Adopt a strict and consistent definition of who is eligible to purchase individual health insurance. States have adopted different definitions of who is eligible for individual insurance. In some states, for example, self-employed people must purchase individual insurance, in others they must purchase small-group policies, and in other states they can choose either

the individual or small-group market. Without clear rules about eligibility, there is too much opportunity for gaming and risk selection among markets and across carriers.

Clarify the link between the individual and small-group markets. There must be coherent boundaries and consistent rules between the small-group and individual markets. In certain areas, such as guaranteed issue, the rules must be the same to prevent adverse selection between the markets. In other areas, such as product design, there is room to have different requirements, provided careful consideration is given to the potential consequences of these variations.

Make associations play by the same rules. Associations and other group arrangements have been used to evade or undermine regulatory reforms in many states. Failure to impose the same regulatory requirements on associations creates market disruption and often leaves consumers without important protections. Massachusetts and other states that have aggressively pursued associations that were formed and operated principally for the purpose of selling insurance have required legitimate associations to comply with the requirements of small-group and/or individual health insurance reforms. Based on our interviews with key informants, these states seem to have had fewer problems with association cherry-picking or other flouting of state consumer protection laws. Rather than endorsing proposals to preempt any meaningful oversight of associations,⁶³ policymakers should impose stricter regulation on associations. The lack of uniform national rules that govern associations creates cherry-picking opportunities for carriers. Although the National Association of Insurance Commissioners has a special task force reviewing association group coverage, the association problem will be difficult to overcome without federal intervention.

Problem #6—Individual Health Insurance Is Unaffordable, Even for the Young and Healthy

Recommendations:

Find ways to keep as many people as possible in the group market. The group market has many inherent advantages over the individual insurance market: risk pools are larger, buyers have more purchasing power, there is less opportunity for risk selection by carriers and consumers, administrative costs are lower, and coverage is generally less expensive. Policymakers should therefore support approaches that make group coverage available to as many people as possible. Such methods include:

- Require the self-employed to purchase coverage in the group market.

- Make groups with fewer than 20 employees eligible for the federal COBRA law, which grants the right of continued eligibility for group coverage. These so-called Mini-COBRA laws have been adopted by 38 states, extending continuation rights to firms with from two to nineteen workers. In 22 states, however, employees are eligible for less than the 18 months of group coverage available to larger groups under COBRA. In four states, the period of continued eligibility is less than four months.
- Require carriers (and employers) to allow dependents to remain eligible for coverage under their parents' policies until the age of 25, under the same terms and conditions as other dependents, provided they are ineligible for other group or public health coverage. This change could help address some of the concerns of parents of recent college graduates. According to our interviews, in many states these parents have been among the more vocal proponents of both age rating and of permitting the sale of short-term, low-benefit health insurance policies. An alternative approach would be to require colleges and universities to offer a COBRA benefit to new graduates granting coverage under the student group plan for 18 months after graduating.

Promote mechanisms to make individual health insurance more affordable by spreading costs of the individual market more broadly. Affordability is a major barrier to expanding the individual health insurance market. Several states have tried to address this problem by spreading the costs of the individual health insurance market more broadly, using such techniques as reinsurance pools, assessments on group health insurers, and sliding-scale premium subsidies funded with public funds. The subsidy programs Healthy New York, Access Program in New Jersey, and the Basic Health Plan in Washington are regarded by many as having been quite successful, although the New Jersey and Washington programs have been cut because of state budget problems. In addition, policymakers need to address the underlying medical expenses that drive much of the cost of individual health insurance. Unless actions are taken to address the cost of individual health insurance, tax credits and other policy approaches are unlikely to have much success, considering the relatively low income of many of the uninsured.

The Potential Need for Federal Regulatory Action

A stronger approach to regulation of the individual insurance market would be for the federal government to create a model set of minimum standards for critical issues. Under this approach, the federal government would adopt minimum regulatory requirements for the individual insurance market, and states would be required to comply with these requirements or adopt more stringent regulations.

