California HealthCare Foundation

Insurance Markets

Rules Governing California's Individual Insurance Market

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ISSUE BRIEF

Introduction

Almost two-thirds of California adults obtain health coverage through an employer — either their own or that of a family member. Individual coverage is the main alternative for those who are not covered through employment and are ineligible for publicly subsidized health coverage. However, the current individual health insurance market is relatively small, because only a fraction of those who do not have other health care insurance options buy individual coverage.[1] In 2003, an estimated 2.4 million people in California — 7.9 percent of non-elderly residents — were covered in the individual (non-group) health insurance market.[2] This compares with 17.9 million (57.1 percent) in employer-sponsored coverage and 6.4 million (20.4 percent) uninsured. Moreover, the number of people purchasing individual health insurance has declined steadily over the past 15 years.[3]

Buying individual health insurance can be complicated and challenging for consumers. First, the wide array of products and prices makes comparing available options complex and time-consuming. Second, an individual's demographic profile — age, gender, geographic region, health history, and health status — can be a barrier to obtaining coverage. Because health insurance carriers[4] offer and price individual policies based on age, individual risk, and health status; those people most interested in securing coverage may not be able to afford it.

This issue brief examines the state and federal laws that apply to the individual health insurance market in California.[5] It provides an overview of the differences between individual and group coverage and explains the basic rules that apply to individual policies, including exclusions for pre-existing conditions, guarantees on renewal, protections for higher-risk individuals who maintain coverage, and regulations governing the transition from group to individual coverage. Because the protections in the individual market are relatively weak, especially for those entering without previous group coverage, this analysis underscores the limitations of this coverage option and the need for consumers to avoid breaks in coverage whenever possible.

How Is the Individual Market Different from Group Insurance?

The individual health insurance market is substantially different than the market for employer-based group insurance. Individual policies are often unavailable to older people and those with pre-existing health conditions; premiums can be more expensive; there are fewer tax incentives for purchasing coverage;

and benefits may be more limited than in the group health insurance market.[6] In addition, the state and federal laws regulating individual insurance are less restrictive and provide fewer protections. These differences are discussed in more detail below.

Tax Implications

Most people who buy coverage as individuals, except self-employed individuals, do not receive tax benefits on the same scale as employers purchasing health coverage for their workers. Employers typically pay a large share of employee health insurance costs and are encouraged to do so, in part, by federal tax policies making employee benefits 100 percent tax-deductible for employers. In addition, employees may be able to set aside pretax dollars to pay their share of health premiums (and health costs that are not covered) if their employer offers a cafeteria plan, sometimes called a flexible spending plan, as permitted under Internal Revenue Code Section 125. These employment-based tax advantages are generally not available to individuals purchasing health insurance on their own, other than self-employed individuals.

Potential for Adverse Selection

To participate in the individual market, consumers must take the initiative to seek out coverage; compare options; make decisions; and pay the full cost, including premiums and any cost-sharing, without any employer contribution. Because of this, individuals who expect to be heavy users of health services may have the strongest motive to buy coverage. This tendency for individuals to seek coverage based on their anticipated need for care increases the likelihood that the "risk pool" of insured individuals could become overloaded with high users of health care services, a phenomenon insurance carriers refer to as "adverse selection." In employer group coverage, people in excellent health, as well as heavy users of health services, are motivated to enroll because employers are contributing to the costs of coverage. In addition, carriers in the group market often require that a certain proportion of an employer's workers sign up for coverage. This spreads both the risk and the expense across the entire group and ensures participation by healthy members.

Health Screening Requirements

Carriers typically require a health screening when consumers first seek individual coverage. Insurers deal with the potential for adverse selection by requiring waiting periods for pre-existing conditions, and by underwriting to exclude or charge higher rates to older individuals, people with high-risk or chronic conditions, and those whose medical histories or profiles suggest a high need for services in the future. Because consumers bear full responsibility for the cost and the effort to obtain individual coverage, they may opt to postpone buying coverage until they believe that they need health care services. Unfortunately, by the time they reach that point, they may be unable to find an insurer willing to write them a policy, particularly if they are ill or in need of regular care. Carrier underwriting practices in the individual market are so successful at limiting enrollment of people with health conditions that even though high-risk individuals might be more likely to seek coverage, the people covered by individual health insurance tend to be in relatively good health.[7]

