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

SHORT CASE STUDIES OF SIX STATES

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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 summary report and analysis of the seven-state study.

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CONTENTS

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CASE STUDY: IOWA
(State with Weaker Regulation)

Key Quotes

"Short-term goals have been achieved: portability, preexisting condition protection, and stability of the industry; but the longer-term goal, making individual health insurance affordable, has not been successful."

Former insurance regulator

"We don't close a block of business; we try to reward people who stay healthy. After the first year, the healthy people (those with an individual medical loss ratio below 16 percent) pay only 93 percent of the general rate increase, while those in poorer health (with an individual medical loss ratio higher than 71 percent) will pay 107 percent of the general rate increase. This keeps healthy people in the block rather than shopping around after the first year, and it puts a cap on how much their experience will affect those in poor health. This way we do not have to close the block with all the sick people and open a new block for the healthy people the way our competitors do."

Commercial insurer

"We offer coverage to those who apply 65 to 70 percent of the time, but many agents know our underwriting guidelines so they won't even go through the application process with us for some of their clients. We impose exclusions or riders for 35 percent of those we do accept."

Same commercial insurer

Overview of State Regulatory Reforms

Iowa instituted individual market reforms in 1996 and modified them slightly in 1997 to comply with HIPAA. The reforms passed in 1996 included:

- Portability provisions—people with group coverage can change jobs or insurers without undergoing a new exclusion period; people with prior group coverage must be offered a basic or standard individual policy, as long as they apply within two months of the end of their group coverage; and anyone in the high-risk pool can transfer to individual coverage after one year without preexisting condition riders.
- Rating restrictions—these involve restrictions on rate variations among blocks of business for the same carrier, but do not limit rate variations within a block of business. In essence, the maximum rate variation across the block midpoint rates are limited to 2:1 (with further variation permitted to adjust for any differences in benefits). Annual rate increases for one block cannot be any more than 15 percent greater than for another block. The intention of these restrictions is to prohibit

carriers from closing blocks of business and opening new ones as a way to keep premiums lower for new, healthier applicants.

- Standardized plans—every insurer in the individual market was required to offer a basic (few benefits) plan and a standard plan. Carriers may also offer other benefit packages.
- A mandatory risk-adjustment system—this system spreads the cost of the guaranteed-issue basic and standard products more broadly. Individual carriers experiencing medical loss ratios of less than 90 percent must subsidize those carriers that have medical loss ratios above 90 percent. If the aggregate loss ratio on basic and standard plans exceeds 90 percent, then all group health insurers in Iowa, including certain self-funded groups, are assessed an amount sufficient to bring the aggregate medical loss ratio on guaranteed-issue business down to 90 percent.

Iowa already had established a high-risk pool, which reached an enrollment of 2,100 at its pre-reform peak in 1992. Known as the Iowa Comprehensive Health Association (ICHA), the high-risk pool charges rates that are 150 percent of the average market rate of the top five carriers, and the products offered were the basic and standard plans. Pool participation dropped in the post-reform period as the portability provisions enabled people to move from the small group to the individual market without rejection or exclusions. There were fewer than 200 participants in ICHA as of 2003. After 12 months in the pool, enrollees can obtain guaranteed issue in the individual market from any carrier. ICHA is subsidized by an assessment on all insurance carriers; the assessment is an offset to the premium tax required of all insurance carriers. The total subsidy in 2003 was roughly $2.5 million. The premium on the least expensive product available in the high-risk pool would consume 30 percent of the income of a 25-year-old male at 200 percent of FPL, and 84 percent of the income of a 63-year-old couple at 200 percent of FPL.

The products available in the individual market, while generally less expensive than those of the high-risk pool, are still very expensive for older and/or sicker people. A healthy 60-year-old in Iowa would pay nearly three times the rate of a healthy 25-year-old. A 60-year-old who had to buy coverage through the high-risk pool would pay a rate more than nine times the rate of the healthy 25-year-old, the second-highest range of the seven states we reviewed.

Rate regulation is weak and difficult to enforce. As one regulator pointed out, "We don't have the expertise to know if the benefit adjustment factors are reasonable. We can't afford the specialized knowledge we need to evaluate this. The rate increase limit is relatively easy to verify but the benefit adjustment factors are a black hole."

Insurers also have found ways to bypass rate restrictions altogether. As one commercial carrier explained, "We have a 'group trust,' which is a way to sign up individuals as group members under a master state policy. We file the rates in Iowa but the Iowa regulators don't have jurisdiction over them. This lets us get rate increases when we want to, in a timely way. All of our individual products in Iowa are sold through the group trust. In other states, we use associations to accomplish the same purpose."

Wellmark Blue Cross Blue Shield, the dominant carrier in the individual market in Iowa, is profitable according to industry observers and available data. (See Exhibit 1 for Wellmark's medical loss ratio history.) The underwriting profit on Wellmark's individual product sold through the Farm Bureau is not allowed to exceed a certain low percent[1] based on private negotiations between the two parties. The Farm Bureau individual product insures roughly 35,000 to 40,000 members, and its premium rates are roughly 16 percent below the market rates for individual coverage.

