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Challenges of partial reform – Lessons from State Efforts to Reform the Individual and Small Group Market Before the Affordable Care Act

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Executive summary

In the early 1990s and through the mid-2000s, a number of states took on the challenge of regulatory reform of their individual and small group health insurance markets. These early health reform efforts, particularly in the individual health market, focused on expanding access to health insurance for those who had difficulty obtaining coverage. The barriers to access were usually due to a combination of health status and affordability.

*During this era, most states pursued approaches that offered **"partial" or "piecemeal" solutions**: states regulated insurance carriers, but did not always level the playing field by applying standards across the whole market...or incentives for consumers to purchase health insurance. Without strong incentives for broader participation, the consumers who took advantage of newfound access tended to be sicker than the overall population, **leading to adverse selection, premium increases, and health plan market exits.***

These states were innovators at the time. Reforms had not yet been tried and tested. States used health plan regulation as their primary reform tool, focusing on three major components 1) provisions to circumscribe health plans' ability to use health status as a basis for premiums, denying coverage, or excluding coverage for pre-existing health conditions; 2) guaranteed issue provisions that require all health plans that operate in the market to offer coverage to eligible individuals and 3) guaranteed renewability and portability requirements that define the terms under which health plans assure enrollees access to coverage over time and across insurance carriers or products.

During this era, most states pursued approaches that offered "partial" or "piecemeal" solutions: they regulated insurance carriers, but did not always level the playing field by applying standards across the whole market. They also did not couple regulation with incentives for large numbers of consumers to purchase and maintain health insurance (such as penalties for going uninsured or substantial subsidies to make insurance more affordable). Without strong incentives for broader participation, the consumers who took advantage of newfound access tended to be sicker than the overall population, leading to adverse selection, premium increases, and health plan market exits.

Informed by this early experience, the Affordable Care Act (ACA) embodied a more comprehensive (and complex) policy approach. The current national debate regarding ACA repeal includes proposals to maintain some of the ACA's components, such as guaranteed issue, while potentially rejecting others, such as the individual mandate and income-based premium subsidies. In this context, examining earlier state experiments with these types of partial reforms offers valuable insights.

This paper summarizes the experiences of four states (New York, Washington, Kentucky, and Massachusetts) that enacted such reforms.[1] Drawing on publicly available analyses, interviews, and experience working with states as they considered their options, the authors describe the policies implemented and the consequences.

The intended impact of state policy reforms was not always clearly articulated and varied among states. Generally, however, states were concerned about 1) reducing the share of the population that was uninsured; 2) increasing enrollment in the individual market; 3) ensuring market viability by maintaining or increasing the number of health plans offering coverage in the individual market thereby enhancing consumer choice; and/or 4) moderating premium increases for some or all segments of the insurance market. Thus, where readily available, the authors provide data on the effects of state reforms on these four outcomes. Authors acknowledge that available data on some of these outcomes, particularly premium costs, is incomplete across states; this inconsistency is reflected in our paper. Each market outcome is affected by many forces (e.g., the overall economy, underlying health care costs, and the availability of coverage through a state Medicaid program) beyond the state policy and reforms covered here, however, so caution is called for in interpreting results.

Although this paper cannot analyze all the factors at play, experiences in the states profiled illustrate the challenges of pursuing partial reform of insurance markets. In particular, the three states that enacted partial reforms (NY, WA, KY) saw little or no positive impact on uninsured rates and individual market enrollment and substantial reduction of consumer choice when plans exited the market. Massachusetts, which took a more comprehensive approach by combining incentives and penalties for broad consumer participation along with market reforms, succeeded in increasing its insurance rate and maintaining a stable market with consumer choice.

- In New York, imposition of community rating combined with guaranteed issue without incentives for broad participation by healthy consumers, led to rising premiums, and declining participation by consumers and plans in New York's individual market. In particular, average health plan premiums tripled between 2001 and 2010; and individual market enrollment fell from 8.9% of the non-elderly population to 5.8% in 2000.
- In Washington, market collapse occurred when selected components of comprehensive reforms were stripped away. Maintaining guaranteed issue and community rating requirements on plans while consumers were free to sort themselves into more or less comprehensive benefit plans, or stay out of the market altogether, caused the individual market to collapse and subsets of it (the unsubsidized Basic Health Plan or BHP) to suffer severe selection.
- Kentucky's reforms suffered some of the same challenges as Washington, as a comprehensive reform effort was pared down. Guaranteed issue and guaranteed renewal, without consumer subsidies or incentives to participate, did not attract increased enrollment and balanced risk, but instead led to dramatically increasing premiums and the number of insurers participating dropping from 40 to 2.
- Massachusetts used the coverage expansion tools adopted by other states -- guaranteed issue and adjusted community rating – but, after experiencing unsuccessful reforms with more piecemeal approaches in earlier efforts, added approaches that increased participation and addressed risk selection, including broadened Medicaid eligibility in MassHealth to achieve more complete coverage, subsidies to the low income through Commonwealth Care, and the imposition of an individual mandate. Under this more comprehensive approach, Massachusetts avoided market disruptions and experienced an increase in the share of its population with coverage. Massachusetts was able to implement these broader reforms because it, with support from the federal government, was able to effectively use a Medicaid 1115 Demonstration renewal to shift existing funds for uncompensated care to a newly established Safety Net Care Pool that permitted greater spending flexibility including the allocation of some of the funds to subsidies.[2,3]

States that enacted partial reforms saw little or no positive impact on uninsured rates and individual market enrollment and substantial reduction of consumer choice when plans exited the market. Massachusetts, which took a more comprehensive approach by combining incentives and penalties for broad consumer participation along with market reforms, succeeded in increasing its insurance rate and maintaining a stable market with consumer choice.

Authors also examined California's experience implementing reforms focused on the small group market. While a different experiment, the experience offers some lessons applicable across markets. California's exchange (first called the Health Insurance Plans of California, or HIPC, and then PacAdvantage) attracted early interest, but that interest was strongest among employer groups already offering coverage. The exchange was offered as one of many options, and rules covering the HIPC/PacAdvantage did not apply to the rest of the small group market. Over time, PacAdvantage encountered adverse selection and closed when it could not sustain plan participation. (Findings on California are summarized in Appendix A.)

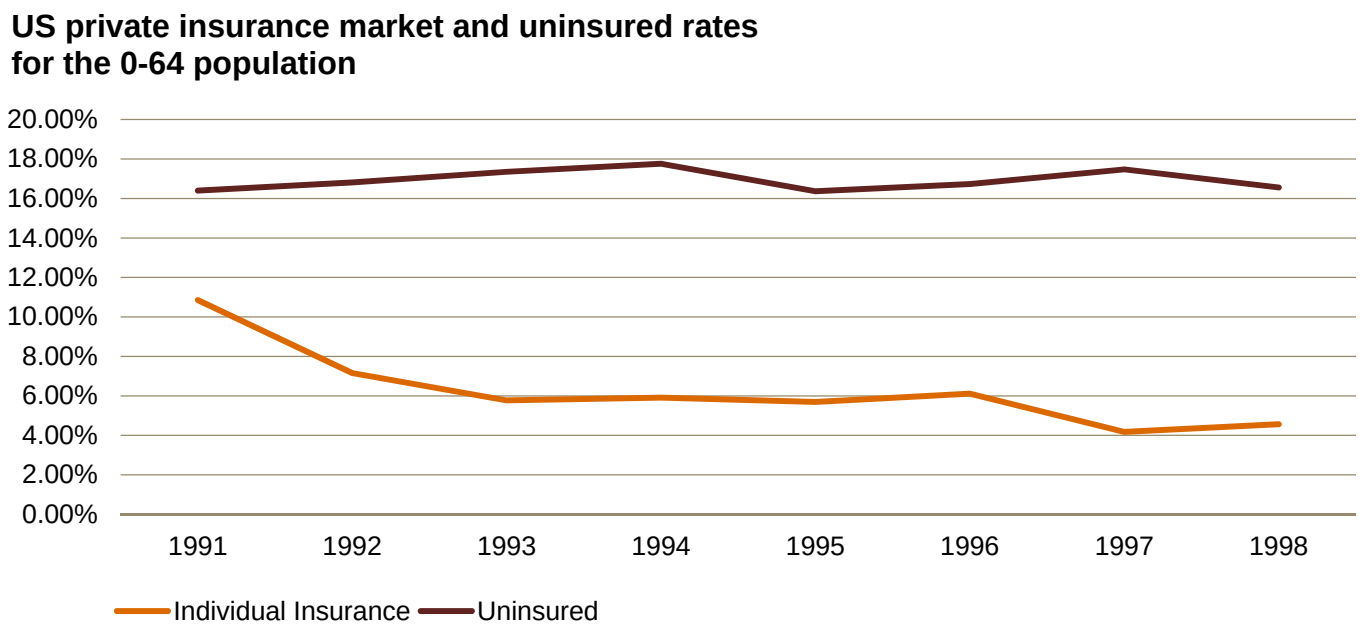
In summary, states that provided easy access to insurance without strong consumer incentives to participate and/or penalties for failing to participate experienced significant increases in premium rates due to adverse selection. In addition, states that applied benefit or rating standards selectively (requiring compliance for some plans but not others) saw adverse selection in those market segments. In some cases, selection concerns caused health plans to leave the insurance market altogether. Lack of subsidies to help cover the cost of insurance also limited consumer participation and contributed further to adverse selection. Only one state reform effort profiled in this paper – the Massachusetts 2006 plan, which combined insurance market reforms, an individual mandate and subsidies – managed to substantially expand coverage while maintaining a stable insurance market, in part because it was able to fund some subsidies by revising the state's existing Uncompendated Care Pool, which comprised total expenditures of $720 million in 2004.

Background

Nationally, the 1980s and early 1990s were a period marked by steeply rising healthcare costs. To limit premium increases and manage their risk exposure, many insurers in the individual market applied strict medical underwriting criteria, denying or limiting coverage for those with pre-existing conditions. Insurer rating formulas were designed to charge premiums based on risk, resulting in wide premium variations driven by difference in health status, gender, and age. In some cases, insurers also limited benefits to better manage their risk, avoiding coverage of costlier procedures. They also imposed annual and lifetime limits on benefits, some with limits as low as $100,000 per year.

As a result, access to affordable, comprehensive healthcare coverage for those lacking insurance through large employers was becoming increasingly limited, particularly for those with pre-existing conditions. Nationally, the number of uninsured residents was high and climbing, rising from 16.4% in 1991 to 17.8% in 1994.

Figure 1



Source: National Health Statistics Reports, Health Insurance Coverage Trends, 1959-2007: Estimates from the National Health Interview Survey, July 2009.

