The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets

prepared for America's Health Insurance Plans

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Section I. Introduction and Scope

America's Health Insurance Plans (AHIP) retained Milliman, Inc. (Milliman) to update our August 2007 report, which provided an overview of guaranteed issue and community rating reforms adopted in eight states in the 1990s, including an examination of their respective impacts on the states' individual health insurance market. The states include Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington. While a number of states have undertaken significant reforms in the last few years, some of which are mentioned here, this paper focuses on the impact of reforms implemented in the 1990s.

In this report, individual health insurance refers to insurance purchased directly from an insurance company, as opposed to insurance obtained through an employer or under a government program. Individual health insurance refers only to major medical coverage. Guaranteed issue (GI) laws generally require insurers to issue insurance to any eligible applicant without regard to current health status or other factors. Community rating (CR) laws prohibit insurers from varying premium rates based on health status, and restrict the amount by which insurers are allowed to vary these rates based on case characteristics such as age or gender.

There are variations in how states apply community rating standards. Pure community rating requires insurers to charge each policyholder the same community rate with adjustments only allowed for family size or plan design. Occasionally, limited variation by geographic area is also included in this category. Modified community rating allows for some limited variations in rates for case characteristics other than health status. Additional terms used in this report are defined in the glossary supplied in Appendix A.

Each of the eight states listed above adopted some form of guaranteed issue and/or community rating reform in its individual insurance market in the 1990s. This report contains the results of our historical study. For each state, we have provided a summary report in a common format tracing the history and impact of reforms in the state. Our report is intended to describe the impact and history of these reforms in subsequent years and may not be suitable for other purposes.

This report should only be distributed in its entirety. Milliman's work is prepared solely for the use of AHIP. Milliman does not intend to benefit third parties and assumes no duty or liability to other parties who receive this work product.

In preparing this report, we relied on a wide variety of data sources, including census data, interviews, prior studies, and information posted on government web sites. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. We have, however, performed a limited review of the data used directly in our analysis (identified in the individual state reports) for reasonableness and consistency and have found no material defects in the data. But, of course, it is possible that a more detailed systematic review could identify data values that are questionable or relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Section II. Background and Summary

Most of the eight states we studied enacted various versions of guaranteed issue (GI) and community rating (CR) in 1992 or 1993. The last state in the study to implement reforms was Massachusetts, which enacted reforms in 1996.

The goals of guaranteed issue and community rating reforms in the individual market were laudable—to make health insurance more accessible by ensuring that unhealthy or older individuals were not denied coverage or charged premiums higher than they could afford. However, as we discuss in this report, these reforms frequently had unintended consequences that disrupted the marketplace.

Traditionally, individual health insurance is issued to people who are able to meet the medical underwriting standards of the issuing company. As time passes, some of these people will develop health problems. The medical costs of these insureds will be subsidized by those who remain healthier through common premium rates. Limited premium rate variation is allowed at the time of issue to reflect likely cost differences between different groups of people, such as variations for age, gender, or geographic location. Premium rates might also be adjusted at issue at the individual level to reflect the expected cost of known health conditions which are not so severe as to result in declination. Guaranteed issue and community rating reforms change these traditional dynamics in the following key ways.

Guaranteed issue encourages people to wait until they have health problems to buy insurance. Said another way, guaranteed issue can encourage healthy people to delay purchasing health insurance. Community rating reforms can have a similar effect since requiring all policyholders to pay the same or similar rates increases rates for the younger or healthier individuals to create new subsidies for the older or less healthy individuals. This cost shift can cause younger or healthier individuals who may have otherwise purchased health insurance to choose to forgo it. Participation of the healthier population—those without expected claims—is a key ingredient for making a voluntary insurance market operate effectively.

In a GI and/or CR environment, the people who purchase insurance can have higher than average medical costs. When this happens, the insurance pool will have higher costs per member, and premiums will tend to increase. This can also result in less favorable financial results for the carriers in the market. Increasing premium rates can, in turn, drive more low risk policyholders from the insurance pool, which leads to further rate increases. If this continues, the pool or market will essentially collapse or shrink to include only the higher risk population. This phenomenon is commonly referred to as an antiselection spiral or “death spiral.” This risk can be managed to some extent through the use of insurance mandates, premium subsidies, or other mechanisms that prevent healthy risks from leaving the insurance pool in significant numbers.

Although results varied widely among the eight states, in general we found that, measured in terms of market size, level of premium, and availability of insurance options, individual health insurance markets deteriorated after the introduction of GI and CR reforms. Often, insurance companies chose to stop selling individual insurance in the market after reforms were enacted which resulted in a decrease in competition. Enrollment in individual insurance also tended to decrease, and premium rates tended to increase, sometimes dramatically. We also did not observe any significant decreases in the level of uninsured persons following the enactment of these original market reforms.