Federal standards are desirable for a variety of reasons. Our case studies illustrate that states vary considerably in their political environment, resources, and capabilities. States have very different abilities to adopt and enforce reasonable regulatory standards, based largely on the size and attractiveness of their markets to insurers. As the experience of Kentucky makes clear, smaller states often are unable to enact and implement strong protections because of their vulnerability to carrier withdrawals and to other “divide and conquer” strategies by regional and national insurers. The success of these strategies becomes an effective deterrent to other states considering similar reforms. Carriers also are able to use weak regulation in some states as a means to avoid and undermine stricter requirements in other states, as has been shown by the disruptive effect in many states of association plans and other group trusts on the individual market.

As a result of state sovereignty, the individual health insurance market is governed by a patchwork of state standards that range from very weak to stringent. This patchwork system is inefficient and favors insurer interests. It is also inequitable because similarly situated individuals who seek individual insurance in different states confront very different markets in terms of availability, benefits, price, and other key consumer protections. State regulation also creates border issues, since state boundaries often are not the same as the geographic area within which consumers purchase health insurance or health services. In addition, the individual insurance market in many states is too small to be credible for rating purposes or to spread risk and costs broadly across enrollees, particularly if there are many carriers selling insurance in the state.

If policymakers want to use federal tax or other policy approaches to encourage the growth of the individual health insurance market, they most likely want to ensure that this market operates according to more uniform rules and provides better and more consistent protections to consumers. The life insurance industry recently has suggested that it would be better off with federal regulation rather than regulation by 50 states.⁶⁴ It is unlikely that the health insurance industry would make a similar suggestion, or that it would be supported by policymakers if it did. A complete federal takeover of health insurance regulation is risky because it might reflect the lowest common denominator level of the 50 states. The adoption of a set of minimum federal regulatory standards, however, would ensure a base of protection in every state while permitting states to adopt more stringent approaches based on their own market conditions and philosophies.

CONCLUSION

The functioning of the individual health insurance market can be improved somewhat with better and more consistent regulation, particularly if the stricter regulatory

approaches we outline are adopted voluntarily by states or imposed on all states through the adoption of minimum federal standards. Even with these reforms, however, the individual market will continue to present a trade-off between availability to those with health conditions and affordability for healthy and low-risk individuals. In a system where the purchase of health insurance continues to be voluntary, insurers and consumers are locked into a dance of avoiding the high-risk population. Policymakers must be realistic about the potential for using the individual health insurance market to make a significant dent in the growing problem of the uninsured. In particular, they should carefully consider if the individual health insurance market is the most efficient and affordable means to promote increased health coverage for the rising number of people without insurance. Other approaches—such as permitting lower-income consumers to buy into public programs—likely hold more promise as a way of reducing the number of people without health coverage.

NOTES

¹ P. Fronstin, “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2004 Current Population Survey.” Employee Benefit Research Institute, Issue Brief No. 276, December 2004.

² The 1996 Health Insurance Portability and Accessibility Act (HIPAA) made it easier for most people with group insurance to purchase coverage in the individual market when they lose their eligibility for group coverage. The law requires insurers to sell individual policies to anyone who has at least 18 months of continuous coverage and is moving from the group to the individual market, provided they are not eligible for any other public or private coverage, have exhausted federal or state group continuation rights, and have not had more than a 63-day-gap in coverage. But HIPAA does not impose limits on how much insurers may charge for individual policies in such cases, although some states have set rate limits. In addition, states have flexibility in how they comply with this HIPAA requirement. Many states use a state high-risk pool rather than requiring private health insurers to sell individual health insurance to those eligible for coverage under HIPAA.

³ L. Duchon and C. Schoen, [*Experiences of Working-Age Adults in the Individual Insurance Market: Findings from The Commonwealth Fund 2001 Health Insurance Survey*](#), The Commonwealth Fund, December 2001.