Wellmark has a dominant market share of roughly 60 percent of the individual market, a figure that has not changed since the 1996 reforms. It has a 95 percent share of the individuals enrolled in basic or standard products, and these people receive premium subsidies from other carriers. This "risk assessment" subsidy for basic and standard products was close to $17 million to $18 million in 2002, an amount that sometimes attracts complaints from the other carriers who must pay it. It was estimated to equal roughly 0.8 percent of individual premiums overall. The carriers themselves, however, wrote the legislation that requires the risk assessment, and so their complaints have not grown into a full-fledged revolt.

As one former insurance industry policymaker concluded, "The reforms of 1996 did not address affordability. We need a much bigger effort to get that. Iowa is experiencing high cost inflation in health. It may be time for another health reform council focused on affordability and access. Iowa has a very good public policy infrastructure. People have to take fairly centrist positions or they won't get much political traction. They can't be bomb-throwers. Health care reform is based on finding common ground."

Exhibit 1. Medical Loss Ratios for the Individual and Total Insurance Business of Dominant Carrier in Iowa

				After reform				
			Before reform	**1998**	**1999**	**2000**	**2001**	**2002**
Iowa	Wellmark-IA	Individual	81.5%	88.9%	98.8%	86.6%	82.4%	83.3%
		Total	85.0%	86.4%	89.3%	87.1%	85.5%	84.4%

Source: Authors' analysis of plan documents files and insurance department reports.

CASE STUDY: KANSAS
(State with Weaker Regulation)

Key Quotes

"Each company has its own quirky underwriting rules: some are very strict about height-weight requirements, others don't like any history of cancer, some reject for asthma or diabetes or high blood pressure, some won't take anyone who takes anti-depressant medication or has ever done any therapy. . . . Essentially, you have to be squeaky clean to be guaranteed of getting coverage from most of them. . . . We sometimes refer to the insurer underwriting departments as the 'new business prevention departments.'"

An insurance agent

"For applicants we accept, we use four rating tiers: better-than-average risk, average risk, some history of a medical problem, or a chronic problem that can be controlled . . . there's about a 20 percent difference in rates from one tier to another."

An insurance company

"Our individual block of business is doing very well . . . it's much more profitable than our large-group or small-group business . . . we have done well with the regulators in terms of rate increases. . . . They know that Kansas will only have a good market for individual health insurance when it makes business sense for insurers . . . we need to do OK financially."

The same insurance company

Overview

Beyond the requirements imposed by HIPAA, Kansas has not enacted any significant regulatory reforms in its individual health insurance market. The state has no guaranteed-issue requirements. Carriers are permitted to accept or reject applicants for coverage and impose preexisting condition exclusions. Waiting periods of up to two years can be imposed for preexisting conditions. Carriers may use a wide range of rating factors, including age, gender, and health status, with no limitations on rate variations.[2] The state's dominant carrier, Blue Cross Blue Shield of Kansas, reports that it rejects approximately 20 percent of applicants. The company also imposes a waiting period of 240 days for several conditions (such as urinary tract infections, gallbladder problems, hernias) but this period is reduced by any prior creditable coverage. BCBS varies premiums based on individual health status, using four different rating tiers.

Kansas has a high-risk pool called the Kansas Health Insurance Association (KHIA). Coverage from KHIA is available to state residents who have been rejected for coverage by two different carriers, or who have been offered individual coverage with a permanent exclusion for a preexisting condition. Benefits are considerably worse than those available in the commercial market and exclude coverage of preexisting conditions for up to 90 days. Premiums are set to be 125 percent to 150 percent of the average rates available from commercial carriers and can vary by age. The premium on the least expensive product available in the high-risk pool would absorb 8 percent of the income of a 25-year-old male at 200 percent of FPL, and 24 percent of the income of a 63-year-old couple at 200 percent of FPL. KHIA covers fewer than 2,000 residents of Kansas, largely because of its high rates. Losses on the high-risk pool are quite low and are funded through an assessment on the state's commercial insurers.

BCBS has approximately 50 percent of the individual market.[3] About a dozen other commercial insurers also market actively in Kansas. As shown in Exhibit 1 below, BCBS's medical loss ratio has ranged from 78 percent to 85 percent over recent years. Since the company does not use agents or brokers, and therefore pays no commissions, it is likely that individual health insurance is quite profitable for BCBS of Kansas.

Exhibit 1. Medical Loss Ratios for the Individual Line of Business: Blue Cross Blue Shield of Kansas

	1997	1998	1999	2000	2001	2002
Medical Loss Ratio	78%	85%	82%	85%	83%	80%

Source: Authors' analysis of plan documents files and insurance department reports.

Affordability and erosion of health insurance coverage are major concerns in Kansas, although few observers see any promising solutions on the horizon. According to one insurance regulator, "These problems are not going to get better. More and more small groups are dropping coverage, which is putting more pressure on the individual market. There is a lot of support for an individual mandate, and making people personally responsible for providing insurance for their families. But before we do that, we need to find ways to make coverage more affordable, including getting consumers more actively involved in health care cost containment. . . . We are sort of disappointed that the high-risk pool assessment is going down, because it takes pressure off the insurers to want to find solutions."

CASE STUDY: KENTUCKY
(State with Weaker Regulation and Rollback of Stronger Reforms)

Key Quotes

"It is not good for a state to be a guinea pig on a national issue."

Legislative staff

"The high-risk pool is only helpful to people with chronic conditions who have money. They used to be in Anthem [Blue Cross] where they paid a lot less than they do [in the high-risk pool] today."

Consumer advocate

"When we switched to guaranteed issue, complaints switched from the sick to complaints from the healthy."