No Guarantee of Initial Coverage

Individuals may not be able to obtain coverage. There are legal limits on the ability of carriers to impose

limitations because of pre-existing conditions, as outlined in the next section. State and federal laws provide some rate and renewal protection for those with existing group or individual coverage, but there is no requirement that carriers accept individuals applying for first-time coverage. Carriers may charge higher rates to people with higher-risk profiles or may offer a more limited range of benefits, including products requiring higher copayments or deductibles. Some applicants may be denied coverage. Recent evidence suggests that California carriers may be rejecting more applicants and charging higher premiums to those they do accept as a result of the limits imposed on pre-existing condition exclusions.[8] By contrast, under state and federal law, no one can be excluded from group coverage because of health or risk status. In addition, under California law, carriers must cover small employers with a workforce of 2 to 50 people.[9] Larger employers are more likely to obtain coverage, even though it is not guaranteed, since their pool of workers may be considered large enough to effectively spread risk across the group.

Higher Prices and Lower Benefits

Individual health insurance premiums vary widely by age. In general, older purchasers pay higher premiums than younger ones.[10] Although applicants who are young and healthy may be offered affordable coverage as individuals, premiums are high in comparison with the group market.[11] In addition, benefits are less comprehensive and patient cost sharing is higher in individual plans.[12] Carriers' administrative costs tend to be much higher in individual coverage, so a smaller proportion of premiums is actually spent on medical care.[13]

Rules and Regulations

There are essentially two categories of government regulation in the individual market. One is the limited set of rules that apply to individuals seeking health insurance after a significant break in coverage, as well as people who want to change carriers or products within the individual market. The other is a more complex and far-reaching framework that pertains to people transitioning from group to individual coverage.

Basic Rules for Individual Coverage

California law has relatively few protections for individual purchasers who are not making the transition from group coverage. For the most part, health insurance carriers are free to deny coverage based on health using criteria not subject to regulatory oversight, and they generally face no limits on the premiums they may charge. Carriers are prohibited from discriminating in their coverage decisions based on factors other than those related to health status or potential risk, such as race, religion, and sexual orientation.

Table 1 summarizes the rules that apply when individuals are not transitioning from group coverage. Key

Table 1. Health Insurance Options for Individuals Without Previous Group Coverage

PROGRAM/ CATEGORY	Applies to:	Guaranteed Issue	Pre-existing Condition Exclusion	Guaranteed Renewability	Restrictions on Rates
Uninsured Individual	• Individual with no existing or prior coverage. • Individual switching from one individual market carrier to another.	No	Yes. Up to 12 months. Credit would apply if applicant had prior qualifying coverage.	Yes	None

provisions applicable to individual health insurance include:

Limits on pre-existing condition exclusions. Carriers may deny coverage based on an individual's health condition or health status. However, once a carrier offers to cover a person, that carrier is prohibited from including any exclusion of more than 12 months. These pre-existing condition exclusions, or exclusions for "waivered conditions," mean that the carrier will not pay for costs related to existing health problems, defined in law as any "condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period (up to 12 months) preceding the effective date of coverage." HMOs that do not invoke pre-existing condition exclusions may impose a waiting period of up to 60 days before coverage takes effect.

Credit for prior coverage and exclusions. If a person had individual coverage from another carrier just prior to applying, the new carrier is required to credit the time of that coverage toward any waiver or pre-existing condition exclusion. For example, suppose a person covered for six months under an individual policy that excluded coverage for a specific condition is accepted for individual coverage with another carrier. Because the law prohibits exclusion periods longer than 12 months, the pre-existing condition exclusion applied by the new carrier cannot exceed six months.