In an effort to provide increased access to affordable coverage and create a more consumer-friendly market, several states attempted to reform their individual or small group health insurance markets. In general, the policy changes centered around guaranteed issue and restrictions on rating formulas. Some states incorporated standardized benefit designs, purchasing pools. Massachusetts alone offered subsidies for low-income individuals. (See Figure 2).

Figure 2

Summary of state reform characteristics when originally implemented							
		New York	Washington	Kentucky	Massachusetts - I	Massachusetts - II	California
Insurance Market	Individual	+	+	+	+	+	
	Small Group		+	+		+	+
Year Enacted	Year	1993	1993	1994	1996	2006	1993
Insurance Coverage	Guaranteed Issue	+	+	+	+	+	+
	Guaranteed Renewability	+	+	+		+	+
	Mandated Coverage					+	
Insurance Eligibility	Pre-Existing Conditions - with lookback and exclusion periods	+	+	+	+		+
Premium Support	Subsidies for Low Income Enrollees					+	
Rating	Pure Community Rating	+					
	Modified Community Rating		+	+	+	+	+
	Allowable Rating Factors:						
	Plan Composition	+					+
	Age		+	+	+	+	+
	Family Type	+	+	+	+	+	+
	Geography	+	+	+	+	+	+
	Wellness		+				
Benefit Design	Standardized Benefit Plans		+	+*	+	+	+*
Risk Adjustment	Risk Adjustment	+					+

Source: PwC Analysis.

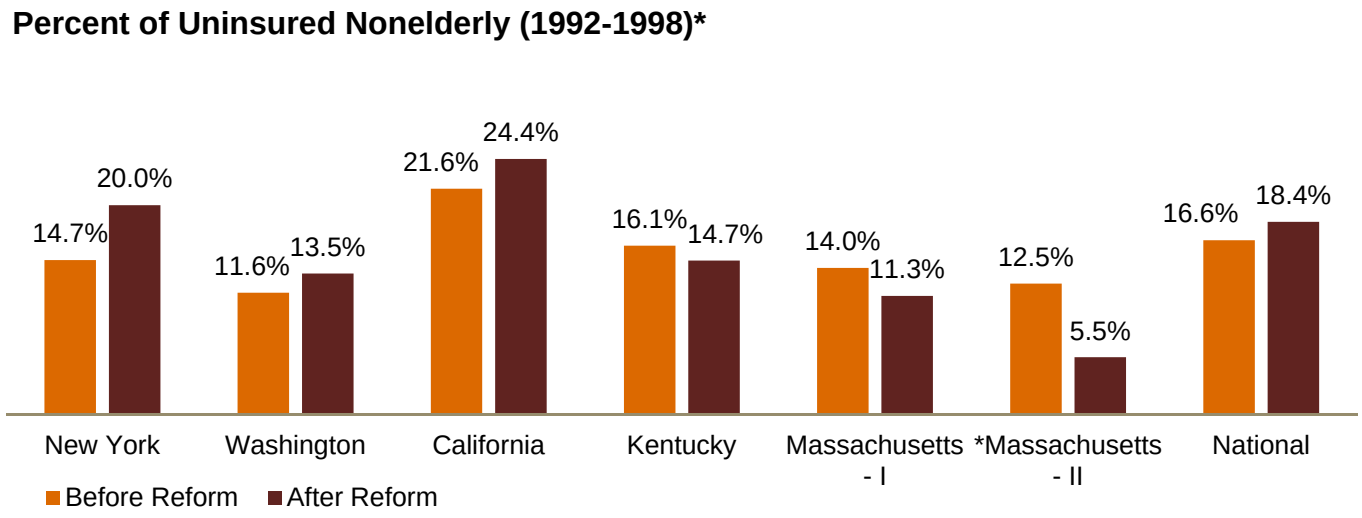
+ marks denote the presence of the characteristic within the reform during the time of implementation. Later changes to the reform are not reflected in this table; detail can be found in Appendix A.

* standardized benefit plans were not applied uniformly to all segments of the marketplace

The states profiled in this paper advanced policy proposals to adjust the terms under which health plans participated in the individual and small group markets. They expected that provisions such as guaranteed issue and limitations on pre-existing condition exclusions would level competition among insurance carriers and increase access for consumers. However, if consumer participation is entirely voluntary, adverse selection – a greater likelihood that sicker consumers will enroll, driving up premiums and leading to a risk spiral and unsustainable financial returns for plans – is likely. The fate of reform proposals discussed here largely centered on the degree to which states provided incentives or requirements for individual consumers to participate.

While this paper focuses primarily on market rules, state efforts to improve the terms under which commercial insurance is offered interact with other features of state health care finance and delivery. For example, the design of a state's Medicaid program and the robustness of its safety net influence take-up of individual and small group coverage as well as the number of uninsured. The authors touch on such contextual factors when necessary to understand market reforms, but they are not the main focus of this paper.

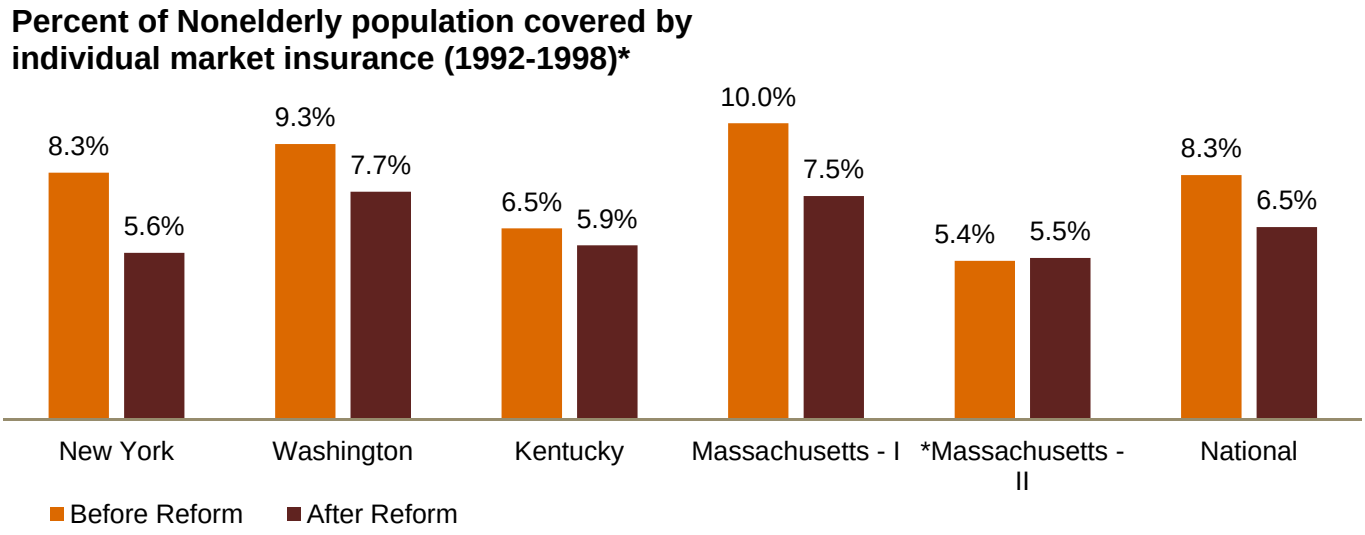
Figure 3



* Massachusetts – II reform compares the 2002-2004 3 year average to the 2007-2009 3 year average

Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured, January 1993, January 2000, November 2005 and September 2010 Issue Briefs.

Figure 4



* Massachusetts – II reform compares the 2002-2004 3 year average to the 2007-2009 3 year average

Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured, January 1993, January 2000, November 2005 and September 2010 Issue Briefs.

Examples of individual and small group state health insurance reform

New York

Health insurance reform – Phase I

In 1993, New York enacted major reforms in the individual and small group markets. The new regulations were among the most restrictive in the nation, with the intent to improve consumer access to affordable health insurance by prohibiting insurers from denying coverage and preventing insurers from charging higher premiums based on consumers' risk characteristics. The key provisions of the legislation required community rating in both markets, guaranteed issue and renewal in the individual market, and limited exclusions for pre-existing medical conditions.[4]

The community rating reforms implemented in both markets were very strict. Variations in premium rates based on age, gender, or health status were prohibited. Small group rates were subject to pure community rating (that is, all small groups purchasing a particular insurance product would be charged identical rates with no differences based on average age), while individual market rates were only allowed to vary based on family composition and geography.[5]

Access to coverage was to be ensured by requiring insurers to offer coverage to all consumers, including those high-risk consumers previously deemed medically uninsurable. No separate high risk pool was created that would have pulled individuals with high medical costs out of the general insurance pool.[6] Consumer participation was voluntary, and there was no requirement for consumers to purchase or maintain coverage nor was there a penalty for failing to have health insurance. No subsidies were provided to improve affordability for lower income individuals.

To mitigate insurers' risk, the legislation included two risk adjustment mechanisms. One was based on differences in the demographic characteristics of enrollees, which was funded by payment from insurers with lower than average risk enrollees to insurers with higher than average risk enrollees. The other reimbursed insurers fixed amounts for enrollees with any of four high cost conditions (AIDS, premature birth, certain cancers, and ventilator-dependency), and was funded by assessments on insurers based on total individual and small group market share. The high cost condition mechanism was intended to mitigate the impact of enrollees with particularly high costs similar to the effect of creating a high risk pool or a stop-loss pool.

Impact of New York's reform efforts – Phase I

Following the enactment of New York's reforms, individual healthcare premiums rose steeply. In the years following the initial reform, rates for indemnity plans in particular increased dramatically - 35% to 40% for some major insurers[7] - leading to the exit of the leading indemnity insurer and the effective collapse of the indemnity market. This was due to adverse selection as consumers with health conditions migrated toward indemnity plans (and a risk adjustment mechanism that didn't capture the full range of expected cost differences based on health status). Indemnity plans were more attractive to people with known health conditions because they provided more choice of providers and did not impose restrictions on utilization --restrictions that were imposed under managed care-type plans.

Health insurance reform – Phase II

To address market instability introduced by the first round of reform, New York introduced additional incremental changes in 1996. The individual market in New York had shifted dramatically toward managed care plans; other plans continued to suffer from adverse selection. In an effort to stem the tide of risk segmentation and increase coverage and provider options for consumers, the new law required all insurers to offer two standardized plans in the individual market: a traditional managed care plan and a point-of-service (POS) plan, which provided access to out-of-network healthcare providers otherwise unavailable to consumers due to the absence of indemnity plans. Prior to the 1996 reform, insurers could choose whether to participate in the individual market.