Insurance regulator

"The 2000 reforms signaled positive signs of competition. This is good for healthy consumers, but not so great for unhealthy consumers.''

Another insurance regulator

Overview

In 1993, then-Governor Brereton Jones called a special legislative session to reform health care. As the first governor to support President Clinton in the primaries, he shared similar political goals and even some of the same political consultants. Jones's plan was to mirror what the Clinton administration proposed. He focused on purchasing alliances, standardized benefit plans (modeled on fairly benefit-rich indemnity coverage), modified community rating (rating criteria allowed for age but not gender or health status, and rates were subject to a 3:1 rate band), guaranteed issue, portability, and shorter periods (six months) for preexisting condition exclusions.

With a legislature that met only for four months every two years, the reform legislation process went very quickly in 1994. Political buy-in, however, was never achieved, and the reforms were never fully implemented. Reprieves on converting existing policies into the standardized, community-rated policies required by the 1994 reforms were extended through 1997. In effect, only new entrants to the individual market were buying reformed products.[4] As a result, more than two-thirds of the individual market was left out of the reformed products. Sick new enrollees switched to reform products for the better rates and more comprehensive coverage, which imposed all

their costs on a small pool of healthy new enrollees. Rates for the reform products rose astronomically for the healthy.

In 1995, 31 commercial carriers left the state, affecting roughly 30,000 individual enrollees. In 1996, another ten carriers left, affecting another 34,000. Most of these enrollees were healthy. Prior to reform, there were only three carriers in the individual market with more than 10,000 enrollees, and Anthem always had at least 80 percent of the market. As one active insurer in the market commented, "We are of mixed opinion whether a lot more carriers in the market is good. There are usually only three or four real players in every state, even though 30 to 40 might be present. The [marginal players] go after the healthy, they open and close pools regularly, hitting sicker enrollees with big rate increases to get rid of them. Industry conduct regulations aren't a bad idea."

Despite this reality, as one consumer advocate complained, "Kentucky has created a folklore that competition is necessary to control costs, and that the reforms were examples of excessive government regulation."

The purchasing alliance never got off the ground. It originally was mandated for all public workers at state, local, state university, and school board levels and launched with more than 300,000 lives.[5] The 1996 legislated rollbacks, however, left only retired state employees in the purchasing alliance. Meanwhile, individuals were allowed to buy in to the standard plan at group rates. This program became Kentucky Care, and within two years it went bankrupt.

Very few people bought modified community rating and standardized plans, which were considered a national threat by the Health Insurance Association of America (HIAA). The trade group launched a well-funded advertising campaign to discredit these reforms. By 1996, insurers were permitted to issue nonstandard plans, and the rating band spread was increased to 5:1, with preexisting condition exclusion periods extended to 12 months. These changes did not stop more commercial carriers from leaving the state.

In 1998, the legislature eliminated most of the restrictions on product design and rating, abolished the Health Purchasing Alliance, and established a stop-loss pool for high-risk individuals insured by the carriers. The Guaranteed Acceptance Program (GAP) was funded by an assessment on carriers that did not offer coverage to GAP-eligible individuals. Roughly 3,000 individuals enrolled over time. But the program soon was replaced by the Kentucky Access Program, a high-risk pool created by the legislature in 2000.

The 1998 reforms were meant to attract carriers back into the market and reduce rates for the healthy enrollees of existing carriers. Rate reductions did not materialize. But

Humana, a national insurer based in Kentucky, did enter the individual market in Kentucky for the first time in 1998.

The Kentucky Access Program (KAP) began in January 2001. It continued the GAP funding mechanism of premium assessments and received a subsidy from the state's tobacco settlement funds. This program did help bring four more carriers into Kentucky, although most are reported to be fairly inactive, marketing mostly very high-deductible and short-term policies. KAP enrolls about 75 new eligibles per month and has a very high turnover rate because it is viewed as a "parking place between group insurance or death." KAP generally has about 1,000 enrollees at any one time. New members generally have been rejected by carriers or have one of 35 "high-cost conditions" that make them eligible for KAP; fewer than one-half of 1 percent of members qualify for coverage based on HIPAA. Roughly 10 percent to 11 percent of enrollees join KAP because the premium quote from private carriers exceeded that of KAP. Premiums are set at 125 percent of the market average. The pool originally was funded with roughly $19 million per year in premium assessment subsidies and approximately $10 million per year earmarked from the state's tobacco settlement funds, although a large proportion of these earmarked funds were taken back for general fund use in 2002 and 2003.

The Kentucky Access Program gets very mixed reviews. While growth rates in individual premiums have stabilized since its passage, some industry observers believe that the rate stabilization occurred because the legislature finally stopped changing the rules of the individual health insurance market. Consumer advocates are upset that tobacco funds are being used to subsidize the high-risk pool rather than to subsidize Medicaid enrollment. The percentage of uninsured in Kentucky has remained around 15 percent to 16 percent despite all the changes in the individual market in recent years.

Meanwhile, the medical loss ratio on the individual market business of the dominant carrier, Anthem, dropped below 70 percent after the 2000 reforms, compared to a range of 75 percent to 92 percent during the 1990s. This figure is better than their overall medical loss ratio of 81 percent to 82 percent before 2000 and is the lowest MLR in the individual business of any dominant carrier in the seven states we reviewed.