Guaranteed renewability. Under state and federal law, health insurance carriers are required to renew an individual's existing health coverage, a rule sometimes referred to as "guaranteed renewability." Although this requirement offers important protections for some consumers, it has significant limitations:

- There is no cap on the rate increases carriers may impose at the time of renewal (see exception to this under federal Health Insurance Portability and Accountability Act [HIPAA] rules discussed on p. 7). This means that carriers must sell renewal coverage to individuals but can effectively discourage a policyholder from purchasing it by imposing high rates. California law does ensure that rates and rate increases are not discriminatory and prohibits carriers from setting different rates based on race, religion, ancestry, genetic characteristics, or sexual orientation. Carriers regulated by the California Department of Insurance also must apply rate increases consistently to individuals in a specific "class" of insured people, such as those sharing the same age, family size, geographic region, or health status. The state Department of Managed Health Care does not have the authority to regulate health plan rates in the same way. As a practical matter, most carriers apply rate increases on a class basis rather than developing rates for individual enrollees.
- The renewal guarantee is not portable. Because guaranteed renewability only requires a carrier to renew the particular policy or product in which an individual is enrolled, applicants who cannot pass the underwriting criteria for newer products or obtain coverage from other carriers must stay with the same coverage, regardless of its price, if they want to maintain their health insurance. For example, as overall medical costs increase and premiums go up, a person enrolled in a comprehensive health maintenance organization might wish to switch to a preferred provider organization product with greater cost sharing in order to pay a lower

premium. But to do so, that person would be subject to a new round of medical underwriting.

Protections for high-risk individuals who maintain individual coverage. California law includes protections for individuals who maintain individual coverage but cannot switch to other carriers or other products because of their risk profile. Without any legal protection, individuals in this situation could be caught in a "risk spiral" in which high-risk individuals cluster in old or discontinued products at ever more expensive rates. California requires carriers that stop selling individual coverage or stop enrolling new individuals in a particular product to either offer another product with comparable benefits, services, and terms with no additional underwriting; or pool the risk for any discontinued products with other, similar products.

California's High-Risk Pool

High-risk individuals who cannot purchase health insurance coverage through the private market have the option of seeking coverage through California's high-risk pool, the Major Risk Medical Insurance Program (MRMIP).

Qualifying individuals pay premiums that represent approximately 53 percent of program costs, with the remainder covered by Proposition 99 tobacco tax funds.[14] Though heavily subsidized, MRMIP rates are significantly higher than those paid by individuals who pass medical review in the private market. Costs to MRMIP subscribers are capped at 37.5 percent above the market rate. Coverage is delivered through contracts with four participating carriers.

The MRMIP has been in existence since 1991 and for much of that time demand for the program exceeded the available budget, leaving applicants on a waiting list. To address the problem, the legislature approved a four-year pilot project that restructured MRMIP as an "incubator" program: High-risk individuals are granted temporary, state-subsidized health coverage while they qualify for private policies subsidized by the state and carriers. The program provides coverage to individuals (and their dependents) who are:

- California residents;
- Not eligible for Medicare;
- Not eligible for COBRA or Cal-COBRA; and
- Unable to obtain coverage, involuntarily dropped from coverage, or offered individual coverage with higher premiums than they would pay through MRMIP.

The MRMIP pilot project, which will continue through September 2007, works as follows:

- Subscribers are limited to 36 months on MRMIP, at which point they are moved into private individual coverage. All carriers selling individual policies must guarantee coverage to former MRMIP subscribers.
- The guaranteed private coverage must offer the same benefits as MRMIP, at a price no more than 10 percent above MRMIP premiums. The private individual policies have capped annual benefits of $200,000. (The MRMIP annual cap is $75,000.) The policies also must provide a lifetime benefit maximum of $750,000, above and beyond any benefits received under MRMIP.[15]
- Costs that exceed premiums associated with coverage for "graduates" who complete

36 months of MRMIP coverage are shared equally between the state and the private insurance carrier.

The pilot project was launched in September 2003, and as of December 2004, 10,171 people had graduated from the program. MRMIP no longer has a waiting list, except for people waiting to satisfy the 90-day post-enrollment waiting period for HMO coverage.

When the incubator program began, 9,300 people were notified that they had until November 3, 2003, to apply for post-graduate coverage. As of December 31, 2003, more than 7,400 graduates — or 79 percent — had enrolled in private coverage, most of them in plans participating in MRMIP. There is no other information available about the subsequent experiences of graduates, but the state board that governs the program is seeking private funding for a survey. The legislation establishing the pilot project requires the Legislative Analyst's Office to conduct a study on the program and report the results to the legislature in October 2005.

Features of the MRMIP program are summarized in Table 2.