Particularly severe consequences resulted in states such as Kentucky, where reforms were applied piecemeal, so that some portions of the individual market operated under pre-reform rating and issue rules for years after reform was originally enacted. Under such uneven treatment, markets will tend to "resegment" with the low risk individuals moving to the non-reform portion of the market, leaving the reform block with the more expensive members. This effectively limits the subsidization goal of CR reforms. In a 2000 paper[1], two regulators from New Hampshire compared individual market regulation to squeezing a balloon—cautioning that unless you "squeeze the balloon on all surfaces at once," the market will resegment.

Of the eight states we studied, two (Kentucky and New Hampshire) have since repealed guaranteed issue and community rating laws in their individual markets entirely, and one (Washington) has significantly weakened its original community rating and guaranteed issue provisions. Maine and New Jersey have relaxed their community rating requirements as well.

Two other states, Iowa and South Dakota, passed guaranteed issue laws in 1995 and 1996, respectively. These states repealed their laws in 2004 and 2003. South Dakota, repealed its law after experiencing a near collapse of its individual market.

At least two states, Massachusetts and Vermont, have recently introduced new reforms targeting universal coverage. The Massachusetts reforms have been implemented and are well documented. The Vermont move toward a single-payer system is contingent on a number of other criteria first being satisfied. These latter changes are outside the scope of this report, but are mentioned in the state specific discussions.

In several of the states we studied, Blue Cross Blue Shield plans acted as insurers of last resort in the individual market prior to the enactment of GI and CR reforms. In some cases, this was required by statute, while in other cases it was the result of regulatory action and historic precedent. Therefore, in these states, there was already effectively a guaranteed issue mechanism in place before reforms, which may have dampened the impact of the GI reform somewhat.

[1] Feldvebel, Alexander K. & Sky, David (February 2000). A regulator's perspective on other states' experiences. *Journal of Health Politics, Policy and Law* Vol. 25, No.1. Duke University Press.

Section III. State Summary Reports

We have provided our report in a common format for each of the eight states. In the top right corner of each state report, we have indicated which reforms (GI, CR, or both) applied to the individual market originally and which reforms are currently in effect as of February of 2012. An entry of "Y" indicates that guaranteed issue (GI) or pure community rating (CR) was in effect, while an entry of "N" indicates it was not in effect. An entry of "Modified" indicates that a modified or weakened form of these provisions was in effect.

This is followed by a description of the reforms and their impact in the state. After the description, a summary of the relevant legal references is provided, as well as a "State Facts" box, any relevant additional statistics, and a list of references.

The "State Facts" boxes contain selected census data for each state for years before and after the initial individual market reforms were enacted. These data are taken from the U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. For each state, the tables and graphs include the percentage of the noninstitutionalized population under age 65 that directly purchased health insurance during each year from 1990 through 2010. The percentages that were uninsured at some point during the year are also given. Data for the 1990 to 2005 period is taken from the Health Insurance Historical Tables (HI) original historical series. The 2006 to 2010 data is taken from the HIB series, which includes data revisions made by the Census Bureau in 2007 to improve the quality and consistency of its estimates. [2] We therefore present each table with a gap to distinguish the change in the data source.

The census data provide one of the only data sources on health insurance coverage available for all states over a long period of time. They do, however, possess limitations. First, the census did not start collecting data on direct purchasers until 1994. Second, some of the relevant survey questions changed over time, which may have an impact on the results. Finally, as mentioned above, the Census Bureau has made revisions to its historical estimates from 1995 to 2003. The overall impact of the revision is less than 1% for 2004 and 2005 and is relatively constant from one year to the next.[3] Despite these limitations, general conclusions may be drawn by comparing trends between states and considering national averages.

Where possible, we supplemented the census data with other data sources. For some states, we have included tables of "Additional Statistics." Due to differences in methodology, these additional data sources are generally not directly comparable with the census data.

When studying the impact of reforms on health insurance markets, it is difficult to establish causality, since market performance is affected by many other factors besides reforms. Moreover, as Adele Kirk noted in her 2000 study of market reforms,[4] "gathering data on, and ascribing meaning to, changes in individual enrollment is particularly difficult because the individual market is a residual market, that is, a market where people generally seek coverage only when they do not have access to other coverage."

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[2] Revised CPS ASEC Health Insurance Data. Accessed via http://www.census.gov/hhes/www/hlthins/data/usernote/index.html on January 31, 2012.

[3] U.S. Census Bureau (March 23, 2007). Census Bureau revises 2004 and 2005 health insurance coverage estimates. Press release. Retrieved February 15, 2012, from http://www.census.gov/newsroom/releases/archives/health_care_insurance/cb07-45.html.

[4] Kirk, Adele M. (February 2000). Riding the bull: Experience with individual market reform in Washington, Kentucky, and Massachusetts. *Journal of Health Politics, Policy and Law*, Vol. 25 No. 1. Duke University Press.

Nonetheless, by comparing and contrasting the reform initiatives and reform experiences in several states, it is possible to learn a number of useful lessons about the impact of guaranteed issue and community rating reforms on the individual health insurance market.