⁴ U.S. Census Bureau, *Income, Poverty and Health Insurance Coverage in the United States: 2003*, Washington D.C.: U.S. Government Printing Office, 2004.

⁵ P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured*, EBRI Brief, December 1998, and Unpublished estimate for 2000 prepared by the Urban Institute and the Kaiser Commission on Medicaid and the Uninsured, as quoted in G. Claxton, “How Private Health Insurance Works,” Henry J. Kaiser Family Foundation, April 2002, p. 1. See also Kaiser Family Foundation, *Employer Health Benefits*, 2004.

⁶ The Medicare reform law established tax-free medical savings accounts, available to people who have health insurance policies with annual deductibles of \$1,000 for individuals and \$2,000 for families. Individuals, their employers, or their family members can put away the amount of their annual insurance deductibles, up to \$2,600 a year for individuals and \$5,150 a year for families. People age 55 to 64 could make additional contributions to build a medical nest egg. The accounts could be set up beginning January 1, 2004. The new law may increase the use of high-deductible health plans in both employer and individual markets.

⁷ The Federal Trade Adjustment Assistance Reform Act of 2002 (TAA) established a federal tax credit for individual health insurance for displaced workers who are receiving unemployment benefits or who have exhausted their benefits. The tax credit is refundable, meaning it can be claimed even if no income tax is owed. The Bush administration has also proposed a tax credit for individuals and families who purchase individual health insurance. The credit would provide a maximum annual credit of \$1,000 per adult and \$500 per child, up to a family maximum of \$3,000. The credit would vary with income, and could be up to 90 percent of the cost of health insurance for low-income taxpayers. The tax credit would be refundable and also “advanceable,” meaning it could be received at the time the individual or family purchases health insurance. Anyone under age 65 without employer-sponsored or public insurance would be eligible for the tax credit.

⁸ R. Pear, “Senate Republicans Propose Plan for Health Insurance,” *New York Times*, May 12, 2004, page A-19; For a discussion of concerns regarding these plans, see http://www.naic.org/government_relations/health_policy/assoc_health_plans.htm.

⁹ By its nature, the individual insurance market has higher administrative costs than the group market because coverage is sold directly on a one-on-one basis to consumers rather than to groups. In addition, agent and broker commissions are usually higher in the individual market than in the group market.

¹⁰ See footnote 2 for information about HIPAA.

¹¹ K. Swartz, “[Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?](#)” *Inquiry* 28 (2) Summer 2001: 113.145.

¹² K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?*, Henry J. Kaiser Family Foundation, June 2001.

¹³ K. Pollitz and L. Levitt, *Explaining the Findings of a Study About Medical Underwriting in the Individual Health Insurance Market*, Henry J. Kaiser Family Foundation, May 2002.

¹⁴ D. J. Chollet and R. R. Paul, *Health Insurance Markets: Causes and Effects of Market Structure*, The Robert Wood Johnson Foundation’s State Initiatives in Health Care Reform Program, Washington, D.C.: Alpha Center, 1996.

¹⁵ D. J. Chollet and A. M. Kirk, *Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States*, Henry J. Kaiser Family Foundation, March 1999.

¹⁶ For variations by age and sex and issues see: J. Gabel, K. Dhont, and J. Pickreign, [Are Tax Credits Alone the Solution to Affordable Health Insurance: Comparing the Costs of Individual Insurance and Group Insurance in 17 U.S. Markets](#), New York: The Commonwealth Fund, 2002; S. Collins, S. Berkson, and D. Downey, [Health Insurance Tax Credits: Will They Work for Women?](#), New York: The Commonwealth Fund, December 2002.

¹⁷ J. Gabel et al., “[Individual Health Insurance: How Much Financial Protection Does It Provide?](#)” *Health Affairs* Web Exclusive, 2002.