Rules When Changing from Group to Individual Coverage

Consumers may lose group coverage when:

- They leave a job;
- They move to a job without health coverage;
- Their employer discontinues coverage; or

Table 2. Features of California's High-Risk Pool for Individuals, Major Risk Medical Insurance Program (MRMIP)

PROGRAM/ CATEGORY	Applies to:	Guaranteed Issue	Pre-existing Condition Exclusion	Guaranteed Renewability	Restrictions on Rates
Major Risk Medical Insurance Program (MRMIP)	• Uninsurable residents of California not eligible for Medicare or COBRA coverage, and able to demonstrate that they have been turned down or dropped from private coverage within the previous 12 months. • Those offered individual coverage at a rate that exceeds MRMIP premiums.	Yes. Four participating carriers provide coverage to the extent funding is available. As of December 2004, there was no waiting list to enroll in the program other than those fulfilling a post-enrollment waiting period.	Yes. Ninety days for PPOs. The 90-day waiting period for any coverage in HMOs will be waived if person had coverage for prior 90 days (or credited for the number of days under 90), or was on the waiting list more than 6 months.	Yes. Up to 36 months. Subscribers may then pursue guaranteed private individual coverage as described below.	Yes. Premiums are set at 25% to 37.5% above what the individual would pay in the private market, depending on the carrier.
MRMIP Graduates through a pilot project extending to September 2007	People who have been on MRMIP for 36 months.	Yes. All carriers in the individual health insurance market must offer a product with the same benefit design as one of the products in MRMIP.	No	Yes	Yes. Ten percent above the subscriber premium in MRMIP.

- As the spouse or dependent of a covered person, through divorce or death.

A number of California and federal programs improve the chances that individuals losing job-based coverage will have access to the individual insurance market.

Table 3 summarizes the features of several programs available to consumers moving from group to individual coverage.

Table 3. Health Insurance Options for Californians Converting from Group to Individual Coverage

PROGRAM/ CATEGORY	Applies to:	Guaranteed Issue	Pre-existing Condition Exclusion	Guaranteed Renewability	Restrictions on Rates
COBRA	Individual losing group coverage from an employer of more than 20 people due to: termination of employment, reduced hours, or loss of dependent status following divorce or the death of an insured person.	Yes. Must be offered the same coverage as the employer group.	Yes. Up to 12 months, with credit for prior coverage.	Yes. Up to 18, 29, or 36 months depending on whether the individual is the primary insured or a former dependent of an insured person.	The same group coverage must be offered at no more than the group rate plus 2%.
Cal-COBRA	• Individual losing group coverage from an employer of 2 to 19 people due to: termination of employment, reduced hours, or lost coverage for dependents following divorce or the death of the covered person. • Individual exhausting federal COBRA prior to 36 months.	Yes. Must be offered the same coverage as the employer group.	Yes. Up to 12 months, with credit for prior coverage.	Yes. Up to 36 months.	The same group coverage must be offered at no more than the group rate plus 10%.
HIPAA in California	Individuals who have been insured under a group policy for 18 months, are not eligible for other health insurance or public programs (such as Medicare), and have exhausted COBRA coverage.	Yes. Must be offered the carrier's two most popular, or "representative," products as defined in state and federal law.	Yes. Up to 12 months, with credit for prior coverage, consistent with exclusions in the carrier's two most-popular products.	Yes. Limited to annual rate increases tied to MRMIP rates for PPOs, and general rate increases for similar policyholders on other individual products.	**PPOs:** Rate cannot exceed the premium for a person of similar age and geographic location in MRMIP. **HMOs and non-PPOs:** Rate cannot exceed 170% of that for a person of similar age and location.
Conversion Coverage	• Individuals exhausting COBRA coverage. • Individuals losing group coverage because the employer terminates health coverage or goes out of business.	Yes. Carriers must offer the same products as under HIPAA.	Yes. Up to 12 months, with credit for prior coverage, consistent with exclusions in the carrier's two most-popular products.	Yes	Yes. Same benefit requirements and rate limits as HIPAA policies.

COBRA and Cal-COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows individuals to retain their group health coverage when they experience a "qualifying event," such as the loss of their job or reduction to part-time status. It applies to employers of 20 or more people. The extension period is generally 18 months and may be as long as 36 months for dependents who lose health insurance for reasons such as the divorce or death of the covered employee. Individuals can purchase the same coverage provided by their employer at 102 percent of the rate the employer paid.