At the same time, Kentucky has the highest premium rate differential of the seven states. The highest rate for a high-risk 60-year-old male is 14.6 times that of the lowest rate for a healthy 25-year-old male. The least expensive product in the individual market ranges from 3 percent of annual income for a 25-year-old male to 23 percent of annual income for a 63-year-old couple, calculated at an income of 200 percent of the federal

poverty level. In the high-risk pool, the least expensive product for the 25-year-old would absorb 18 percent of income, and for the 63-year-olds, 89 percent of income, calculated at an income of 200 percent of the federal poverty level.

Perhaps the greatest gain of the reforms was that the state was temporarily rid of cherry-picking commercial insurance companies. There are products on the market for sick individuals, but they are generally not affordable in a state like Kentucky that has a large low-income population. As one state policymaker concluded, "Medicaid expansions may have done something for the uninsured but the individual insurance market reforms did nothing at the end of the day."

Exhibit 1. Enrollment in the Individual Insurance Market in the State of Kentucky

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Anthem*	51,867	58,749	58,053	87,913	85,502	81,954	88,990	88,166	82,462	92,947
Kentucky Kare	n/a	n/a	n/a	7,979	6,745	3,104	0	0	0	0
Humana							n/a	n/a	5,031	5,018
Other**				75,000	n/a	n/a	n/a	n/a	24,500	n/a
Total				170,892					112,000	

* Enrollment for 1993 to 1998 includes members of Southeastern United MediGroup and SouthEastern Group. The two merged in 1998 to form Anthem Blue Cross Blue Shield.

** In 1996, 45 of the largest companies that left the market were covering about 75,000 individuals. By 2002, six carriers were selling policies in the individual market.

Source: Authors' analysis of plan documents files and insurance department reports.

Exhibit 2. Concentration in the Individual Insurance Market in the State of Kentucky

	1994	1995	1996	1997	1998	1999	2000	2001	2002
Largest Insurer	72.22%	54.24%	82.55%	86.02%	89.74%	100.00%	100.00%	94.25%	94.88%

Source: Authors' analysis of plan documents files and insurance department reports.

Exhibit 3. Medical Loss Ratios for the Largest Carrier in the Individual and Total Insurance Market in the State of Kentucky

			After reform							
		Before reform	1995	1996	1997	1998	1999	2000	2001	2002
Kentucky Anthem KY	Individual	75.9%	55.6%	87.1%	76.8%	92.1%	83.5%	80.6%	69.2%	69.1%
	Total	75.8%	84.8%	94.3%	88.6%	85.0%	84.5%	80.5%	82.3%	80.8%

Source: Authors' analysis of plan documents files and insurance department reports.

CASE STUDY: MASSACHUSETTS
(State with Stronger Regulation)

Key Quotes

"If the market has been structured to serve healthy people, any reforms to help the unhealthy will disadvantage the healthy. That's the central tension and the major political dilemma and challenge with health insurance market reforms. Our market now works much better for unhealthy people but not as well as before for the young and healthy. . . . We have had to be constantly vigilant to resist attempts to undermine or roll back our reforms . . . and the pressures are intensifying because of rising health care costs."

Consumer advocate

"Having big local carriers makes a huge difference. It lets the state resist the assault of national players who have a uniform agenda and want the same weak rules in every state . . . it's easy to sink to the lowest common denominator unless the state has local carriers who can't go anywhere."

State legislator

"We find we can't be creative in the individual market because it's too regulated in terms of benefits. . . . Products are much more expensive than they need to be. It would be better to set a minimum floor on coverage and then let us be creative, like we can be in the small-group market. . . . Some coverage is better than none."

Health insurance executive

"Carriers are not marketing individual or small-group coverage actively in Massachusetts. The health plans like big glamorous accounts. They say they are afraid the markets will explode. The only risk of explosion I see is an explosion in insurer profits . . . coverage could be much more affordable if insurers did their jobs well."

Small business association executive

Overview

Individual market reforms were adopted in Massachusetts in 1996, with some subsequent modifications in 2000. The 1996 reforms were enacted largely as a result of the efforts of a coalition of consumer advocates, small business associations, and Blue Cross Blue Shield of Massachusetts (BCBSMA). Consumer advocates were concerned about availability of coverage, particularly for those with preexisting health conditions, as well as the lack of coverage for certain benefits, including prescription drugs. Small business associations were concerned about adverse selection, which was occurring because of different underwriting

rules in the small-group and individual insurance markets.[6] BCBSMA wanted a "level playing field" for all carriers in the individual market and, in particular, to stem its financial losses on the individual line of business. Prior to reform, BCBSMA was the only carrier required to accept all applicants (although it could impose a waiting period of up to three years for preexisting conditions). Unlike other carriers, it was required to use community rating and to have its rates receive prior regulatory approval, after a lengthy and often contentious public rating hearing process.

The major provisions of the 1996 reform law (Chapter 176M of the Massachusetts General Laws) were: mandatory participation in the individual market for carriers that covered more than 5,000 people in the state's small-group market; guaranteed issue at least during the annual two-month open enrollment period (carriers could issue coverage at other times during the year, provided it was on a guaranteed-issue basis); guaranteed renewability; prohibition of preexisting condition exclusions and waiting periods; the adoption of three "actuarially equivalent" standardized benefit packages (medical, preferred provider, and managed care); and modified community rating, which permitted the use of age and geography for rating purposes subject to certain rating bands. Carriers were permitted to continue to maintain and renew individual plans that did not comply with the new reform law for a period of up to three years.