¹⁸ J. Gabel, K. Dhont, and J. Pickreign, [Are Tax Credits Alone the Solution to Affordable Health Insurance: Comparing the Costs of Individual Insurance and Group Insurance in 17 U.S. Markets](#), New York: The Commonwealth Fund, 2002; S. Collins, S. Berkson, and D. Downey, [Health Insurance Tax Credits: Will They Work for Women?](#), New York: The Commonwealth Fund, December 2002.

¹⁹ K. Pollitz and L. Levitt, *Explaining the Findings of a Study about Medical Underwriting in the Individual Health Insurance Market*, Henry J. Kaiser Family Foundation, May 2002.

²⁰ K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?*, Henry J. Kaiser Family Foundation, June 2001.

²¹ D. J. Chollet, A. M. Kirk, and M. E. Chow, *Mapping State Health Insurance Markets: Structure and Change in the States’ Group and Individual Health Insurance Markets 1995–1997*, Academy for Health Services Research and Health Policy, December 2000.

²² While there is considerable disagreement about exactly how many people face barriers to access, unaffordable premiums, and exclusions and riders (contrast, for example, Pollitz and Sorian, op. cit. and T.D. Musco and T.F. Wildsmith, *Individual Health Insurance: Access and Affordability*, HIAA Brief Analysis, October 2002), there can be little debate that many people experience significant barriers to obtaining accessible, adequate, and affordable coverage in the individual health insurance market in many states. These problems are worse for those with health problems or greater health risks.

²³ Chollet, Kirk, and Chow, 2000.

- ²⁴ D. J. Chollet, A. M. Kirk, and M. E. Chow, *Mapping State Health Insurance Markets: Structure and Change in the States' Group and Individual Health Insurance Markets 1995–1997*, Academy for Health Services Research and Health Policy, December 2000.
- ²⁵ T. McBride, C. Andrews, A. Coburn, A. Makarkin, and E. Ziller, *The Dynamics of Individual Health Insurance Coverage in the U.S. Academy Health*, June 2003.
- ²⁶ L. M. Nichols, “State Regulation: What Have We Learned So Far?” *Journal of Health Politics, Policy and Law* 25 (February 2000): 175–96.
- ²⁷ A. M. Kirk, “Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts,” *Journal of Health Politics, Policy and Law* 25 (2000) 133–73.
- ²⁸ M. A. Hall, “An Evaluation of New York’s Reform Law,” *Journal of Health Politics, Policy and Law* 25 (2000): 71–99.
- ²⁹ M. A. Hall, “An Evaluation of Vermont’s Reform Law,” *Journal of Health Politics, Policy and Law* 25 (2000): 101–31.
- ³⁰ K. Swartz and D.W. Garnick, “Lessons from New Jersey.” *Journal of Health Politics, Policy and Law* 25 (2000): 45–70.
- ³¹ F. A. Sloan and C. J. Conover, “Effects of State Reforms on Health Insurance Coverage of Adults,” *Inquiry* (Fall 1998): 280–93.
- ³² S. Zuckerman and S. Rajan, “An Alternative Approach to Measuring the Effects of Insurance Market Reforms,” *Inquiry* (Spring 1999): 44–56.
- ³³ S. H. Long, M. S. Marquis, and J. Rodgers, “Do People Shift Their Use of Health Services over Time to Take Advantage of Insurance?” *Journal of Health Economics* (January 1998): 112–15.
- ³⁴ S. Serota, “The Individual Market: A Delicate Balance,” *Health Affairs*, October 23, 2002.
- ³⁵ D. J. Chollet, “Consumers, Insurers, and Market Behavior,” *Journal of Health Politics, Policy and Law* 25 (2000): 27–44.
- ³⁶ M. L. Schriver and G. Arnet, *Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations*, Heritage Foundation Backgrounder, August 14, 1998.
- ³⁷ National Center for Policy Analysis, *Community Rating: A Cure Worse Than the Disease*, Brief Analysis No. 114. July 6, 1994.
- ³⁸ L. M. Nichols, “State Regulation: What Have We Learned So Far?” *Journal of Health Politics, Policy and Law* 25 (February 2000): 175–96.
- ³⁹ A. M. Kirk, “Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts,” *Journal of Health Politics, Policy and Law* 25 (2000): 133–73.
- ⁴⁰ M. A. Hall, “An Evaluation of New York’s Reform Law,” *Journal of Health Politics, Policy and Law* 25 (2000): 71–99.
- ⁴¹ D. J. Chollet, A. M. Kirk, and K. I. Simon, *The Impact of Access Regulation on Health Insurance Market Structure*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, October 20, 2000.
- ⁴² M. Pauly, B. Herring, and D. Song, *Tax Credits, the Distribution of Subsidized Health Insurance Premiums, and the Uninsured*, No. 8457 in NBER Working Papers from National Bureau of Economic Research, Inc., 2001.
- ⁴³ M. Susan Marquis and Stephen H. Long, “Worker Demand for Health Insurance in the Non-Group Market,” *Journal of Health Economics* 14 (1995): 47–63.