Cal-COBRA is a California law that closely mirrors federal COBRA, but applies to employers with up to nineteen employees and goes beyond federal law. Cal-COBRA extends the coverage period to 36 months for all Californians. It allows individuals in both categories — those employed by smaller businesses and those who have exhausted federal COBRA — to purchase coverage at 110 percent of the rate charged to the employer group. This is, generally, superior to what individuals could secure on their own in the individual market. However, young, healthy individuals may find they can obtain more favorable rates by buying an individual policy rather than exercising their Cal-COBRA guarantee.

Prior to January 1, 2005, California health plans and insurers were required to offer continuation coverage to individuals aged 60 to 64 who worked for their employer for five years or more. The Senior Cal-COBRA program was repealed in 2004[16] because coverage under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, as implemented in California,[17] had stronger rate protections for that age group. Senior Cal-COBRA was a barrier to HIPAA coverage, which is only available to people who do not have other coverage options. California now ensures the availability of individual coverage for anyone leaving or changing jobs under HIPAA regardless of their age, as discussed below, and requires carriers to offer coverage to individuals aged 60 to 64 at no more than 170 percent of average rates for 59-year-olds.

HIPAA

The federal Health Insurance Portability and Accountability Act included specific protections for workers who leave or change jobs. HIPAA allows people who lose job-related coverage and have had at least 18 or more months of group coverage to purchase an individual policy (provided they are not eligible for COBRA or have already exhausted their COBRA coverage). HIPAA requires carriers to offer eligible individuals their two most popular products, but does not restrict the premiums they may charge.

After HIPAA took effect, some carriers began charging people with HIPAA policies twice as much as the rate offered to groups. In response, California passed legislation to regulate HIPAA coverage and rates.[18] Under these state restrictions, premiums and renewal rates for individual PPO products cannot exceed those paid by high-risk subscribers in the MRMIP pool. For HMOs and other products, rates are held to 170 percent of the amount charged to other enrollees of comparable age living in the same geographic region. In the case of seniors between the ages of 60 and 64, non-PPO rates cannot exceed 170 percent of the price charged to 59-year-olds. Carriers are also limited to one rate increase per year.

Health Savings Accounts

Congress recently passed legislation that effectively extends a tax benefit to people buying a specific type of individual coverage. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 created health savings accounts (HSAs), permitting individuals covered by high-deductible health insurance plans to set aside pretax dollars to pay for medical expenses.

The coverage that must accompany an HSA account can be purchased by individuals or may be set up or paid for as employer group insurance. HSA-compatible products are subject to different rules depending on whether they are individual or group plans. For example, carriers can apply pre-existing condition limits to individual HSA-compatible plans in the same way, and under the same rules, as they can for other individual coverage.

Other aspects of HSAs that apply to individuals are as follows:

- To qualify for the HSA tax deduction, the accompanying insurance product must have a deductible higher than $1,000 for individuals and $2,000 for families. High-deductible plans may provide preventive care benefits without a deductible, or with a deductible lower than the qualifying deductible amount.
- Contributions to HSA accounts can come from any source, including both individuals and their employers, but are limited to $2,600 for individuals and $5,150 for families per year. A consumer who purchases a health plan with a higher deductible than the annual savings limit must make up the difference.
- The HSA account is portable, so it stays with the individual. Individuals who establish an HSA through an employer-offered plan can take the accounts with them, but the accompanying health coverage would be subject to the same rules as any other group plan changing to individual coverage.

Conversion Coverage

Under California law, people who exhaust their COBRA coverage or lose group coverage when their employer terminates its health insurance plan can pursue "conversion" coverage through the group insurer if they sign up within specified time limits. The group carrier cannot refuse to cover these individuals because of health status or subject them to pre-existing condition exclusions. To be eligible for conversion coverage, individuals must have been covered for the three months prior to group coverage termination.