As the individual market shifted towards managed care plans, adverse selection and risk adjustment issues arose – prompting even the largest insurers to request rate increases between ***50 and 80%.***

In 2000, subsequent reform legislation established a state-funded stop-loss program for the two standard plans. The program was significantly under-funded, reimbursing approximately one-third of the costs submitted for the standard HMO plan in 2005 and less than one-half of the costs submitted for the standard POS plan.[8] Further program changes were made in 2007 to pool high-cost claims in both the individual and small group markets, but the amounts were capped and funded through assessments on insurers. Only a portion of the cost of high cost claims were paid out through the pool.

Phase II changes were intended to reduce some of the selection effects resulting from the Phase I changes. However, they did not eliminate the underlying challenge of providing unfettered access without consumer participation incentives or penalties.

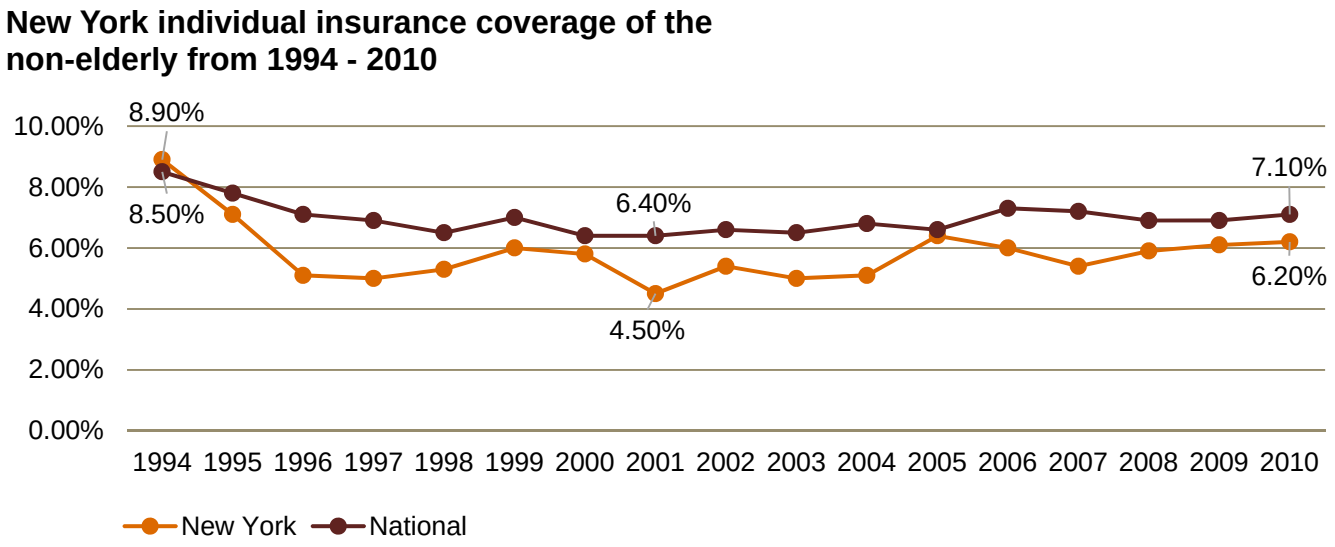
Impact of New York's reform efforts – Phase II

In 1998, due to growing financial losses several insurers requested rate increases between 50% and 80%, including the two largest insurers in the individual market.[9] The steep increases continued with average health plan premiums tripling between 2001 and 2010.[10] These increases were significantly higher than the national average and led to average premiums in 2009 that, according to an informal survey by America's Health Insurance Plans, were more than double the premiums in California and Florida, which were also considered high-cost states.[11]

The high premium increases were largely driven by limitations in the reforms. The laws did not mandate healthcare coverage nor provide financial incentives to buy coverage, and allowed consumers to buy insurance when they perceived a need with only a short waiting period for coverage, increasing the likelihood of adverse selection. Further, coverage could be dropped when the consumer felt it was no longer needed. The adverse selection allowed through these combinations of policies contributed to increasing costs within the individual risk pool. Additionally, in the absence of other counterbalancing incentives for young people to purchase insurance, the community rating approach which raised premium rates for younger consumers, drove an increase in the average age of the insured population, leading to higher average costs in insurers' risk pools and, thus, higher premiums.[12]

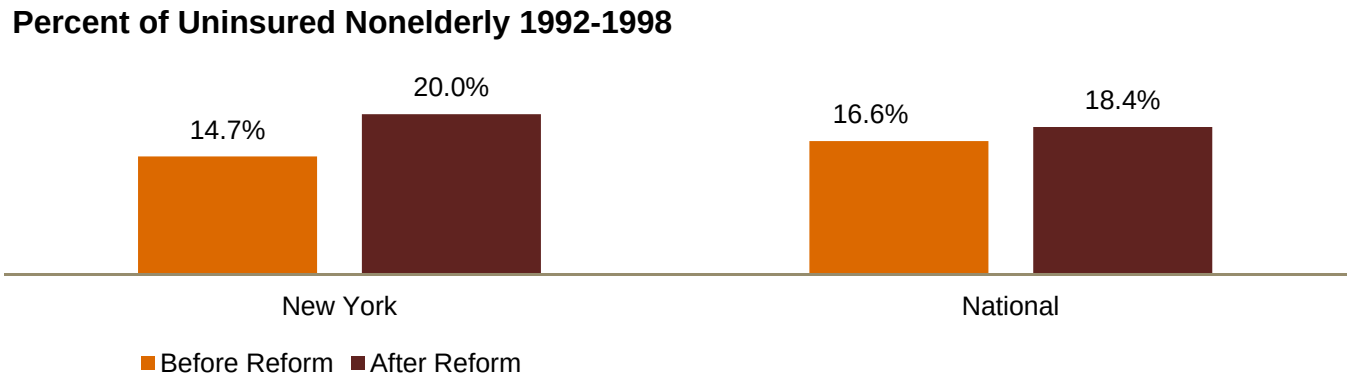
As a result of the increases in premiums, coverage became increasingly unaffordable for consumers and private insurance coverage declined. In 1994, 8.9% of the non-elderly population were enrolled in individual plans, very close to the national average of 8.5%.[13] Less than a decade later in 2000, only 5.8% of the non-elderly New Yorkers were still enrolled in the individual market, a figure that dropped further to just 5% in 2013.[14] (See Figure 5). New York's overall rate of uninsured rose to 20% in 1998 (see figure 6), and dropped only slightly over the next 10 years.[15] In sum, between 1994 and 2010, expanded access to the individual market, along with community rating rules that did not take into consideration age or health status, without incentives or requirements for broad participation, caused severe adverse selection and declining participation by consumers and plans in New York's individual market.

Figure 5



Source: America's Health Insurance Plans, The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets, http://www.statecoverage.org/files/Updated-Milliman-Report_GI_and_Comm_Rating_March_2012.pdf

Figure 6



Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. January 1993, January 2000 issue briefs.

Washington

Health services act of 1993

Through the 1980s and into the 1990s, the state of Washington was experiencing health care cost increases that were running at about triple the rate of inflation, and approximately 11% of the State's population were uninsured.[16] Individuals and small groups found it particularly difficult to obtain health insurance as insurers tightened their underwriting criteria to try to slow the rising costs.[17]

In an attempt to address these issues, in 1993 the legislature passed the Washington Health Services Act (WHSA). The WHSA was wide ranging and had five primary purposes:[18]

1. Stabilize and reduce unwarranted health care costs,
2. Provide universal access,
3. Improve the public's health through public health promotion and prevention strategies,
4. Address the health care needs of minorities, and
5. Preserve the viability of businesses by lowering health care costs.

The WHSA's design was based on the promise of "managed competition," featuring health insurance purchasing cooperatives, standardized benefit plans, minimum coverage standards for some market segments, and expectations of competition among health plans based on price and quality. It included premium caps to control cost growth and incentivize efficiencies, as well as provisions to promote the increased use of managed care.

The goal of universal access was to be advanced by requiring insurers to offer coverage on a guaranteed issue and guaranteed renewable basis, modified community rating, individual and employer mandates, and expansion of subsidized state healthcare plans (described below), as well as subsidies for small businesses. Individuals and small groups would be combined into an aggregate risk pool.[19]

The coverage mandates were to be phased in, beginning with large employers on July 1, 1995. By July 1, 1999, all individuals without employer coverage or other qualifying coverage (such as Medicaid or Medicare) would be required to obtain coverage through either the State's subsidized health program for low-income individuals not eligible for Medicaid (the Basic Health Plan), under a standardized minimum benefit package from a health plan, or through a purchasing cooperative. Health plans were required to offer standardized benefit (Uniform Benefit Package) coverage on a pure community-rated basis for no more than the maximum premium set each year by the state's health services commission.[20] Pre-existing exclusion periods were limited to three months, which was the shortest in the industry.[21] Shorter exclusion periods provide a greater opportunity for adverse selection, as people needing immediate health care services can often wait a short period of time for their coverage to become effective, while longer waiting periods create incentives to obtain coverage in advance of need for a specific service.

*As control of the legislature changed hands, **key provisions of the law were stripped away before it could go into effect.** Among others, the individual and employer mandates were eliminated, while the guaranteed issue and pre-existing condition provisions remained intact.*

To improve access to affordable coverage, the WHSA removed caps that existed on enrollment in the state-subsidized BHP program and allowed individuals with income over 200% of the federal poverty level to buy the BHP on an unsubsidized basis. Because the BHP utilized safety-net providers and mirrored Medicaid rates, reimbursement was lower than in the commercial market. The BHP premiums, even when unsubsidized, were more affordable than many in the general insurance market. The WHSA also required employers covered by the bill to contribute at least 50% of the premium of the lowest-priced UBP for employees and their dependents in order to encourage employee participation and reduce adverse selection.

Repeal of key reform provisions

As originally conceived, the WHSA's design was comprehensive, imposing requirements on plans, consumers and small businesses as well as offering subsidies and premium controls. However, in 1995, after a change in control of the legislature, many of the key provisions of the WHSA were repealed or significantly altered before they could take effect. Most significantly, the individual and employer mandates, caps on premiums, and individual and small group pooling were eliminated, while the guaranteed issue provisions and limits on pre-existing condition exclusions were retained.[22] Pure community rating was replaced with modified community rating allowing for variations for age, family type, geography, length of enrollment, and wellness activity.