DISCUSSION

Kentucky's experience with health insurance reform of the individual market is often held up as an example of failure and unintended consequences. The initial reforms passed in 1994 included guaranteed issue and modified community rating (a 3:1 rate band for age, family composition, and geographic area combined).[5]

The law also established two new public agencies: a health policy board that was to design standardized benefit plans and a purchasing alliance. Originally, all new business in the individual market after July 1995 was to be issued under one of the standard plans. The purchasing alliance aimed to create a critical mass of policyholders by including state and other public employees on a mandatory basis and individuals and small groups on a voluntary basis.

However, for a variety of reasons, the reforms never truly penetrated the individual market. The reforms were strongly opposed by both insurers and providers. The original timetable for adopting the reforms was delayed by the health policy board and several executive orders. Insurers were allowed to delay switching existing policyholders to standardized plans, and state workers were not moved into the purchasing alliance until January of 1996, six months after initially planned. Coupled with lawsuits challenging the legality of the reforms and confusion over rate increase decisions and reversals by the insurance commissioner in late 1995, these delays created an uncertain environment for insurers.

Some of the 1994 reforms were significantly modified by the legislature in 1996. Guaranteed issue and standardized plans were retained, but the community rating provisions were relaxed to allow limited rating by gender, occupation, and healthy lifestyles (up to a 5:1 total rate band). The 1996 law also allowed insurers to renew non-standard policies for a further 12 months, and it exempted associations of employers or individuals from the community rating and standardized benefits reforms. At the same time, the law strengthened the insurance commissioner's rate review powers.

A 2000 study[6] by Adele M. Kirk found that the reforms never reached the majority of the consumers in the individual market. Kirk attributed this to the association exemptions and the ongoing ability of insurers to renew non-standard policies.

The most widely reported result of the 1994 and 1996 reforms in Kentucky was the flight of insurers from the market. According to a memorandum[7] by the Kentucky Legislative Research Commission, more than 40 insurers had left the individual market by January of 1998. Of these 40 companies, about 17[8] held fewer than 100 non-group policies. By late 1996, only one health insurer and Kentucky Kare (a self-insured plan for state employees that also sold policies to individuals through the purchasing alliance) were selling new policies to non-association individuals.

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[5] Clark, Michael. Market Responses to Kentucky's Health Insurance Reforms. Center for Business and Economic Research, University of Kentucky.
[6] Kirk, Riding the bull, ibid.
[7] Clark, M. & Wilson, G. (January 1998). Status of the Health Insurance Market in Kentucky. Research Memorandum No. 480, Legislative Research Commission. Retrieved February 15, 2012, from http://www.lrc.state.ky.us/lrcpubs/Rm480.pdf.
[8] See p. 152 of Kirk, Riding the bull, op. cit.

Given the ability of healthy individuals to avoid the standardized plans and community rating reforms by either keeping their existing nonstandard coverage or seeking coverage through an association, insurers and Kentucky's Department of Insurance both feared adverse selection would occur in the standardized portion of the market.

Regardless of whether adverse selection occurred, the potential for adverse selection combined with the constantly changing regulatory environment and stringent rate approval process made Kentucky an uncertain proposition at best for insurers.

Starting in 1998, many of the remaining reforms have been repealed. The standardized plans and guaranteed issue requirements were replaced by a complex "pay or play" system called the Guaranteed Acceptance Program and a high risk pool called Kentucky Access, although insurers were still required to offer a single standard plan. Rating restrictions were also further modified, replacing the approval and hearing process with a file and use process subject to a minimum loss ratio guarantee.

In 2004, the legislature enacted a three-year moratorium on mandated benefits, eliminated the requirement to offer standard plans, and reduced administrative regulations. All of these measures were designed to encourage insurers to return to the individual market, and they have had some success in this regard. As of July 2011, the Department web site lists six companies selling individual insurance.[9]

[9] Kentucky Department of Insurance: Companies Selling in Kentucky's Individual Market. Retrieved February 2, 2012 from http://insurance.ky.gov/Documents/IndHealthList070611.pdf.

LAW

Citation(s):
P.L. 1994 c. 512
Ky.Rev.Stat.Ann. §304.17A

Enactment Date: April 15, 1994
Effective Date: Originally to be phased in through July 15, 1996.
Repeal Date: 1998 (CR), 2000 (GI)

Original GI Provisions

- Guaranteed issue required.

Original CR Provisions

- Rates could not vary by health status or gender.
- 3:1 rate band for age, family composition, and geographic area combined.
- Insurers could only sell eight standardized plans designed by the health policy board.