The individual health insurance law was amended in 2000 in several significant ways. Carriers are now required to have continuous open enrollment to ensure availability at all times for consumers. To prevent adverse selection, carriers are permitted to impose up to a six-month exclusion or waiting period for preexisting conditions for applicants without prior insurance coverage. Self-employed people are now permitted to obtain coverage in either the individual or small-group markets, instead of being required to purchase in the small-group market. Carriers have been given flexibility to offer one benefit package in addition to the standardized products, although any nonstandard plan must receive prior regulatory approval and meet a range of regulatory requirements. Finally, the rate bands were expanded somewhat to permit greater variation in rates based on age (from a range of 1.5 to 1, to 2 to 1).

Individual market reform appears to have been quite successful in Massachusetts in promoting availability of coverage while retaining some choice of carrier. The reforms were enacted with minimal market disruption. The link between participation in the small-group and individual markets seems to have been effective at keeping carriers in the market. The major carriers were local plans that could not withdraw from the market. A few commercial carriers left the small-group market because they did not want to sell

individual coverage, and a number of other carriers that had sold individual products decided not to sell the new guaranteed-issue plans. These carriers, however, had relatively few enrollees.

As shown in Exhibits 1 and 2, enrollment in the individual market has declined dramatically and become sharply concentrated since reform. BCBSMA now has more than 60 percent of members who have individual health insurance. Several factors seem to explain these market trends. First, the reform eliminated the ability of carriers to market short-term individual health insurance policies. These plans had covered a significant number of enrollees prior to reform, particularly younger people and those between jobs. Second, many self-employed people now purchase coverage in the small-group market, partly as a result of better public information about their ability to do so. Third, rising premiums and the growing unaffordability of health insurance coverage has no doubt contributed to the reduction in people with individual coverage.

Market concentration has increased because of the weak rate regulatory standards in the law. 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. This weak 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. According to one consumer advocate, "The biggest concern in the reforms is that rate regulation is missing. However, there is little legislative appetite for adopting tougher standards." Lastly, BCBSMA's overall membership and share of the Massachusetts health insurance market has grown significantly in the past several years, in part because of the financial difficulties of several major competitors.

The reforms had the financial effect BCBSMA had hoped for: the individual line of business has become quite profitable for the company, with a medical loss ratio of 85 percent or less in most years since reform (Exhibit 3). Based on our interviews, other carriers have experienced similar financial results.

Affordability of individual insurance coverage is a major issue in Massachusetts. Policymakers have responded by allowing carriers to market products with higher cost-sharing (as high as an annual deductible of $5,000) and without coverage for prescription drugs, a benefit that is required in the standardized plans.

Exhibit 1. Enrollment in the Guaranteed-Issue Individual Insurance Market in the State of Massachusetts

Carrier	1996	1997	1998	1999	2000	2001	2002
BCBSMA	40,800	38,600	28,272	27,390	25,804	27,848	31,473
Harvard Pilgrim	29,800	20,232	23,370	18,648	13,231	9,593	8,128
Others	64,763	67,351	42,522	28,909	16,233	11,693	11,693
Total	135,363	126,183	94,164	74,947	55,268	50,911	51,294

Source: Authors' analysis of plan documents files and insurance department reports.

Exhibit 2. Market Share in the Individual Insurance Market in the State of Massachusetts

Carrier	1996	1997	1998	1999	2000	2001	2002
Largest carrier	30.1%	30.6%	30.0%	36.5%	46.7%	54.6%	61.3%
Largest two insurers	52.2%	46.6%	54.8%	61.4%	70.6%	73.5%	77.2%
Smallest 50%	0.8%	0.4%	1.2%	0.8%	2.0%	3.1%	2.7%

Source: Authors' analysis of plan documents files and insurance department reports.

Exhibit 3. Medical Loss Ratios for the Largest Carrier in the Individual and Total Insurance Market in the State of Massachusetts: Blue Cross Blue Shield of Massachusetts

	Average for three years prior to reform	1997	1998	1999	2000	2001	2002
Individual line of business	90+%	75.8%	87.7%	90.4%	83.3%	84.4%	79.8%
Total business	88.5%	80.2%	85.1%	85.2%	84.9%	85.2%	86.1%

Source: Authors' analysis of plan documents files and insurance department reports.

CASE STUDY: WASHINGTON
(State with Weaker Regulation and Rollback of Stronger Reforms)

Key Quotes

"The individual market just isn't fixable at the state level."

Experienced Washington State policymaker

"The only way to have a private individual insurance market is to exclude the sick."

Insurance broker for the small and individual market

"You can't just address one of the markets, the small-group or individual market, without realizing the problem will pop up somewhere else. People and their brokers will find the cheapest option. Insurers always are trying to keep these moles out of their holes. We call it 'Whack-a-Mole.'"

Insurance company staff involved with individual and small group markets.[7]

"The high-risk pool is not means-tested. While thousands of people with incomes above 125 percent of Federal Poverty Level are being cut off the Basic Health Plan [a Medicaid expansion plan], the state is allowing a $30 million subsidy to support a couple of thousand people in WSHIP [the high-risk pool]. Only the sick who can afford the WSHIP premium can get into it. Who is more deserving of community assistance in paying for their care?"