The expansion of the BHP program, allowing consumers to buy in on an unsubsidized basis, was retained. Additionally, insurers in the individual market were required to offer a BHP look-alike plan although they could continue to offer their own custom plan designs. The state-defined UBP minimum benefits package was repealed, and the BHP became one of the most comprehensive plans in the market, including coverage for maternity, mental health and substance abuse, and prescription drugs that many other individual plans excluded or severely limited.[23]

Impact of Washington's reforms – Phase I

*"By 1998, **17 of the 19** health insurers had left the individual market due to growing financial losses, and the two remaining plans stopped selling new business in 1999."*

The modified reforms had a swift and severe impact on the individual market. By 1996, health insurance premiums had started to increase substantially. One of the largest individual insurers increased premiums on its most popular product by 78% in the three years following the reforms, about 10 times the rate of medical inflation.[24] The unsubsidized BHP and BHP look-alike plans experienced significant adverse selection as individuals sought coverage through these plans that was unavailable elsewhere in the individual market. For the newly eligible, unsubsidized population, BHP rates increased 72% in 1998 and 63% in 1999 -- in striking contrast to 12.5% and 9% premium increases, respectively, for the subsidized BHP population.[25]

By 1998, 17 of the 19 health insurers had left the individual market due to growing financial losses, and the two remaining plans stopped selling new business in 1999.[26]

Health insurance reform – Phase II

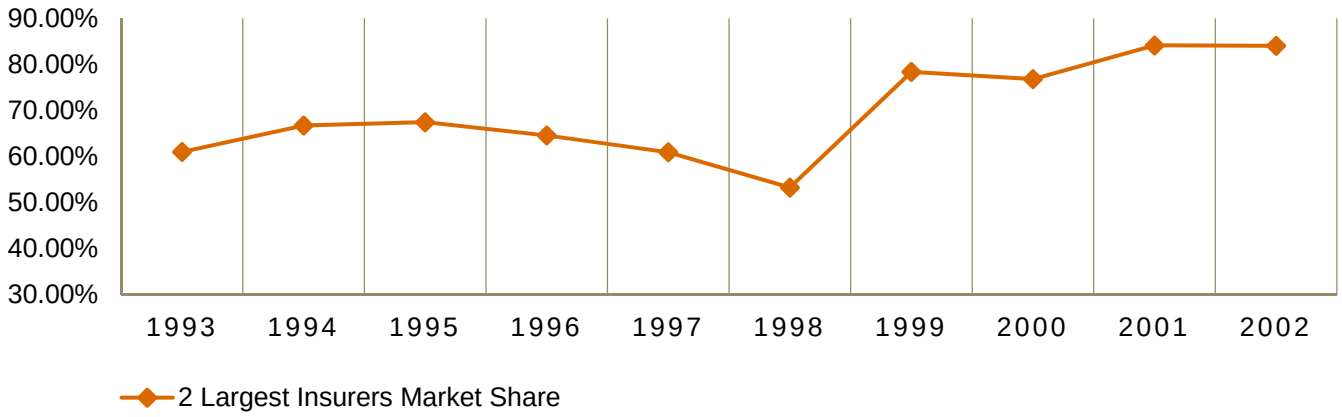
In 1999, in response to the collapse of the individual market, the legislature modified the guaranteed issue provision to allow health plans to deny coverage for high risk individuals. These individuals would then be eligible to purchase coverage through the state's high risk pool. High risk individuals were identified through a standardized questionnaire commonly used for underwriting health insurance policies. The high risk pool offered benefits that were often better than the market at premiums that were 125% t0 150% of the average premiums of the top five health plans.[27]

Impact of Washington's reform efforts – Phase II

Subsequent to the changes implemented in the 1999 legislation, several major health plans returned to the market. However, the market was more concentrated than before the reforms. (See Figure 7). In 2008, the commissioner's rate approval authority was reinstated.[28]

Figure 7

Washington individual market carrier concentration 1993-2002

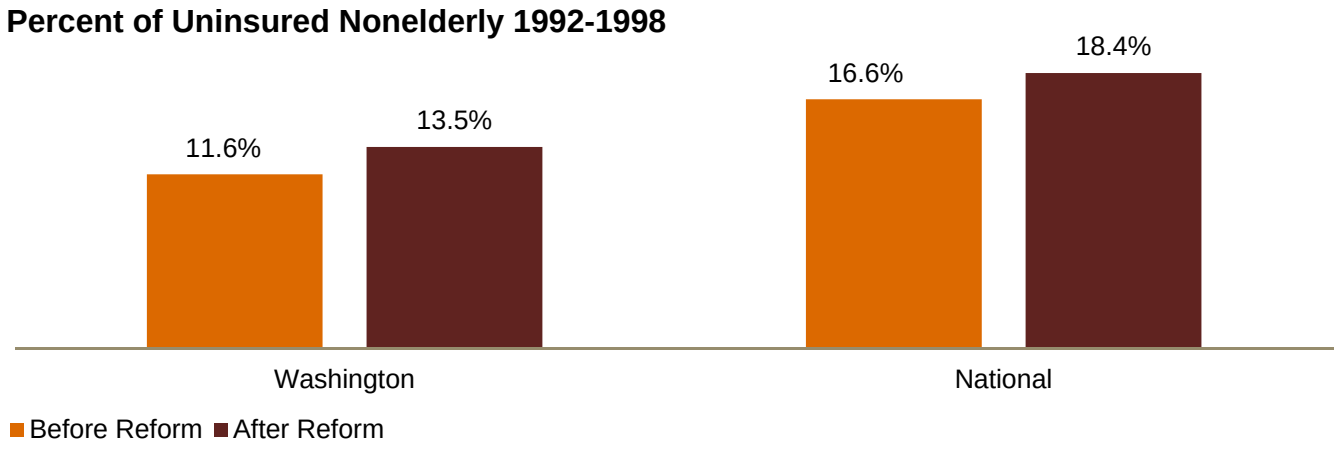


Source: N. Turnbull, et al: Insuring the healthy or insuring the sick? The dilemma of regulating the individual health insurance market

Despite its initial ambition for universal access, Washington's reforms had a limited impact on coverage. Immediately prior to the reforms, in 1992, about 12% of the under age 65 population was uninsured. (See Figure 8). In 2010, before the implementation of the Affordable Care Act, the uninsured rate was 15.7%.[29]

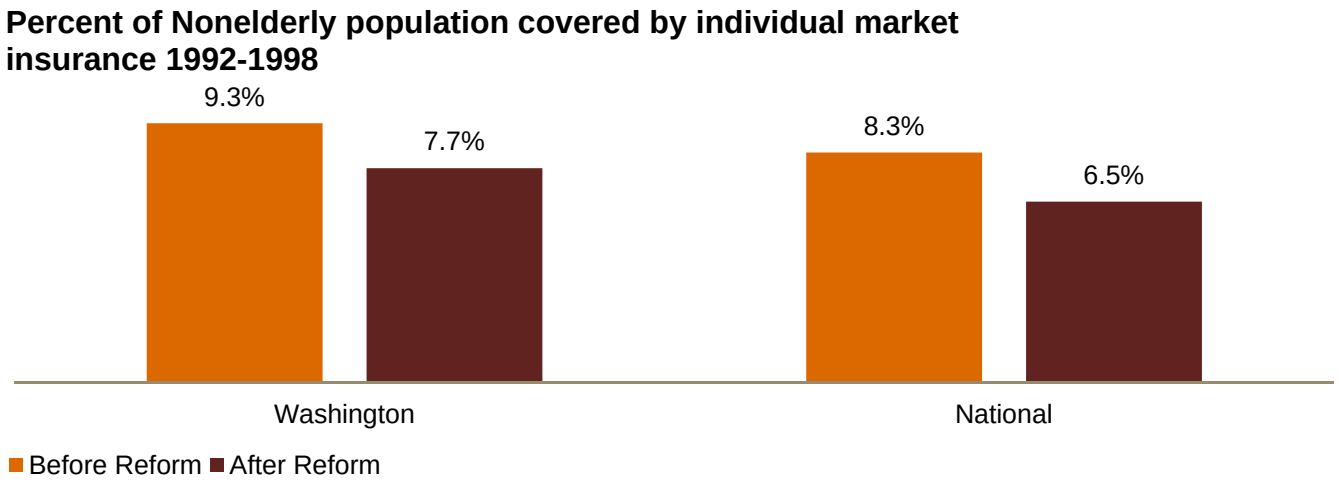
Though originally developed as a comprehensive reform effort in 1993, some of Washington's intended reforms were short-lived and others were never fully implemented. Imposing guaranteed issue and community rating requirements on plans while consumers were free to sort themselves into more or less comprehensive benefit plans, or stay out of the market altogether, caused the individual market to collapse and subsets of it (the unsubsidized BHP) to suffer severe selection. Although further policy adjustments helped the market rebound, Washington nevertheless fell far short of its 1993 reform goals.

Figure 8



Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. January 1993, January 2000 issue briefs.

Figure 9



Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. January 1993, January 2000 issue briefs.

Kentucky

Health care reform act

*"By October 1995, more than **40 carriers had announced their intention to depart the Kentucky market** citing concerns about guarantee issue, modified community rating, and the standardized plans."*

In 1993, Kentucky legislators were concerned about high uninsured rates, rising medical costs, and barriers to access experienced within their state. In 1994, the Kentucky General Assembly passed the Health Care Reform Act which established a statewide purchasing alliance, a government health policy board and a standard set of benefits for the individual and small group markets.[30]

The new reform granted guaranteed issue and renewal and limited pre-existing condition exclusion periods.[31] Two new state bureaucracies were formed, an independent Health Policy Board and the Health Purchasing Alliance ("Alliance"). While the Health Policy Board focused on benefit plan design, the Alliance created a large pool of people (across different insurance markets) with the size and leverage necessary to create purchasing power and drive efficiencies.[32] Participation was mandatory for state and public employees, and voluntary for small employers and individuals.[33]

In both the individual and small group markets, modified community rating was compulsory with rating factors limited to age, geography, and family composition. The variation between the highest and lowest rate was limited to a maximum 3:1 ratio. All insurers were required to offer the same standardized benefit plans, which were to be designed by the Health Policy Board.[34]

However, rocky politics during the creation of Kentucky's Reform Act excluded existing policies from converting to the standardized, community-rated policies until 1997. This meant that only new entrants to the market were required to obtain the reformed products, and the remaining two-thirds of enrollees were left out.[35]

Reform modifications

The haste to implement the changes, confusion regarding the new reforms, and intense opposition to the reforms by some health plans caused major disruptions in the market. Due to the relatively rich nature of the standardized plans, sick people entering the individual market flocked to the reformed products – quickly overwhelming the small pool of healthy enrollees. Premiums shot up in response.[36] By October 1995, more than 40 carriers had announced their intention to depart the Kentucky market citing concerns about guaranteed issue, modified community rating, and the standardized plans.[37]

In 1996, a rollback of the reform was enacted, abolishing the Health Policy Board. The rollback also changed Alliance membership for university and local government employees from mandatory to voluntary, thereby reducing the purchasing pool's size and diminishing its prospects for influencing the market. It also expanded the allowable community rating factors to include gender and occupation. It exempted certain associations (coalitions of individuals and small employers with a common interest that came together to purchase insurance coverage as a group,) including small group plans, from required use of community rating, thus segregating healthy and unhealthy risk pools.[38] However, it retained the guaranteed issue and renewal provisions.