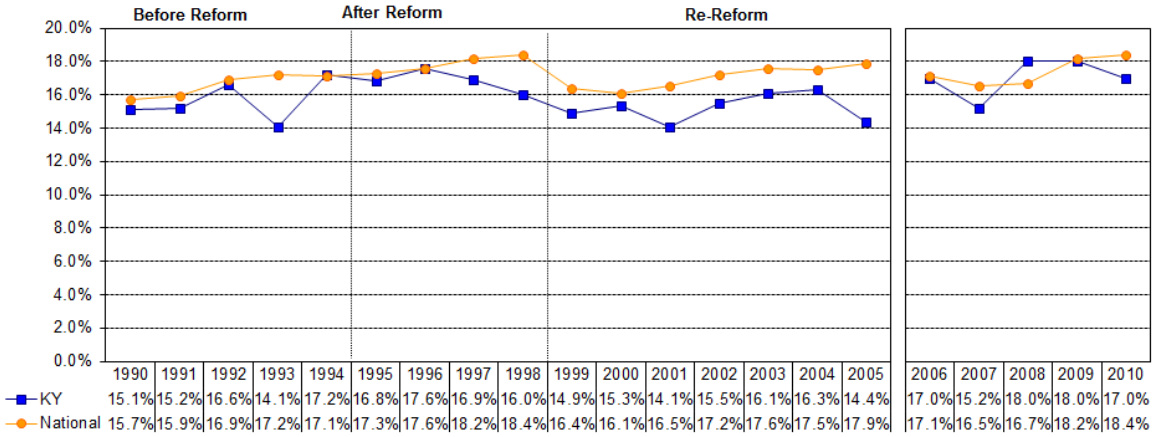
Subsequent History

- **1996**: SB 343 allows limited gender rating, increases the overall rating band, and excludes policies sold through associations from rating restrictions.
- **1997**: Governor calls legislature into special session to consider repealing reforms; legislation fails.
- **1998**: HB 315 modifies guaranteed issue requirements, requires "pay or play" risk pooling, repeals CR, dissolves purchasing alliance, and removes individuals from Kentucky Kare.
- **2000**: HB 517 creates Kentucky Access (high risk pool) with tobacco settlement money, eliminates GI, and further loosens underwriting restrictions.
- **2004**: Kentucky bans new mandates for three years and eliminates requirement to offer standard plans.

Current status: GI and CR repealed.

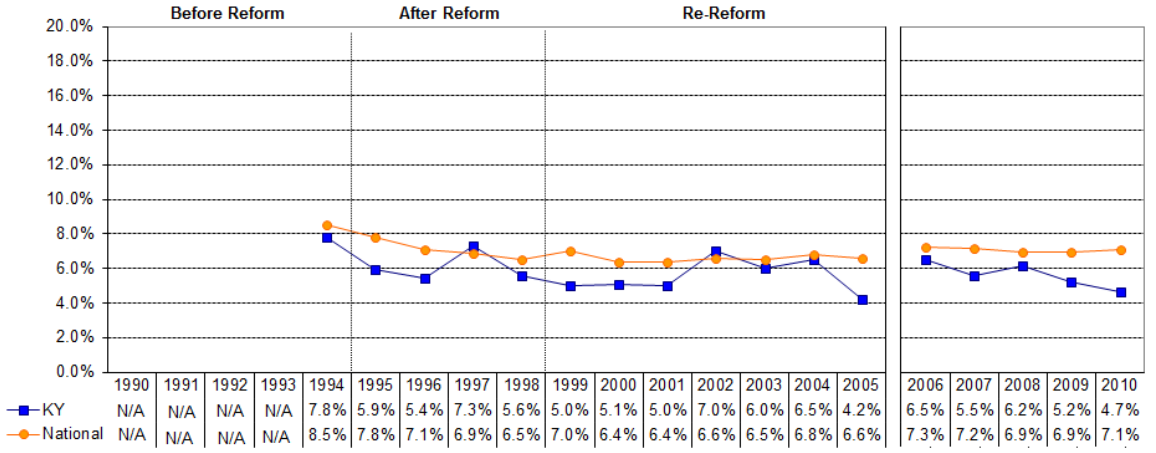
KENTUCKY FACTS*

Percentage of Uninsured Under Age 65



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
KY	15.1%	15.2%	16.6%	14.1%	17.2%	16.8%	17.6%	16.9%	16.0%	14.9%	15.3%	14.1%	15.5%	16.1%	16.3%	14.4%	17.0%	15.2%	18.0%	18.0%	17.0%
National	15.7%	15.9%	16.9%	17.2%	17.1%	17.3%	17.6%	18.2%	18.4%	16.4%	16.1%	16.5%	17.2%	17.6%	17.5%	17.9%	17.1%	16.5%	16.7%	18.2%	18.4%

Percentage of Direct Purchasers Under Age 65



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
KY	N/A	N/A	N/A	N/A	7.8%	5.9%	5.4%	7.3%	5.6%	5.0%	5.1%	5.0%	7.0%	6.0%	6.5%	4.2%	6.5%	5.5%	6.2%	5.2%	4.7%
National	N/A	N/A	N/A	N/A	8.5%	7.8%	7.1%	6.9%	6.5%	7.0%	6.4%	6.4%	6.6%	6.5%	6.8%	6.6%	7.3%	7.2%	6.9%	6.9%	7.1%

Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994. Perhaps the most surprising data is the percentage of nonelderly uninsured in Kentucky, which for the most part stayed slightly below national averages throughout the period from 1992 through 2010, except in 2008. In some years, particularly 1993, 1998, 2001, and 2005, it was significantly below the national average.