⁴⁴ J. Gruber and L. Levitt, “Tax Subsidies for Health Insurance: Costs and Benefits,” *Health Affairs* 19 (Jan/Feb 2000).

⁴⁵ American Medical Association, “Expanding Health Insurance: Costs and Benefits,” *Health Affairs* 19 (Jan/Feb 2000): 10.

⁴⁶ G. Wozniac and D. Emmons, *Tax Credit Simulation Project Technical Report*, Center for Health Policy Research, American Medical Association, June 2000.

⁴⁷ J. Gruber and L. Levitt, “Tax Subsidies for Health Insurance: Costs and Benefits,” *Health Affairs* 19 (Jan/Feb 2000).

⁴⁸ Lewin Group, *Health Coverage 2000: Cost and Coverage Analysis of Eight Proposals to Expand Health Insurance Coverage*. Prepared for RWJF, Sept 2000, Impact estimates for AMA proposal.

⁴⁹ For detailed information on regulations in each state, as of May 2004, see table available at: http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf.

⁵⁰ Our work in New Jersey and New York was less comprehensive than in the other five states, in large part because there have already been a number of excellent studies the individual health insurance reforms in these two states. (See especially Kathy Swartz’s research on New Jersey and Mark Hall’s research on New York.) In New Jersey, Margaret Koller and Amy Tiedemann of the Rutgers University Center for State Health Policy, who have considerable knowledge of the New Jersey reforms and the state’s individual health insurance market, conducted key informant interviews.

⁵¹ Based on our interviews, we believe these data significantly understate the percentage of the population in Iowa that has individual coverage. In 2003, approximately 100,000 people in Iowa obtained individual insurance through the Iowa Farm Bureau. If this group is classified as having individual rather than group insurance, nearly 13 percent of the population in Iowa is covered by individual insurance.

⁵² The deductibles for the least expensive products may seem surprisingly low in several of the less-regulated states; this is because we only include here products that include maternity, mental health, and drug coverage. Higher deductible products are available but do not cover these services, even on an optional basis.

⁵³ *Health Insurance Coverage in America: 2002 Data Update*, Kaiser Commission on Medicaid and the Uninsured, December 2003, p. 7.

⁵⁴ These estimates understate the cost of individual health insurance relative to group coverage for the same income level, since individual health insurance premiums are paid with after-tax dollars rather than from gross income in most cases.

⁵⁵ In Iowa, the size of the pool is also affected by the fact that carriers are required to issue coverage to any applicant who has at least 12 months of continuous prior coverage. Coverage through the Iowa high-risk pool counts toward meeting this requirement.

⁵⁶ These results are consistent with other recent findings: see D. J. Chollet et al., *Mapping State Health Insurance Markets, 2001: Structure and Change*, Washington, D.C.: Academy Health, September 2003.

⁵⁷ Ibid.