Impact of Kentucky's reform efforts

Kentucky's attempt to stabilize the market was unsuccessful. The individual market shrank from over 40 carriers to two. Both in serious financial distress by the end of 1996, the two remaining carriers asked the state to approve a 28% premium rate increase to stop the drain on the plans' reserves.[39]

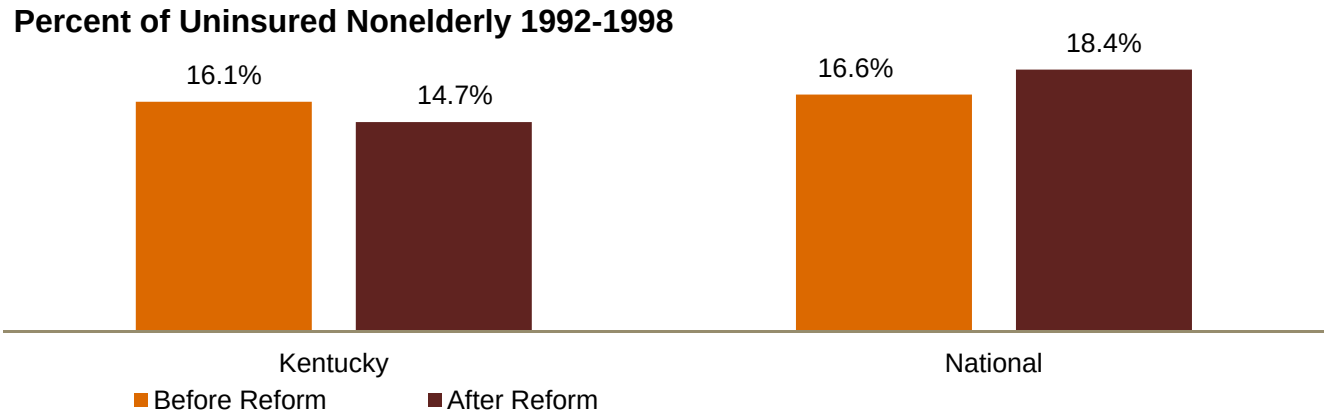
In 1998, some adjustments were made to medical loss ratio (MLR) requirements. Although intended to attract carriers back to the market, there were few re-entrants and no material rate reductions.[40]

Eventually, the Alliance was abolished all together, and a stop-loss pool for high risk individuals was established in its place. Beginning in 2001, the Kentucky Access Program acted as a high turnover, high deductible mechanism for coverage of high risk individuals. While its impact on premium stabilization is contested, individual premiums did flatten after the program came into effect.

The percent of uninsured in Kentucky pre-reform hovered just above 16%. (See Figure 10). Post reform the non-elderly uninsured rose further to 17.4% from 2007-2009.[41] The non-elderly population covered by individual insurance dropped from 6.5% in 1992 to 5.9% post reform (see Figure 11), bottoming out at 5.5% from 2007-2009.[42]

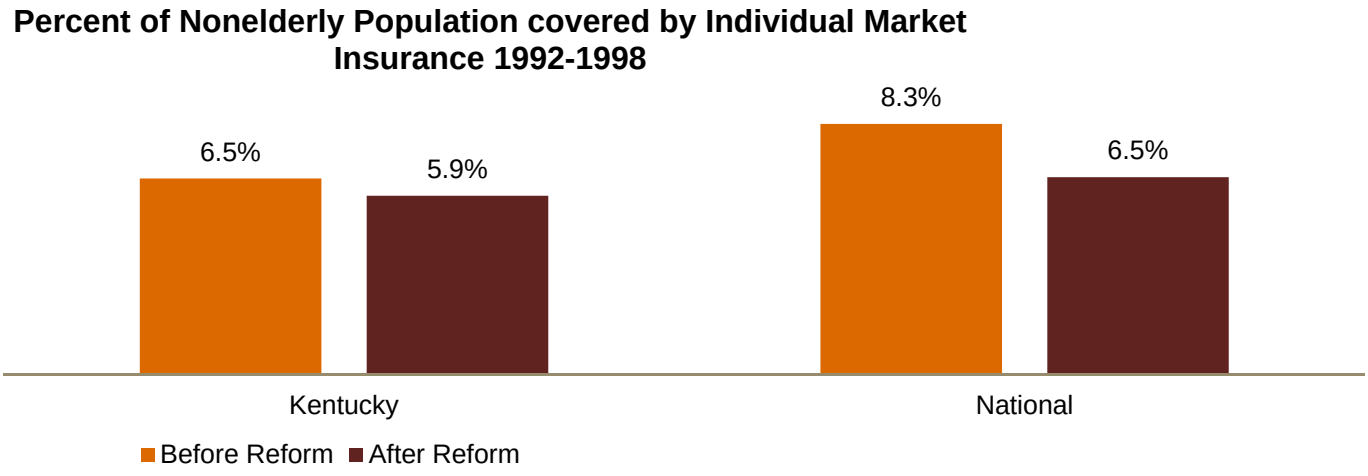
Kentucky's reforms suffered some of the same challenges as Washington, with a more holistic reform approach paired down to selected partial reforms. The longest-lasting provisions were guaranteed issue and guaranteed renewal; without strong incentives for consumer participation, these did not attract increased enrollment and balanced risk, but instead led to increasing premiums and a dramatic decline in insurance carrier participation.

Figure 10



Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. January 1993, January 2000 issue briefs.

Figure 11



Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. January 1993, January 2000 issue briefs.

Massachusetts

Health insurance reform

Massachusetts began a major experiment in health reform starting in 1996 with the passage of the Non-Group Health Insurance Reform Act. This legislation included guaranteed issue and modified community rating, and required all insurers with more than 5,000 members in small group products to offer at least one of three standardized products (an HMO, a PPO and an indemnity product) on a guaranteed issue basis in the individual market. The standardized products established a minimum benefit package and limited member cost sharing.

Massachusetts began its own reform of the individual market in 1996. Familiar factors like guaranteed issue and modified community rating were included. However, in an additional attempt to curb adverse selection, ***eligibility specifications*** *were enacted to discouragoe those who might abuse the health insurance system.*

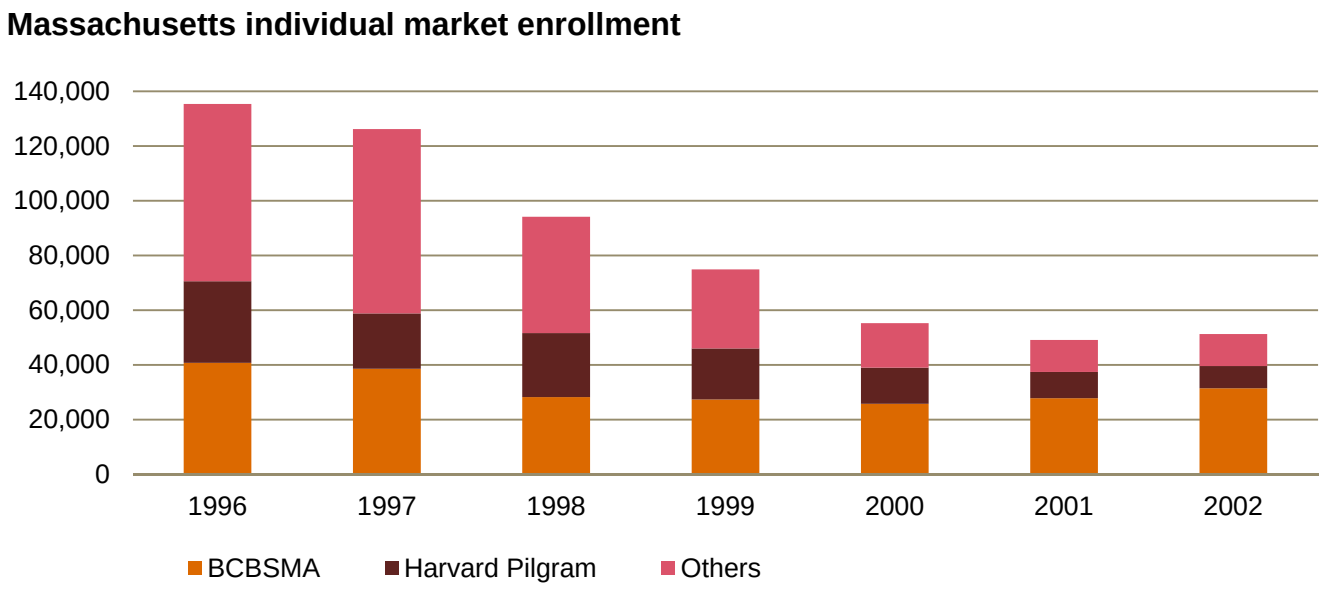
To help address adverse selection risks, those who were eligible for group insurance were not permitted to buy in the individual market, open enrollment was limited to a two month period each year, and coverage began 30 days after the close of open enrollment. Modified community rating standards allowed variation for age, family type and geography. Allowable variations in rates by age were limited to 2:1 and, for geography, to 1.5:1. At the same time, insurers were permitted through mid-2000 to renew existing policies that did not meet the standardized requirements.[43]

Prior to the legislation none of the commercial insurers in the Massachusetts market offered products similar to the standardized reform products. Once the reforms were implemented, insurers had to offer at least one product, and could offer two or three that were consistent with the standardized benefit designs. To preserve their market share, the insurers that held the majority of the pre reform market share, and several new HMOs, decided to participate in the reform market.

In the first few years, there was substantial variation in the standardized premium among the health plans. After three years, variation lessened, but the minimum premium increased and enrollment was highly concentrated in the two largest insurers. The large majority of policies were HMO or PPO products. Very few purchased the indemnity products.

A study of the reforms found that individual enrollment decreased substantially and attributed this to a combination of insufficient marketing and higher premium due to the richer benefit package and the guaranteed issue requirement.[44] (See Figure 12).

Figure 12



Source: N. Turnbull, et all: Insuring the healthy or insuring the sick? The dilemma of regulating the individual health insurance market

There were efforts throughout the late 1990's to repeal or revise the individual market reforms. In 2000, a modification to the law permitted insurers to offer a second non-standard plan of each type, subject to regulatory approval. It also established a continuous open enrollment period.