On the other hand, the percentage of the nonelderly population directly purchasing health insurance in Kentucky did fall faster (from 7.8% to 5.4%) than the national averages from 1994 through 1996, and, except for a rebound in 1997, it remained below national averages until 2002. After remaining near national levels in 2003 and 2004, the direct purchaser percentage fell again in 2005 to 4.2%, well below the national average of 6.6%. It is therefore unclear whether the individual market in Kentucky has fully recovered from the state of flux it endured in the late 1990s.

*Note: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

Additional Sources

Citations/Legal references:

1. Westlaw. http://www.westlaw.com. Thompson West.
2. Current laws accessible at http://insurance.ky.gov/Laws.aspx. Accessed February 2, 2012.
3. Original legislation from 1997 onwards available at http://www.lrc.ky.gov/legislat/pastses_new.htm. Accessed June 6, 2007.
4. Kentucky Office of Insurance http://insurance.ky.gov/Documents/IndHealthList070611.pdf. Accessed February 2, 2012.

History:

1. "Status of the Health Insurance Market in Kentucky." Clark, M. and Wilson, G. Research Memorandum No. 480, Legislative Research Commission. January, 1998. Available online at http://www.lrc.state.ky.us/lrcpubs/Rm480.pdf as of February 2, 2012.
2. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." Adele M. Kirk. Journal of Health Politics, Policy and Law, Vol. 25 No. 1. Duke University Press, February 2000.

DISCUSSION

Maine enacted guaranteed issue and modified community rating reforms for the individual market in 1993. Carriers offering individual insurance were required to offer two standardized plan designs (a "basic" plan and a "standard" plan) on a guaranteed issue basis. Starting in 1995, all HMOs were required to offer individual coverage on a guaranteed issue basis.

Under the modified community rating law, rate variations based on gender, health status, claim experience, or policy duration are explicitly prohibited. Limited variations from the community rate were allowed for age, occupation or industry, and geographic area. Originally, these variations were to be phased out by 1997; however, subsequent legislation in 1995 set a rate band for these three case characteristics combined at +/- 20% of the community rate. Rates may also vary by smoking status and family size.

After the implementation of these reforms, there was a decline in the number of carriers participating in the indemnity market. Of the five carriers offering individual health insurance in 1994, only Anthem Health Plans of Maine (formerly Blue Cross Blue Shield of Maine) was issuing new business in 2001. Two new carriers did enter the market in 1995 and 1996, but left in 2000.

According to a white paper[10] prepared by the Maine Bureau of Insurance, by 2001 it was "clear that the future viability of the individual health market in Maine [was] at serious risk." Moreover, the Bureau concluded that "the market for individual HMO coverage does now appear to be in a death spiral," citing poor experience and large rate increases. All but one HMO had a rate increase of at least 25% in 1998 or 1999, and in 2000 all of the HMOs had an increase between 30% and 64%.[11] Furthermore, even when adjusted for differences in administrative costs, individual community rates for the standard plan exceeded group rates by 16% to 102%.[12]

The Agency for Healthcare Research and Quality has reported[13] that the average nationwide premium for an individual health insurance policy increased by a total of 44% over the entire six year period from 1996 to 2002. This average increase is not directly comparable to the increases described above, as it reflects the impact of other factors, such as changes in nationwide average demographics and benefit levels over this time period. However, it can be used as a general point of reference when reviewing the impact of the individual market reforms in Maine.

Changes in benefit mix during this period were significant, as illustrated by the experience of Anthem Health Plans of Maine's (Anthem's) HealthChoice product. This product includes both the mandated basic and standard plans, as well as a variety of other plans. In the mid-

[10] Maine Bureau of Insurance (January 22, 2001). White Paper: Maine's Individual Health Insurance Market. Maine Department of Professional and Financial Regulation. Retrieved February 15, 2012, from http://www.maine.gov/pfr/legislative/documents/indiv_health_2001.pdf.
[11] Maine Bureau of Insurance, ibid. p. 10.
[12] Maine Bureau of Insurance, ibid. p. 11.
[13] Bernard, D.M. (March 2005). Premiums in the Individual Health Insurance Market for Policyholders Under Age 65, 1996 and 2002. Statistical Brief #72, Agency for Healthcare Research and Quality, Rockville, MD. Retrieved February 15, 2012, from http://www.meps.ahrq.gov/mepsweb/data_files/publications/st72/stat72.pdf.

1990's, Anthem started selling HealthChoice policies with high deductibles, ranging from $2,250 to $15,000. By the end of the decade, the company had stopped selling the lower-deductible versions of the HealthChoice product entirely, except for the basic and standard plan designs mandated by the state. However, these mandated plans were very expensive compared to the high deductible plans, and consequently had very low enrollments. As of June 2006, about 96% of all HealthChoice contracts were in the high deductible plans, with fewer than 2% of contracts in the state-mandated plans.

After much debate, Maine established a semiprivate health insurance program in 2003 with the passage of the Dirigo Health Reform Act (DHRA). The Dirigo program provides private coverage to uninsured Maine residents, groups of fewer than 50 employees, and the self-employed. Its aim was to cover all uninsured Maine residents by 2009 through a set of subsidized plans called DirigoChoice.