State legislative staffer involved in health care legislation

Overview

The reforms in Washington State that began in 1993 were intended to improve access to the individual and small-group markets, and in particular to improve access for high-risk individuals.[8] They were passed in an era of anticipation of a national universal health program, under the sponsorship of a new Democratic governor and a Democratic-controlled legislature with a comprehensive agenda for health reform. These efforts included the elimination of medical underwriting; elimination of riders and permanent exclusions for preexisting conditions; shortening the preexisting condition limitation to a three-month period, down from pre-reform periods of as long as two years; and the imposition of guaranteed-issue and guaranteed-renewal, community rating based on family size and geography only, and rate review. Another feature of the 1993 reforms was an employer mandate. Between 1993 and 1995, enrollment in the individual market grew from 218,000 to a peak of 296,000 enrollees (Exhibit 1). At the same time, in 1994 close to 30 insurers—mostly commercial carriers with very small market shares—cancelled their products and left the state.

Republicans took over control of the state legislature in 1994. The reforms of 1995—largely rollbacks of the 1993 reforms—reflected a more conservative approach to health insurance. The employer mandate was eliminated before regulations came into effect, and community rating criteria were expanded to allow rates to reflect age and industry. In addition, individual products were permitted to omit maternity, mental health, and substance abuse benefits. Small-group reform was passed in 1996 that allowed groups of one to participate in this market, which attracted healthy individuals from the individual market into small-group products. Between 1995 and 2000, enrollment in the individual insurance market steadily dropped to 134,000. The largest insurer in the individual market, Premera Blue Cross Blue Shield, stopped writing new business in November 1998. It was followed in early 1999 by Regence and by Group Health of Puget Sound, the only other major carriers that sold individual health insurance (Exhibit 2).

In 2000, the remaining 1993 reforms were repealed in an effort to attract carriers back into the market. Rate regulation was replaced with a minimum medical loss ratio of 72 percent. Medical underwriting was allowed; a uniform 700-question[9] medical questionnaire was designed so carriers could reject up to 8 percent of new applicants. As well, the preexisting condition exclusion period was extended to nine months. After the 2000 reforms, the locally domiciled existing carriers resumed writing new business. But its enrollment grew to only 157,000 as of 2002, or roughly 23,000 more members than it had at its point of lowest enrollment two years before. As of January 2003, no new major carriers reentered the market. Market concentration had increased, however, and the market share of the top two carriers was 84 percent in 2002 compared to 61 percent in 1993 (Exhibit 3). This change primarily was caused by the consolidation of locally domiciled carriers, although the exit of commercial carriers played a small role.

Washington State created a high-risk pool in 1988. During the period when the state prohibited medical underwriting and shortened preexisting condition exclusion periods to three months, enrollment in the pool dropped from 4,400 in 1993 to a low of 712 in 1996. Enrollment began to rise again after the 1995 rollbacks, and reached 2,333 by 2000. As of 2003, enrollment has not grown beyond 2,500. In the high-risk group—for the least expensive product that included maternity, mental health, and prescription drug coverage in 2003—premiums ranged between 16 percent of income for a 25-year-old male to 70 percent of income for a couple aged 63. These rates are calculated for people with an income level equal to 200 percent of the federal poverty level. The premiums are generally viewed as unaffordable, despite a state subsidy mechanism that contributes $30 million to the pool: an average of $12,000 per recipient. Many of the participants in the pool have third parties covering their premiums, including the state (for HIV patients who

would otherwise be in Medicaid) and a foundation supporting kidney dialysis patients. Enrollment in the pool does not come close to the roughly 16,000 people rejected by carriers for high scores on the health questionnaire. One survey of a small sample of people who were screened out with the health questionnaire indicated that roughly one-third went into the WSHIP and 27 percent were uninsured. Roughly another 40 percent found other insurance either through a family member, a public program, or a new job, or they retook the health questionnaire and were accepted into the individual market.

Exhibit 1. Enrollment in the Individual Insurance Market in the State of Washington

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Group Health Cooperative of Puget Sound	25,915	25,824	24,726	20,519	20,489	22,296	22,943	17,069	19,572	21,066
Premera Blue Cross★	133,254	187,113	199,396	171,811	144,609	104,620	75,493	56,961	70,877	58,407
Regence Blue Shield★★	42,862	47,497	48,873	53,795	55,713	55,684	56,382	46,076	56,753	73,771
Other	16,313	19,931	22,591	19,830	16,433	12,860	13,439	14,034	4,525	4,054
Total	218,344	280,365	295,586	265,955	237,244	195,460	168,257	134,140	151,727	157,298

★ Enrollments for 1993–1997 include members of Medical Services Corp. of Eastern Washington and Blue Cross of Washington and Alaska. The two merged in 1998 to form Premera Blue Cross.

★★ Enrollments for 1993–1996 include members of Pierce County Medical Bureau and King County Medical Blue Shield, which merged with Regence Blue Shield in 1997.

Source: Authors' analysis of plan documents files and insurance department reports.