Subsequent reforms

In an effort to reduce the number of uninsured, more comprehensive insurance reform was adopted in 2006. New legislation retained the earlier reforms and included an individual mandate that required people to purchase health insurance or face financial penalties, merged the individual and small group markets, created a government run exchange for the merged market, and provided sliding scale premium support for lower income individuals funded in part through the state's uncompensated care pool, which, in 2004 comprised $720 million.[45]

An actuarial study based on enrollment prior to the 2006 reforms confirmed that the individual market included members who were older and more costly than those in the small group market. After the merger of the individual and small group markets, there was a 20% to 33% reduction in the cost of individual premiums, while premiums in the small group market also increased. From 2008-2009 premiums in the four largest small group HMOs increased by 12.4%.[46]

*In 2010 Massachusetts reached a non-elderly uninsured rate of **6.3%***

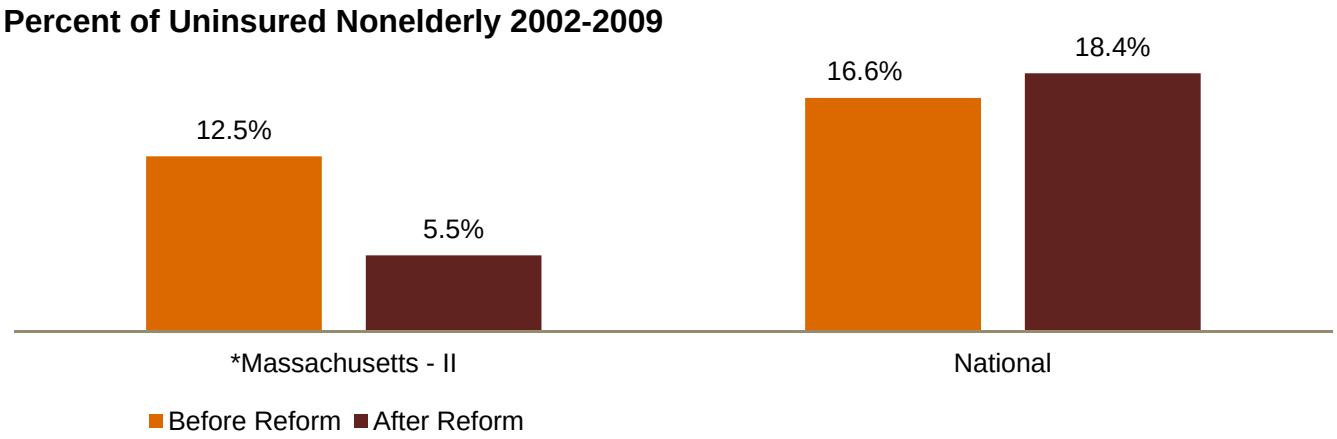
*Comparatively, the national non-elderly uninsured rate was **18.4%.***

The two programs under the exchange, Commonwealth Care and Commonwealth Choice, were successful in expanding health insurance coverage. Commonwealth Care offered premium subsidies to individuals up to 300% of the Federal Poverty Level who did not have an offer of employer sponsored health insurance. The subsidies were funded through the terms of the state Medicaid 1115 waiver, which permitted Massachusetts to redirect federal Medicaid uncompensated care and Disproportionate Share Hospital funds previously paid to Medicaid managed care plans and safety net institutions to subsidize the purchase of insurance for the low income uninsured.[47] Only managed care plans contracting with Massachusetts Medicaid were permitted to offer Commonwealth Care for the first three years of the reform. [48]

Commonwealth Choice offered unsubsidized private coverage on an exchange platform. It offered a range of policies selected through a competitive bidding process classified as bronze, silver and gold based on variations in the level of benefits provided and member cost sharing. Initially the benefit design was not standardized other than requiring that products fit within actuarial value ranges, but in 2010 the program moved to standardized benefit design that allowed more apples-to-apples comparison. This produced three benefit designs in each tier.[49]

Massachusetts used the coverage expansion tools adopted by other states -- guaranteed issue and adjusted community rating-- but added approaches that increased participation and addressed risk selection: broadened Medicaid eligibility to achieve more complete coverage, and the imposition of an individual mandate, after experiencing unsuccessful reforms with more piecemeal approaches in earlier efforts. As a result, Massachusetts became the state with the highest rate of insurance coverage in the country. Gains were greatest among people with high care needs and adults with disabilities, younger adults, and people with low income. Between 2006 and 2008, health insurance coverage for those aged 19 to 64 increased from 86.0% to 95.5% and remains at that level today. There was also an increase in employers offering health insurance to their employees. The employer offer rate increased from 70% in 2005 to 76% in 2011. In comparison, the national employer offer rate was unchanged at 60% during the same period.[50]

Figure 13



Massachusetts - II reform compares the 2002-2004 3 year average to the 2007-2009 3 year average
Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. November 2005, and September 2010 issue briefs.

Conclusions

The four states enacting partial reform—New York, Washington, California, and Kentucky, sought to improve access to affordable coverage by enacting consumer-friendly market reforms. They expected that provisions such as guaranteed issue and limitations on pre-existing condition exclusions would increase access for consumers and level the playing field among plans. Guaranteed issue and bans on pre-existing conditions are important protections and tools to improve coverage for people with preexisting conditions. But without strong incentives for broad consumer participation in the market, adverse selection led to unsustainable risk levels for plans, spiking premiums, plan exits and, in some cases, market collapse.

*"But **without strong incentives for broad consumer participation in the market, adverse selection led to unsustainable risk levels for plans,** spiking premiums, plan exits and, in some cases, market collapse."*

To encourage low risk individuals to enroll in coverage requires strong incentives. With the exception of Massachusetts in 2006, the states profiled here guaranteed access and imposed rate limitations, but did not offer premium subsidies to encourage participation nor impose penalties on those who did not obtain coverage. As a result, low-income people and healthier people often opted out, eroding the risk mix in the market.

Several states also encountered challenges when they adjusted market rules in more targeted ways. When minimum benefits requirements were applied selectively, rather than uniformly across the market, risk selection and market distortions followed. Rating rules influenced the interest of health plans to participate in the market; those with the broadest allowance for variation in premium in the absence of a mandate had higher levels of participation, while those that had tight rating restrictions combined with limited requirements on consumers to participate had higher premiums and lower levels of health plan participation.

In contrast to the states enacting partial reforms, Massachusetts paired guaranteed issue and a minimum benefits requirement with individual and employer mandates and generous subsidies. As a result, it fared much better in covering its residents and, at the time of the passage of the Affordable Care Act, continued to attract robust participation among health plans. Although Massachusetts already had one of the lowest rates of uninsured before the 2006, overall the percentage of adults increased from 86% to over 95% within two years and remains near that level today, making it the state with the highest rate of insurance coverage.[51]

Appendix A

California

California's experience is unique among states profiled in this report in that it did not enact individual health insurance market reforms, focusing instead on the small group market only. The changes imposed on health plans in California's small group market shared many features with those imposed in other states' individual markets. As with individual market reforms in other states, California's small group reforms were partial rather than comprehensive. New obligations on health plans were imposed yet employers and consumers were not compelled or provided with substantial incentives to participate. A small group purchasing pool was created, initially known as the Health Insurance Plan of California, or the HIPC, and ultimately renamed to PacAdvantage. However, participation in the pool was voluntary on the part of small employers and health plans and certain elements of health insurance reform applied, such as risk adjustment, applied only to the Pool. Consequently, the Pool ultimately suffered from adverse selection.

Health insurance reform

In 1993, as part of broad small group health reform legislation, California adopted insurance reforms that included guaranteed issue and renewal of coverage, limits on pre-existing condition exclusions, and restrictions on allowable variations in premiums across small groups.

Also as part of the reform, California established the HIPC as the nation's first state run purchasing exchange for small businesses. The policy goal of the HIPC was to provide employees in small firms (3 to 50 workers) health plans that were similar in quality to those offered by larger firms. Protections against potential adverse selection included minimum employee participation rates and minimum employer contributions.

The HIPC offered both HMO and PPO plans. Each type of plan had a standard and a preferred benefit package, where the standard package required higher member cost sharing. Premiums varied by age band, family type and geography. Participating carriers were prohibited from selling the same benefit plan at a lower premium outside of the exchange. Health plans that participated in the HIPC were obligated to offer a similar product in the general insurance market, but participation in the HIPC was voluntary for small employers and health plans.

Employee choice was the main distinction between the HIPC and the outside market. The HIPC offered the opportunity for employees of participating employers to individually choose from all of the offered health plans. For small groups this was a significant departure from typical small employer underwriting, which required that all enrollees had to enroll in the same benefit plan and carrier.[52]

Impact of California's reforms

By June 1996, three years after implementation, the HIPC had enrolled 6,000 small groups that covered over 62,000 employees and nearly 50,000 dependents. The mean group size was 10 employees. After five years, enrollment reached approximately 150,000, an estimated 1% of the small group insured market. While there is some evidence that employer sponsored coverage increased among the smallest firms, 80% of the participating employers had offered health insurance coverage prior to joining the HIPC.[53]

In the third year of operation, more than 90% of HIPC enrollees were in HMOs, two of the three PPOs left the exchange, and one new PPO entered. The remaining PPO raised its rates, and the new plan entered with the highest rates. This was a change from the first two years where HMO and PPO rates were more similar and was the result of significant adverse selection against the PPO plans.

*Risk adjustment was used to encourage **a wider range of health plans, and preserve PPO participation in the HIPC.** Although only 1% of premium was transferred, PPO plans received the vast majority of the transferred funds*

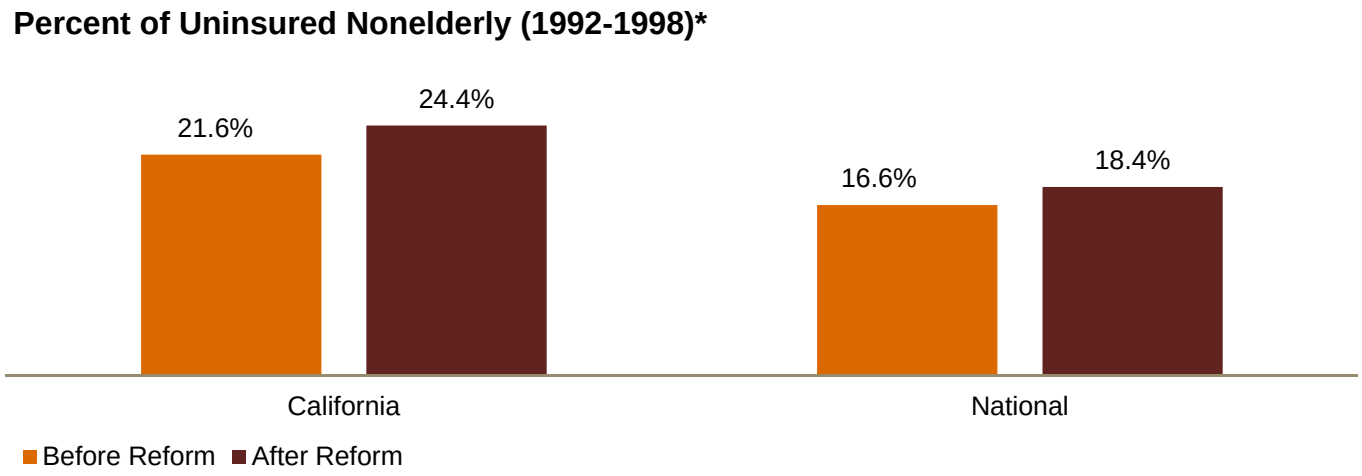
Beginning the fourth contract year, 1996-1997, MRMIB adopted a formal risk adjustment process that transferred funds among the health plans to compensate for differences in risk selection.[54]

The law that authorized the establishment of the HIPC required that ownership be transferred to a non-profit organization after five years, and in 1998, the Pacific Business Group on Health (PBGH), a non-profit coalition of large employer health purchasers, won a competitive bid to administer the HIPC and renamed the exchange PacAdvantage. Some modest changes were made to underwriting criteria and new offerings were added. To mitigate adverse selection, it continued to apply the same risk assessment methodology that transferred funds among the participating plans, and ultimately converted to a more robust risk adjustment mechanism that considered risk identified through physician and other services in addition to hospitalizations.