Although it did not directly change the regulatory structure of the individual market, the DHRA did impose an additional tax on carriers that may have led to increased costs to consumers. The Dirigo program was also partially funded through federal tax relief money in the first year.

The Dirigo program designers expected payors of health care costs (insurers and self-funded plans) to be able to negotiate lower rates with hospitals and other providers after the program's inception, and they also expected a reduction in charity and emergency care for the uninsured. The new tax established under the DHRA was meant to capture these savings to fund the DirigoChoice subsidies.

However, this funding mechanism proved controversial. The state claimed savings of $43.7 million in 2005 and $34.3 million in 2006,[14] and representatives of health insurers and other payors filed a lawsuit asserting that they owed much less. In August 2006, a judge ruled in favor of the state. The decision was appealed. On May 31, 2007, the Maine Supreme Court ruled 5-1 in favor of the state, although the court noted in its opinion that the statute in question was ambiguous.[15] In 2008, the funding method was changed to a fixed percent of claims volume for insurers and third party administrators, as well as a dedicated portion of alcohol and soft drinks taxes.[16]

The Dirigo program faces other problems besides funding issues. Enrollment has been much lower than projected—only 18,800 people enrolled as of April of 2007, while the program had originally aimed to have 31,000 enrollees by the end of 2005. Enrollment into the DirigoChoice program was limited after September 2007, when enrollment was at 15,123 members. Enrollment was re-opened in August 2010 and was reported as 14,272 in November 2010.[17]

Also, claim costs have been much higher than projected which has led to premium increases, suggesting that the program may be having trouble attracting and keeping good risks. Moreover, a 2005 survey[18] of early DirigoChoice enrollees sponsored by the Dirigo

[14] Belluck, Pam (April 30, 2007). Plan falters, Maine explores changes. New York Times.
[15] Supreme Court decision available at http://www.courts.state.me.us/opinions/2007%20documents/07me69di.pdf, accessed June 18, 2007.
[16] Kilbreth, Elizabeth (August 2008). The Dirigo Health Reform Act: A Case Study of Small Group Market Reform in Maine. University of Southern Maine, August 2008.
[17] Maine.gov. Agency Stats: Dirigo Health. Retrieved February 15, 2012, from http://www.dirigohealth.maine.gov/Pages/agency_stats.html.
[18] Bowe, Taryn (August 12, 2005). DirigoChoice Member Survey: A Snapshot of the Program's Early Adopters. Institute for Health Policy, Muskie School of Public Service, University of Maine. Retrieved February 15, 2012, from http://muskie.usm.maine.edu/publications/ihp/DirigoMemberSurvey2005.pdf.

Health Agency reported that only 22.4% were uninsured at the time of enrollment. Even taking into account those that were uninsured or underinsured at some point in the year preceding enrollment, a solid majority (62%) of enrollees had private insurance for the entire year before they switched to the state-subsidized plan.

Dirigo is scheduled to be phased out by December 2013.[19]

In 2006, a Commission was created to recommend methods for reducing and controlling health care cost in Maine. Based on their report, at that time only about 3% of Maine's population was covered under individual health insurance and 11% of the under 65 population remained uninsured.[20]

Various legislative proposals were considered in subsequent years. These included instituting a loss ratio requirement for the individual market and mandating individual and/or employer coverage. In 2011 Public Law 90 was approved, which includes an "Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services".

The most recent regulatory framework incorporates adjusted community rating rules and wider rating bands. It expands rate bands for open blocks from the current 1.5:1 ratio to a 3:1 ratio by July 1, 2012. It would continue to expand the ratios for open blocks up to a 5:1 ratio by January 1, 2015 if allowed under the federal Patient Protection and Affordable Care Act (PPACA).[21] The rate bands for closed blocks are increased to 2:1 in July 2012 and 3:1 by January 2014. Similar to the PPACA, it also provides for a rate adjustment of up to 50% based on tobacco use.

Although the guaranteed issue provisions remain in place, the Public Law also established the Maine Guaranteed Access Reinsurance Association to provide subsidized insurance to high risk enrollees. Via the reinsurance program, high risk individuals would be able to purchase coverage at the same rate as lower cost members and carriers would be protected from adverse selection. The program is funded through a series of insurer assessments.

It is clear that the 1993 reforms reduced availability of individual coverage in Maine by driving almost all carriers out of the market, and that they contributed to increases in premiums. The uninsured portion of the nonelderly population remains similar to pre-reform levels. The Dirigo program had trouble attracting a large pool of diverse risks, and at present falls far short of its goals of universal coverage, although it may have helped to reduce the high levels of uninsured that followed the 1993 reforms. The new regulatory framework looks to address the uninsured issue by providing additional rating flexibility to carriers while providing protection and market stability through the reinsurance program.

[19] Enacted as part of Maine's FY 2012/FY 2013 biennial budget. L.D. 1043, 125th Maine Legislature, 2011, Sec. BBB-2, Retrived February 9, 2012 from at http://www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC380.pdf.
[20] Gorman, Bella, Gorman Actuarial, LLC (May 30, 2007) Reform Options for Maine's Individual Health Insurance Market. Institute for Health Policy, Muskie School of Public Service, University of Maine
[21] Maine Legislative Document H.P. 979 (March 29, 2011). An Act To Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services. Retrieved February 15, 2012, from http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP0979&item=1&snum=125.