⁵⁸ Unpublished tabulations of the NJ Family Health Survey, IHCP Supplement, 2002, by the Rutgers Center for State Health Policy.

⁵⁹ This carrier rejected from 30 percent to 35 percent of applicants, and another 35 percent of applicants were accepted subject to an exclusion or rate add-on for poor health or the potential for poor health (for example, age).

⁶⁰ M. Suszynski, “Florida Court Rules Against Out-of-State Insurer” in BestWire, May 6, 2002 (wire service by A.M. Best Company, Inc., found on LexisNexis Nov. 10, 2003); see also American Medical Security Group, Inc., Form 10-K, for fiscal year ended December 31, 2002.

⁶¹ American Medical Security Group, Inc., Form 10-K, for fiscal year ended December 31, 2002.

⁶² http://www.naic.org/government_relations/health_policy/assoc_health_plans.htm.

⁶³ Congress is considering legislation that would largely exempt association health plans from state insurance regulation in an effort to make insurance more accessible to small businesses. In place of state requirements, the U.S. Department of Labor would be responsible for oversight of association health plans. Critics of this legislation express concerns about the lack of stringent standards to be imposed upon association plans, as well as fears that the Department of Labor lacks the expertise or resources to adequately oversee the plans.

⁶⁴ J. Treaster, “Insurers Want One Regulator Instead of 50,” *New York Times*, December 26, 2003, C1.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

[*Stretching State Health Care Dollars During Difficult Economic Times*](#) (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Despite budgetary-crisis conditions that have limited states' spending on health programs, many states have managed to implement innovative strategies: they have stretched health care dollars by using a portion of state money to leverage private, federal, and additional state funds. In other words, these states have expanded health care access, coverage, and efficiency through sound financial management—by judiciously investing a little to gain a lot.

[*The Affordability Crisis in U.S. Health Care: Findings from the Commonwealth Fund Biennial Health Insurance Survey*](#) (March 2004). Sara R. Collins, Michelle M. Doty, Karen Davis, Cathy Schoen, Alyssa L. Holmgren, and Alice Ho. The authors report that widespread support for federal action on the looming affordability crisis in American health care may stem from discontent with the health care system among both those with and without health insurance.

[*Approaching Universal Coverage: Minnesota's Health Insurance Programs*](#) (February 2003). Deborah Chollet and Lori Achman, Mathematica Policy Research, Inc. In 2001, Minnesota had the highest rate of health insurance coverage among the nonelderly—95 percent. While a high rate of private insurance is an important factor, the state also operates five public programs that collectively cover nearly all adults and children without private coverage. This report reviews the eligibility rules, covered services, and funding for each of these programs and attempts to identify lessons for policymakers across the country.

[*Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times*](#) (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

[*Health Insurance Tax Credits: Will They Work for Women?*](#) (December 2002). Sara R. Collins, Stephanie B. Berkson, and Deirdre A. Downey, The Commonwealth Fund. This analysis of premium and benefit quotes for individual health plans offered in 25 cities finds that tax credits at the level of those in recent proposals would not be enough to make health insurance affordable to women with low incomes.

[*Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*](#) (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work. These include raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

[*Individual Insurance: How Much Financial Protection Does It Provide?*](#) (April 17, 2002). Jon R. Gabel, Kelley Dhont, Heidi Whitmore, and Jeremy Pickreign, Health Research and Educational Trust. *Health Affairs* Web Exclusive (*In the Literature* summary). This article demonstrates that a \$1,000 tax credit would be more than adequate to buy individual coverage for healthy, young, single males, but it would not even come close for their middle-aged peers.

[*Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*](#) (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

[*Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?*](#) (December 2000). Katherine Swartz, Harvard School of Public Health. Efforts to improve the functioning of individual insurance markets require policymakers to trade off access for the highest risk groups against keeping access for the lowest risk groups. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, discusses how individual insurance markets might best be designed in view of this trade-off.