Despite these efforts, the number of participating plans shrunk from 10 in 1994 to 3 in 2006. Waning interest from health plans resulted from an inability to capture market share and adverse selection, paralleling experiences in this report's individual market case studies. When one of the health plans notified the program that it would withdraw due to sustained financial losses, the two remaining health plans indicated that they would not continue if only two carriers remained.[55] PacAdvantage ceased operations at the end of 2006, mainly due to adverse selection both within the exchange and within the exchange relative to the outside market.

California's small group reforms were intended to improve choice and stabilize coverage for employers and employees. Although California's exchange attracted early interest, that interest was strongest among employer groups already offering coverage. Over time, the exchange encountered adverse selection and could not sustain plan participation. Because of the narrow focus of California's reform, it is perhaps unsurprising that the overall rate of uninsurance in California remained firmly in the 20% range – rising 3% in the years post reform (see figure 14) to settle around 21% from 2007-2009.[56]

Figure 14



Source: EBRI, Sources of Health Insurance and Characteristics of the Uninsured. January 1993, January 2000 issue briefs.

Appendix B

New York

Insurance market	Individual and Small Group
Year enacted	1993
Administration	N/A
Guaranteed issue	Guaranteed issue required
Guaranteed renewability	Guaranteed renewability required
Coverage mandate	No individual mandate
Specific eligibility modifications	Pre-existing condition look-back limitation set at 6 months, exclusionary period set at 12 months
Rating	Pure Community Rating Variation for plan type, family type, geography
Benefit design requirements	N/A
Risk adjustment	Implemented two risk adjustment mechanisms which addressed demographic mix within a rating region and specific reimbursement for certain high cost conditions
Changes to Law	1996: Modified Risk Adjustment mechanism and pool Insurers offer two plans: traditional managed care and POS 2000: State funded stop loss in response to rapid premium increase Pre-ACA: Continued Guaranteed Issue and Pure Community rating

Washington

Insurance market	Individual and Small Group
Year enacted	1993: Washington Health Services Act
Administration	N/A
Guaranteed issue	Guaranteed issue required
Guaranteed renewability	Guaranteed renewability required
Coverage mandate	No individual mandate
Specific eligibility modifications	Pre-existing condition limitation set at 3 months
Rating	Modified community rating (Original legislation called for Pure Community Rating but it was changed before the law fully implemented) Variation for age, family type, geography, tenure discounts and wellness activity

Washington

Benefit design requirements	Mandated benefits, including maternity coverage
Risk adjustment	None (Original legislation called for risk adjustment but it was changed before it was fully implemented)
Changes to Law	1995: repealed pure community rating and risk adjustment before it took effect; insurers to offer Basic Health Plan "look-alike" for low income not eligible for Medicaid 1999: Modified guaranteed issue to exclude those identified for high risk pool and pre-existing condition exclusion period was increased. Pre-ACA: Continued Guaranteed Issue (except high risk pool) and modified Community rating

Kentucky[57]

Insurance market	Individual and Small Group
Year enacted	1994, with phase in through 1996
Administration	Established an independent Health Policy Board, which would be responsible for designing the standardized benefit plans. Additionally, the Health Purchasing Alliance was created with the intention of creating a large pool of people across insurance markets, with the ability to drive efficiencies with their size and collective purchasing powers.
Guaranteed issue	Guaranteed issue required
Guaranteed renewability	Guaranteed renewability required
Coverage mandate	No individual or small group mandate
Specific eligibility modifications	Pre-existing condition look-back limitation set at 6 months, exclusionary period set at 12 months
Rating	Modified Community rating Could not vary by health status or gender Variation was based on 3:1 band for age, family composition and geography combined
Benefit design requirements	Eight standardized plans developed by health advisory board All new individual business after 1995 under a standardized plan
Risk adjustment	Yes, but limited based on data availability
Changes to Law	1996: Allows limited gender rating; widens rating band to 5:1 1998: Repeals community rating; institutes "pay or play" insurance pooling; modifies guaranteed issue requirements 2000: Creates high risk pool – Kentucky Access; eliminates guaranteed issue 2004: Restricts new mandates for three years and eliminates requirement to offer standardized plans Pre-ACA: Guaranteed Issue and Community Rating Repealed

Massachusetts – Early efforts

Insurance market	Individual
Year enacted	1996: Non Group Health Insurance Reform Act
Administration	N/A
Guaranteed issue	Large market share insurers (at least 5,000 small group covered lives) were required to offer at least 1 guaranteed issue product on the individual market No exclusions or waiting periods for eligible individuals Those who become eligible outside the open enrollment period have 30 days to purchase new coverage Limited 2 month open enrollment
Guaranteed renewability	Guaranteed renewability required
Coverage mandate	No individual mandate
Specific eligibility modifications	Limit pre-existing condition exclusions and look-back period of 6 months Self Employed required to purchase through small group market "Group of 1" Eliminated short term policies to reduce adverse selection
Rating	Modified Community Rating Variation using age 2:1 rate band and geography 1.5:1 rate band Allowed non standardized policies that existed prior to reform to be renewed through July 2000
Benefit design requirements	Standardized products that varied in the degree of managed care (Indemnity, HMO, PPO) Floor for benefits and cost sharing
Risk adjustment	N/A
Changes to Law	2000: Allowed second plan with approval; Continuous open enrollment Permit up to 6 month exclusion for preexisting conditions for those without prior coverage Self-employed purchase through individual or small group market 2006: Revised by major reforms

Massachusetts – Later efforts

Insurance market	Individual and Small Group
Year enacted	2006
Administration	Established Health Connector Commonwealth Care: Subsidized coverage for those without employer sponsored coverage up to 300% FPL funded through Safety Care Net Pool under Medicaid 1115 Waiver Commonwealth Choice: Unsubsidized coverage selected through competitive bidding
Guaranteed issue	Guaranteed issue required
Guaranteed renewability	Guaranteed renewability required
Coverage mandate	Individual Mandate • Adults over 17 years of age • Penalty up to 50% of least expensive monthly premium • Affordability exemptions, including those < 150% FPL Employer Mandate • Employers with >11 FTE demonstrate "fair and reasonable" contribution to coverage or face penalty • Offer a Section 125 plan that permits employee premium payment with pre-tax dollars Affects approximately 12% of employers
Specific eligibility modifications	Limit pre-existing condition exclusions and look-back period of 6 months Subsidies became available for individuals up to 300% of the Federal Poverty Level.
Rating	Modified Community Rating Uses 2:1 rating bands for a combination of factors Variation using age, geographic region, use of standardized benefit packages in Massachusetts health reform industry, participation in wellness programs, and tobacco use Evidence that higher risk mix in individual market prompted merger of small group and individual market
Benefit design requirements	Initially minimum creditable coverage standard and limits on annual deductibles. No requirement for standardized benefit package Standardized based on level of benefits and member cost sharing starting in 2010
Risk adjustment	N/A
Changes to Law	Was made ACA compliant

California

Insurance market	Small Group 2-50 employees
Year enacted	1993
Administration	Established Health Insurance Plan of California (HIPC), a state sponsored small group purchase exchange for employers with 3-50 employees
Guaranteed issue	Guaranteed issue required
Guaranteed renewability	Guaranteed renewability required
Coverage mandate	No individual or employer mandate
Specific eligibility modifications	Limit pre-existing condition exclusions and look-back period of 6 months for entire small group market Insurers may impose participation requirements (e.g., % of employees sign up, minimum employer contribution)
Rating	Modified Community Rating Variation based on benefit and product design, age (in specified brackets - no rate bands), family type (in four tiers) and geographic region (nine standardized areas) +/- 10% rate band based on health status or claims history
Benefit design requirements	Basic health benefits if regulated by the Dept. of Managed Health Care Plans are required to cover state mandated benefits
Risk adjustment	Risk adjustment was used to transfer funds from those plans with relatively healthy populations to those plans with relatively unhealthy populations within the HIPC. The result was budget neutral. Risk adjustment did not apply to the rest of the market.
Changes to Law	1996: Major Risk Medical Insurance Board (MRMIB) adopted a formal risk assessment process which transferred funds among health plans t0 compensate for differences in risk selection within the HIPC. 1998: Ownership was transferred to Pacific Business Group on Health, creating PacAdvantage. Under the new exchange underwriting criteria was changed and new offerings were added. 2006: PacAdvantaged ceased operations, due to adverse selection issues; the Small Group reforms continued.

Appendix C

Key policy characteristics of individual and small group health insurance reform

Prior to the ACA, states considering options for providing health insurance coverage pursued several common policy approaches. Traditionally, health insurance in the individual market was issued only to those who passed the medical underwriting standards of the health insurer. This was also true of the small group health insurance market until the passage of federal standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which required portability of insurance from one carrier to another. There were limited guidelines on the factors that those health plans could use to set the premiums of those individuals and small groups that they did accept. Here we provide a brief description of some of the common elements considered in health reform legislation.

Guaranteed issue

"Guaranteed issue" laws prohibit insurers from denying coverage based on health status. In 1996, the federal law Health Insurance Portability and Accountability Act (HIPAA) required all insurers to sell all their small group policies on a guaranteed-issue basis. Therefore, in the small group market today, all health insurance policies must be sold on the basis of guaranteed-issue.

Insurers continue to have the option of having a limited open enrollment period and imposing rules for participation outside of the open enrollment period.

Guaranteed renewability and restrictions on reentry

Guaranteed renewability laws prohibit insurers from canceling coverage on the basis of diagnosis of an illness or high cost medical claims. Following HIPAA, all group and individual health insurance policies must be guaranteed renewable.

Under guaranteed renewability, there may be rules that limit the level of rate increase at the time of renewal. For example, a surcharge based on prior year claims experience may be limited to 15% in addition to factors such as medical trend that apply to the entire covered population and can be actuarially justified at the renewal.