Exhibit 2. Medical Loss Ratios for the Largest Carriers in the Individual and Total Insurance Market in the State of Washington

		Before 1996	1996	1997	1998	1999★	2000	2001	2002
Premera Blue Cross-WA	Individual			80.8%	80.0%	80.8%	79.8%	83.4%	83.5%
	Total			88.8%	86.4%	84.4%	85.6%	85.2%	84.9%
Regence Blue Shield-WA★	Individual	130.8%	113.5%		90.8%	78.4%	82.8%	81.7%	84.8%
	Total	102.3%	84.7%	82.6%	85.3%	85.3%	86.4%	82.1%	82.9%
Group Health Cooperative of Puget Sound-WA	Individual	123.3%	112.6%	113.5%	98.2%	90.8%	99.4%	97.6%	110.8%
	Total	96.3%	93.6%	96.8%	95.7%	95.4%	89.9%	85.9%	86.5%

★ Premera BCBS stopped writing new individual insurance in 1999, claiming large financial losses due to the individual market regulations. Note that the MLRs on individual business are lower than those on the total business. While there are generally higher administrative costs associated with the individual business, a 20 percent administrative expense ratio seems more than adequate considering Premera claimed that it was making money on the individual line since the 2000 reforms. And yet the post-2000 MLR is several percentage points higher after the reforms.

Source: Authors' analysis of plan documents files and insurance department reports.

Exhibit 3. Concentration in the Individual Insurance Market in the State of Washington

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Largest two insurers	61.03%	66.74%	67.46%	64.60%	60.95%	53.30%	78.38%	76.81%	84.12%	84.03%
Smallest 50% of insurers	7.47%	5.10%	5.57%	3.71%	3.45%	3.97%	4.57%	10.46%	2.98%	2.58%

Source: Authors' analysis of plan documents files and insurance department reports.

CASE STUDY: NEW JERSEY
(State with Stronger Regulation)

Margaret M. Koller, M.S., and Amy M. Tiedemann, Ph.D.

New Jersey's Individual Health Coverage Program (IHCP) was created from the Health Care Reform Act of 1992 and represented the state's attempt to address access issues by restructuring the individual coverage market. These regulations were implemented in 1993, and at its peak in 1996, the IHCP boasted an enrollment of over 200,000. However, after a surge in the mid-1990s, the IHCP experienced a steep enrollment decline, losing membership at a rate of approximately 3 percent per quarter until 2002 when the decline began to abate.

Some of the key features of the IHCP include: guaranteed issue and renewal; pure community rating;[10] standardization of benefit plans; a carrier loss assessment reimbursement mechanism; and the creation of the Individual Health Coverage Program Board, an independent regulatory body vested with oversight authority. While enrollment trend data indicate that the IHCP was successful in its early years (through the mid-1990s), the current decline suggests that additional regulatory intervention may once again be necessary to stabilize the market. While the steep membership decline has slowed over the recent quarters, and many would be reluctant to characterize the market as being in a "death spiral" (a phrase frequently used to describe the market in 2002–2003), policy changes may be necessary to once again make the IHCP a robust, sustainable market.[11]

Interviewees agree that the cycle of increasing premiums and decreasing membership has left the market unattractive and unaffordable for young, healthy subscribers. While there may be agreement among policymakers and other stakeholders with respect to identifying the problems in the IHCP, there is considerable debate among these players with regard to the market's overall performance, the priority for policy options, and the general prognosis for the future of the non-group market.

Select Features of the IHC Market Reforms

The Loss Assessment Mechanism. In New Jersey, there has been a steep decline in the number of carriers providing coverage in the individual market: from a high of 28 in the initial post-reform years to nine carriers in 2004. Of the nine carriers, three are responsible for 90 percent of the covered lives (Exhibit 1).[12]

The loss assessment mechanism, a major feature of New Jersey's 1992 reform legislation, is thought to be closely linked to the initially large number of participating carriers and the subsequent exodus of many carriers. The goal of the loss assessment was to encourage carriers to participate in the individual market by offering a mechanism by which losses above

a certain amount would be reimbursed. The regulators wanted to make the market more competitive and avoid the continuing scenario of one carrier (in New Jersey's case, Blue Cross Blue Shield) being burdened with all the risk and the title of "payer of last resort." The "Play or Pay" feature requires that 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.

Prior to 1997, carriers were reimbursed for their first-dollar losses in the individual market, including nonmedical losses. In 1998, the New Jersey legislature amended the carrier loss assessment mechanism to require carriers to incur a 115 percent loss, excluding nonmedical losses, before they would be eligible for any reimbursement.[13] Without this financial "carrot," many of the smaller carriers decided to abandon the market.

Exhibit 1. Total Market Share in New Jersey's Individual Health Coverage Program

	1997	1998	1999	2000	2001	2002	2003
Largest carrier	56.3%	62.3%	64.8%	62.4%	60.8%	59.3%	57.5%
Largest two carriers	63.6%	71.0%	78.2%	81.2%	81.5%	77.5%	74.7%
Largest five carriers	79.5%	91.0%	95.2%	97.9%	98.0%	97.7%	97.8%

Source: NJ Department of Banking & Insurance fourth quarter administrative data.

Standardization of Plans. One of the key features of the 1992 IHCP reforms was the standardization of plan designs to promote administrative simplification and facilitate consumer access to coverage. Further, it would allow consumers to comparison shop for benefits based on premiums and would not be overwhelmed by carriers offering a multitude of plan options (Exhibit 2).[14]

Exhibit 2. Characteristics of the Standard Health Benefits Plans

	Plan A/50	Plan B	Plan C	Plan D	HMO
Carrier/Covered Person Coinsurance	50%/50%	60%/40%	70%/30%	80%/20%	Carriers have the option to cover drugs at 50%
Deductible/ Copayment Options	$1,000/$2,500	$1,000/$2,500	$1,000/$2,500	$500/$1,000	$10/$15/$20/$30
Hospital Copay	No	Yes-In addition to deductible	No	No	Yes

Source: New Jersey Individual Health Coverage Insurance Program Buyer's Guide found at http://www.state.nj.us/dobi/reform.htm.