Historically, conversion policies were very expensive and provided limited benefits. Legislation passed in 2002 expanded and clarified the rules for conversion coverage.[19] HIPAA requirements regarding products, benefits, and premium rates now apply to conversion policies. Pre-existing condition limitations may not exceed 12 months, with credit for previous coverage, and must be consistent with the exclusions included in the carrier's most popular products, as under HIPAA rules. Conversion coverage is now available for anyone who loses group health insurance but is not eligible for COBRA or Cal-COBRA because the coverage their employer carried no longer exists. For example, if employers drop coverage because they are going out of business or are bankrupt, their employees become eligible for conversion policies.

Conclusion

The complex rules governing the market for individual health insurance make such coverage most accessible to people who are young and healthy. In addition, state and federal legal protections differ significantly depending on whether consumers are entering the individual market for the first time (or after a significant break in coverage) or are making a direct transition from group

coverage. Recent state and federal laws have increased the protections available to people who are switching from an employer's group plan to individual coverage. This environment makes it important for consumers to know their legal options for continuation and conversion coverage.

For those who have been uninsured, the law provides very few protections. Individuals without previous coverage can be turned away or charged higher rates because of their health history, health status, or risk factors. It can be hard to know what coverage will be available for any one individual. The specific underwriting and rating rules carriers will apply to a new applicant are not typically available to consumers and are not subject to regulatory review or statutory limitations.

There is increasing interest in policy changes to further reform the individual market as one strategy to reduce the number of uninsured people. Proposed strategies include: expanding tax credits for buying individual coverage, placing further restrictions on rating and underwriting practices, developing or expanding state-run high-risk pools, subsidizing coverage, and requiring individuals to have health coverage, as most states do for auto insurance.[20]

Policymakers focusing on the individual market need to balance the somewhat contradictory goals of keeping coverage available and affordable for younger, healthy people, while improving the options for those who are older and in less than perfect health. One example of the policy tradeoffs is the evidence that California carriers reject more applicants and apply higher premiums on those they do accept since the passage of statutory limits on pre-existing condition exclusions.[21]

As employers continue to scale back or drop insurance coverage for workers or their dependents, the demand for individual health insurance could grow. However, in its current form, the individual health insurance market is unlikely to be a viable alternative for large numbers of uninsured individuals, particularly low- and middle-income people and those with complex health histories and conditions. Without additional regulation, the individual market seems a shaky foundation on which to place hopes for broad coverage expansion.

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FOR MORE INFORMATION, CONTACT:

California HealthCare Foundation
476 Ninth Street
Oakland, CA 94607
tel: 510.238.1040
fax: 510.238.1388
www.chcf.org

ENDNOTES

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2. California HealthCare Foundation. *Snapshot: California's Uninsured, 2004.* Oakland, CA: October 2004. Second annual report based on analysis of Current Population Survey data by the Employee Benefit Research Institute (www.chcf.org/topics/healthinsurance/index.cfm?itemID=106448).

3. Buntin et al.

4. In this document, "insurance carrier" or "carrier" is used to refer generically to both health plans regulated by the California Department of Managed Health Care and insurers regulated under the California Department of Insurance.

5. This report addresses the rules that apply in the non-Medicare individual market. Different rules apply in the Medicare supplemental market. More information about Medicare rules can be obtained at the California Department of Insurance (www.insurance.ca.gov and/or www.calmedicare.org).

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11. Turnbull and Kane.

12. Ibid.

13. Gabel et al.

14. Managed Risk Medical Insurance Board. *MRMIP Fact Book.* April 1999 (www.mrmib.ca.gov).

15. According to data collected for CHCF by Milliman, annual maximums are uncommon in the private market for individual coverage. Some individual products have lifetime maximums, typically in the $5 million to $6 million range.

16. AB 254 (Montanez), Chapter 64, Statutes of 2004.

17. SB 265 (Speier), Chapter 810, Statutes of 2000.

18. SB 265 (Speier), Chapter 810, Statutes of 2000.

19. AB 1401 (Thomson), Chapter 794, Statutes of 2002.

20. For more information about one widely discussed proposal for an individual health insurance mandate, see Michael Calabrese and Laurie Rubiner. *Universal Coverage, Universal Responsibility: A Roadmap to Make Coverage Affordable for All Americans.* New America Foundation, Washington, D.C.: January 2004 (www.newamerica.net/Download_Docs/pdfs/Pub_File_1443_1.pdf).

21. Pollitz et al.