While a health insurer cannot cancel individuals or specific small groups due to health status or claims experience, it can cancel and stop selling the policy and disenroll the entire pool of people who are covered under that policy. The insurer may replace the policy with another benefit structure or may leave the market. If the health plan exits the market, there is usually a period of time before it may re-enter and again sell new policies in that market. HIPAA requires an insurer to provide a 180-day notice before it can exit a market and bars insurers that leave the individual market from reentering for five years. States have the authority to extend or add other provisions.

Rating

Most states have rating rules for the small group market that prohibit or restrict the ability of insurers to charge higher premiums based on health status or likelihood of future medical claims. Some states have enacted similar laws for the individual market. These have generally taken two forms – rate bands and community/adjusted community rating. These may be used separately or in combination.

Rate bands

Rate bands limit how much insurers can vary premiums for each policyholder or group based on the health and claims of the policyholder. These limits force insurers to spread some risk more broadly across all policyholders. Under the ACA, rating differences are limited to 3:1. In other words, the most expensive premium can be no more three times as high as the least costly premium. In comparison, prior to the ACA rating differences were more typically 5 or 6:1, suggesting that the true cost of covering older enrollees is closer to five or six times the cost of covering the youngest enrollees. Prior to the ACA, it was also common to charge a higher premium for women in their child-bearing years than for men of the same age. Even at older ages women were typically charged a higher premium based on the differences observed in the cost of providing care.

The extent that premiums can vary under rate bands depends on the size of the rate band permitted and what factors are constrained by the rate band. The factors that are constrained by the rate band align with the rules that have been adopted for community rating.

Community rating

Community rating means that insurers are required to set prices for policies based on the aggregate claims experience of everyone with such a policy. They are not allowed to vary rates based on the health status or claims of a given person or business. This is in contrast to experience rating where individual and group premiums are based upon medical history, health status, and other factors that predict health care spending.

Under adjusted or modified community rating, premiums may be adjusted based on selected factors such as geographic location, age or age groupings, the type of policy (e.g., individual, two adults, adult with child (ren), family), and for employers, size of group. Until recently adjustments for sex were also permitted.

When the policy is renewed, premium adjustments are based on the claims experience of all the people with that policy.

Covered benefits

Health insurance policies generally cover medical expenses associated with hospitalizations, surgical and out-patient care, care provided by doctors and other clinical personnel. States may also impose mandated benefits, a requirement that insurers cover certain diagnoses, benefits and services. Such mandates vary substantially across states and may apply differently across markets, such as individual, small group and large group, or health maintenance organizations versus other types of delivery systems. Mandates are a way to spread the cost of a condition or treatment across the broader population, making it less expensive for those who require such care.

Standardized benefit designs may be adopted as part of health reform efforts in order to establish a minimum or “floor” for acceptable products sold in a market, and to make comparison of policies across carriers easier for consumers. In addition to specifying the services that must be covered, the standardized design may require that benefits meet actuarial value standards and establish overall guidelines for member cost sharing but allow health plans flexibility to vary benefit design within those requirements. Other health reform efforts might standardize the benefit package across all health plans, such that covered services and member cost sharing are exactly the same. This permits “apples-to-apples” comparison where premium differences result from differences in provider networks and health plan operational costs, but not from differences in covered services.

Mandates for coverage

Mandates to purchase health insurance may be imposed at the employer or the individual level. These may be accompanied by financial penalties for those who do not purchase, and/or incentives and subsidies for those who may not otherwise afford coverage. There may also be provisions for exemptions for low income people for whom the coverage is considered "unaffordable" or who meet hardship and other exemption criteria.

The employer and individual reaction to the mandate requirement has to be evaluated in the context the design and the pricing of the policies that are offered on the market.

For example, if an individual mandate with a standardized minimum coverage requirement is imposed, it is likely that many people's current health insurance will not meet those standards. Existing market policies may not cover all the required benefits; impose deductibles and coinsurance that are above allowable limits; or it impose other impermissible limitations and restrictions. Compliance with new minimum coverage requirements will lead to higher premiums and dissatisfaction among consumers who felt their pre-reform coverage offered acceptable levels of coverage.

[1] Other states that enacted individual market reform include: Iowa (1996), Minnesota (1992), New Hampshire (1994,1998), New Jersey (1993), Ohio (1993) and Vermont (1993)
[2] M Reynolds. Maximizing the Use of Federal Matching Funds to Help Finance Universal Coverage. Implementation Policy Brief. Medicaid Policy Institute. Blue Cross Blue Shield of Massachusetts. October 7, 2005.
[3] M Reynolds. Maximizing the Use of Federal Matching Funds to Help Finance Universal Coverage. Implementation Policy Brief. Medicaid Policy Institute. Blue Cross Blue Shield of Massachusetts. October 7, 2005.
[4] U.S. Department of Health & Human Services, "The Regulation of the Individual Health Insurance Market." Winter 2008
[5] ibid
[6] Ibid. Coverage exclusions for pre-existing medical conditions were limited to a 6-month look-back period and a 12-month coverage exclusion period
[7] M Hall. "An evaluation of New York's reform law." Journal of Health Politics, Policy, and Law. February 2000
[8] ibid
[9] ibid
[10] Los Angeles Times, "A cautionary tale in healthcare reform." February 21, 2010
[11] ibid
[12] America's Health Insurance Plans, "The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets." March 2012
[13] America's Health Insurance Plans, "The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets." March 2012
[14] Kaiser Family Foundation, Health Insurance Coverage of nonelderly 0-64, 2013, http://kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=2&selectedDistributions=non-group
[15] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey", September 2010.
[16] Health Care Financing Review, "Washington State Health Services Act: Implementing Comprehensive Health Care Reform." Spring 1995
[17] Journal of Health Politics, Policy, and Law, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." February 2000
[18] Health Care Financing Review, "Washington State Health Services Act: Implementing Comprehensive Health Care Reform." Spring 1995
[19] Journal of Health Politics, Policy, and Law, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." February 2000
[20] Health Care Financing Review, "Washington State Health Services Act: Implementing Comprehensive Health Care Reform." Spring 1995
[21] Journal of Health Politics, Policy, and Law, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." February 2000
[22] ibid
[23] Journal of Health Politics, Policy, and Law, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." February 2000
[24] Wall Street Journal, "The Lesson of State Health-Care Reforms." October 15, 2009
[25] Journal of Health Politics, Policy, and Law, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." February 2000
[26] The Washington Post, "Washington state provides case study on effects of health-care reform." June 16, 2012
[27] The Commonwealth Fund, "Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market." February 2005
[28] ibid
[29] ibid
[30] The Heritage Foundation, "Kentucky Health Care Experiment: How 'Managed Competition' Clamps Down on Choice and Competition", June 1997.
[31] McCubbin, Rachel. "The Kentucky health care experiment: how managed competition clamps down on choice and competition." *State Backgrounder*. 1119VS. (June 1997).
[32] Willis, Cary B. "Unintended Consequences: Kentucky's experiment with health care offers lessons for nation." *America's Health Insurance Plans*. www.ahip.org.
[33] Journal of Health Politics, Policy, and Law, "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." February 2000
[34] Nichols III, George. "Health Insurance Reform in the 1990s: A Kentucky Historical Perspective." *Kentucky Department of Insurance.* Insurance.ky.gov, December 2016.
[35] The Commonwealth Fund, "Insuring the healthy or insuring the sick? The dilemma of regulating the individual health insurance market", February 2005.
[36] Ibid.
[37] Nichols III, George. "Health Insurance Reform in the 1990s: A Kentucky Historical Perspective." *Kentucky Department of Insurance.* Insurance.ky.gov, December 2016.
[38] Nichols III, George. "Health Insurance Reform in the 1990s: A Kentucky Historical Perspective." *Kentucky Department of Insurance.* Insurance.ky.gov, December 2016.
[39] Nichols III, George. "Health Insurance Reform in the 1990s: A Kentucky Historical Perspective." *Kentucky Department of Insurance.* Insurance.ky.gov, December 2016.
[40] The Commonwealth Fund, "Insuring the healthy or insuring the sick? The dilemma of regulating the individual health insurance market", February 2005.
[41] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey", September 2010.
[42] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey", September 2010.

[43] L Wachenheim and H Leida. The Impact of Guaranteed Issue and Community Rating Reforms on State's Individual Insurance Markets. Prepared for Americas Health Insurance Plans. Milliman. March 2012.
[44] AM Kirk. Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts. J Health Policy Politics and Law Vol. 25, No. 1, February 2000.
Blue Cross Blue Shield of Massachusetts Foundation. Health Reform in Massachusetts: Expanding Access to Health Insurance Coverage. Assessing the Results. March 2014
MT. Doonan and KR. Tull. Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate. The Milbank Quarterly, Vol. 88, No. 1, 2010 (pp. 54–80)
[45] Office of the Inspector General Commonwealth of Massachusetts Gregory W. Sullivan Inspector General Ongoing Review of the Uncompensated Care Pool Pursuant to Chapter 240 of the Acts of 2004 Second Report to the House and Senate Committees on Ways and Means November 2005, Page 2.
[46] Small Group Health Premiums in Massachusetts, Report on Small Group Health Increases Based on Information Obtained in Hearings, 2009-2010, July 2010.
[47] M Reynolds. Maximizing the Use of Federal Matching Funds. Op cit.
[48] J Holohan and l Blumberg. Massachusetts Health Care Reform: A look at the Issues. Health Affairs 25, no 6.(2006): p 432-443
[49] Massachusetts Health Connector: Seal of Approval: Product Strategy Evolution and Current State. Board of Directors Meeting, May 12, 2016.
[50] KA Love and RW Seifert. 10 Years of Impact: A Literature Review of Chapter 58 of the Acts of 2006. Center for Health Law and Economics, University of Massachusetts Medical School. April 2016
[51] Ibid.
[52] M Weinberg and W Kramer. Building Successful SHOP Exchanges: Lessons from the California Experience. Pacific Business Group on Health. Issue Brief. 2011
[53] TC Buchmeuller Managed competition in California's small-group insurance market.
Health Affairs 16, no.2 (1997):218-228. doi: 10.1377/hlthaff.16.2.218
[54] JM Yegian, TC Buchmeuller, et al. The Health Insurance Plan of California: The First Five Years. Health Affairs 19, no.5 (Sept/Oct 2000):71-78
[55] PacAdvantage Will No Longer Provide Access to Health Insurance Offerings. Press Release, PacAdvantage. August 11, 2006.
[56] Employee Benefit Research Institute, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey", September 2010.
[57] Wachenheim, Leigh and Hans Leida. "The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets." *State Coverage.* www.statecoverage.org. January 2017.