LAW

Citation(s):
P.L. 1993 c. 477
Me.Rev.Stat.Ann.Tit.24-A. § 2736-C

Enactment Date: July 13, 1993
Effective Date: December 1, 1993
Repeal Date: N/A

Required Participation: HMOs required to participate in the individual market starting in 1995.

Original GI Provisions

- Guaranteed issue required.
- Basic and Standard plans must be offered by all insurers that choose to participate in the individual market.

Original CR Provisions

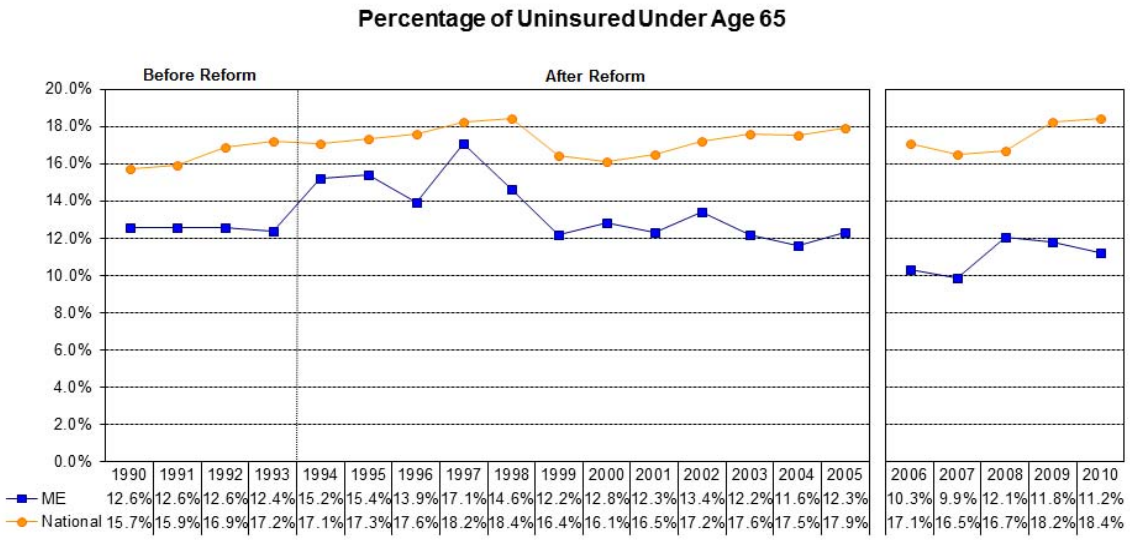
- Modified community rating required (limited variation allowed for age, occupation or industry, geographic area, smoking status, and family size).

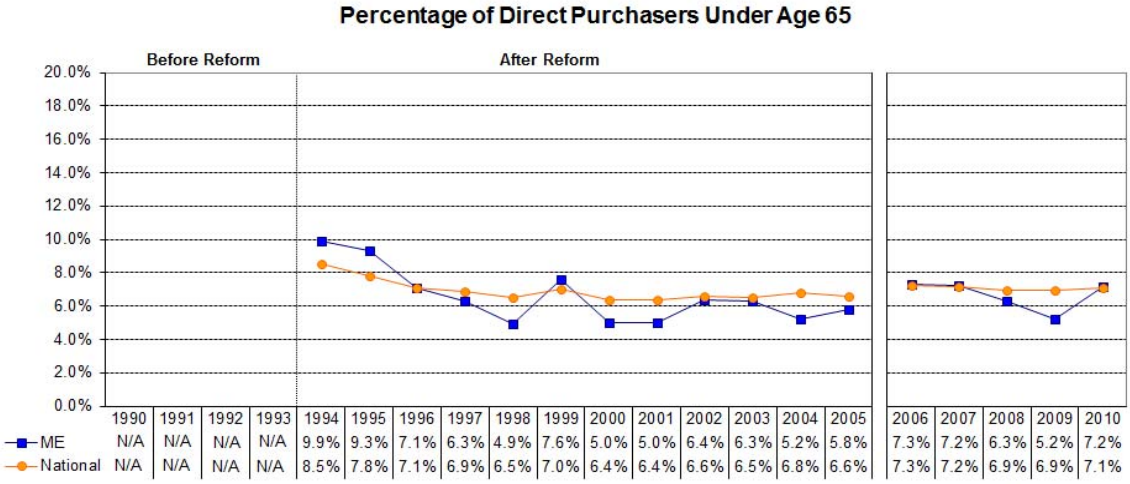
Subsequent History

- **1995:** HMOs required to offer individual insurance on a guaranteed issue basis, community rating rate bands changed.
- **2003:** Dirigo Health Reform Act creates semiprivate health insurance program aiming to cover all uninsured Mainers by 2009
- **2011:** Rating bands are expanded and a high risk reinsurance program is established. Dirigo program set to expire in December 2013.