Basic and Essential Health Plan. In addition to the five plans described above, in January 2003, New Jersey implemented its Basic and Essential Health Plan designed to provide "bare bones" health coverage to members. With lower premiums and a narrower benefit scope, the plan was designed to attract the younger, healthier subscribers and keep some people from completely foregoing health insurance. Premiums vary by carrier and can be modified as community rated or pure community rated. Rates in 2003 for single Basic and Essential coverage ranged from a low of $120 per month to a high of $2,987 per month. Copayments can be quite steep—$500 copayment per hospital stay and $100 copayment for an emergency room visit.[15] Through the second quarter of 2004, take-up in this plan has been quite modest, with a total enrollment of 1,387 lives.

Potential Policy Options

The apparent adverse selection spiral that characterized the market in the late 1990s and into the beginning of this decade seems to have slowed, with an estimated membership of 77,000 in the second quarter of 2004.[16] IHCP enrollment cycles appear linked to the economic employment trends in the state. During the mid- to late-1990s when New Jersey enjoyed an economic boom and an increase in employer-sponsored coverage, the individual market eroded as people had access to other forms of more affordable health insurance coverage. Despite the recent stabilization, most experts agree that this market is still in need of repair. This is particularly true considering the fact that at its peak in 1996, the IHCP boasted an enrollment of 200,000. The goal of new reforms would be to make the market more attractive to younger, healthier people—who may not have access to employer-sponsored coverage—by making it more affordable.

Modified community rating and flexibility in plan design appear to be two of the more popular and politically viable reform options. However, there has been some additional discussion about creating a high-risk pool or some form of reinsurance mechanism to offset some of the costs carriers incur for catastrophic cases or merging the individual and small group markets. These latter two options, however, were met with greater skepticism by interviewees.

Regardless of which strategy for modification is pursued, a complete dismantling of the current IHCP structure seems unlikely and trade-offs will be necessary for reform to move forward and be successful.

NOTES

[1] In our interview with this individual, we promised not to reveal the exact percent.

[2] Based on a 1994 law, carriers must pool experience for closed and open blocks in setting premium rates, to prevent carriers from closing blocks of business as a means of "cleaning up" their individual plans.

[3] There were virtually no data available on the individual health market in Kansas: The insurance department had no enrollment history and virtually no information about the financial results of individual carriers.

[4] In response to the 1994 reforms, Anthem designed an association product, through its relationship with the local Farm Bureau, and sent roughly 30,000 healthy new enrollees to the Farm Bureau association for cheaper coverage until the time the 1998 rollbacks took effect.

[5] Forty percent of the privately insured market was self-insured; total population was only 4 million.

[6] Under the state's small-group law adopted in 1991, small-group carriers were required to provide coverage on a guaranteed-issue basis to small groups with 1–25 employees (the self-employed were the so-called groups of one). In contrast, carriers in the individual market, other than BCBS, were allowed to medically underwrite, including rejecting applicants or imposing permanent exclusions for preexisting conditions. Self-employed individuals and even some small groups took advantage of these different underwriting requirements to obtain coverage in the market most advantageous to them. Healthy people purchased individual coverage; people with health problems sought small-group coverage.

[7] This was a part of a conversation about the interaction between small-group and individual markets, in particular, the role associations play in retaining healthy members while finding ways to get unhealthy members out of their risk pools. Association business (such as chambers of commerce) and MET business (multiple employer trust) are rated as a large group and is not subject to community rating. Some of these groups have employees or members fill out the health survey and put employees into separate "pods" for costing purposes. Then they rapidly increase the rates on the high-cost "pods."

[8] A. M. Kirk, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Politics, Policy & Law* 25 (February 2000): 133–73.

[9] If you could answer "no" to the 10 basic questions, you did not have to answer the remaining 690.

[10] Guaranteed issue and renewal states that an eligible person is guaranteed health insurance coverage in the IHCP regardless of health status. There is a 12-month waiting period for preexisting conditions, though members will continue to receive coverage for conditions unrelated to their preexisting condition. Community rating means that the same premiums will apply to all people who purchase the identical IHCP plan. There can be no premium differentiation based on age, sex, gender, occupation, geography, or health status. Additional detail on these definitions can be found at http://www.state.nj.us/dobi/bgihc98.htm#DESCRIP.

[11] J. C. Cantor et al., "Non-Group Health Insurance in New Jersey," *Facts & Findings* (New Brunswick, N.J.: Rutgers Center for State Health Policy, July 2004); A. C. Monheit, J. C. Cantor, M. Koller, and K. S. Fox, "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey," *Health Affairs* 23 (July/August 2004): 167–75.

[12] NJDOBI 2004 administrative data.

[13] Monheit et al., "Community Rating," 2004.

[14] Cantor et al., "Non-Group Health," 2004.

[15] New Jersey Individual Health Coverage Insurance Program Buyer's Guide found at http://www.state.nj.us/dobi/reform.htm.

[16] The second quarter 2004 enrollment number is relatively unchanged since second quarter 2003. In fact, the decline slowed to below 2 percent per quarter beginning in 2002 and the decrease slipped even lower in 2003. Source: NJDOBI administrative data.

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.