Current status: Modified CR and GI. Additional rating flexibility and high risk reinsurance pool become effective July 2012.

MAINE FACTS*





Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994.

The data indicate that the percentage of nonelderly uninsured increased from 12.4% in 1993 (substantially lower than the national average of 17.2%) to a high of 17.1% in 1997 (compared to a national average of 18.2% in that year). Since 1997, the percentage of nonelderly uninsured in Maine fell to 12.2% in 1999, and has remained around 12% since then except for a spike of 13.4% in 2002 and a dip to approximately 10% in 2006 and 2007.

The census figures also show a significant decrease in the percentage of Mainers directly purchasing insurance from 1993 to 1998, and the numbers fell faster than national averages. Since 1998, the percentage has fluctuated quite a bit, although it has only exceeded national averages in 1999 and 2010.

*Notes: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

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2. 2000 Blue Ribbon Commission on Health Care Final Report. Found at http://www.dirigohealth.maine.gov/2000%20Bl%20Ribbon%20Comm%20on%20HC%20pt%201.pdf (Part 1) and http://www.dirigohealth.maine.gov/2000%20Bl%20Ribbon%20Comm%20on%20HC%20pt%202.pdf (Part 2). Accessed on May 15, 2007.
3. Dirigo Health Program web page, http://www.dirigohealth.maine.gov. Accessed May 16, 2007.
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5. Report of the Blue Ribbon Commission on Dirigo Health. January 2007. http://www.dirigohealth.maine.gov/dhsp07ja.htm, accessed May 16, 2007.
6. Jack Burke, Milliman. Private Communication. May 17, 2007.
7. Anthem Health Plans of Maine. Private Communication. May 21, 2007.
8. "The Impact of the PL90 on Maine's Health Insurance Markets" Gorman Actuarial, LLC. Prepared for the Maine Bureau of Insurance, December 2011.

DISCUSSION

Massachusetts has been experimenting with health care reform for a long time. It originally enacted a universal health care plan in 1988 that would have mandated a play or pay system for employers. However, this plan was never implemented, and was eventually repealed in 1995.

The individual market was reformed in 1996, when the legislature passed the Non-Group Health Insurance Reform Act,[22] which included guaranteed issue and modified community rating. Prior to reform, Blue Cross Blue Shield of Massachusetts (BCBS-MA) was the insurer of last resort for individuals.

Under the 1996 law, any insurer covering more than 5,000 members in the small-group market must guarantee issue of at least one of three standardized products (HMO, PPO, or traditional indemnity). Non-standard policies issued prior to reform could be renewed until mid-2000. Insurers could also issue plans with richer benefits than the standard plans, but could still only offer one of each type.

Those eligible for group coverage were not allowed to purchase individual insurance, and a two-month annual open enrollment period applied in the individual market. Community rating standards were applied with variations allowed for age, geographic region, and family composition, but only within a 2:1 rate band for age and a 1.5:1 band for area.

The law also stipulated that rates for each standard product falling more than two standard deviations above the mean for all insurers would be subject to further review by the Division of Insurance. As Adele M. Kirk points out in her 2000 study,[23] this criterion is problematic. When there is a lot of variation in premium rates, a standard deviation can be quite large, and hence insurers may still be able to have very different rates without triggering the review process. This happened in 1998, when Kirk reports that standard deviations for the three plans were $100, $158, and $117 for a 25-year-old in Boston.

In 1999, there was considerably less variation in rates (standard deviations of $28, $33, and $14 for the same 25-year-old in Boston), but minimum rates had increased considerably. In particular, rates for the indemnity product essentially rose to meet the outliers from the previous year.

In the 1997 and 1998 open enrollments, Kirk found that the membership was highly concentrated among the insurers offering the lowest rates with the two largest commercial insurers holding 92% of enrollees in 1997 and 82% in 1998. In both years, the vast majority of policies were sold in the HMO or PPO products, with only a handful of people choosing the indemnity option.

Although none of the commercial insurers in the individual market in 1995 chose to offer reform policies, by 1998 other commercial insurers had chosen to enter the reform market. The two insurers that together held more than three quarters of the pre-reform market, chose to stay, as did several HMOs. Thus, although many insurers did leave the market because

[22] Massachusetts calls individual insurance “non-group” insurance.
[23] Kirk, Riding the bull, ibid.

of the reforms, the impact was probably not significant.

Finally, Kirk found that the reformed market was smaller than the pre-reform market. She attributes this to either a complete lack of marketing efforts by insurers and the Division of Insurance or to the fact that the standardized products were much more expensive than pre-reform products, which was due to richer benefits and the rating and guaranteed issue regulations.

At the end of the 1990s, there were several unsuccessful attempts to repeal the individual market reforms. The repeal efforts delayed Massachusetts' compliance with federal HIPAA legislation for several years, as they were attached as amendments to bills establishing compliance. Compliance was achieved in 2000, as part of a bill that also allowed insurers to offer a second nonstandard plan of each type, subject to the approval of the Massachusetts Insurance Commissioner. The 2000 law also established a continuous open enrollment period for the individual market.

In 2006, Massachusetts adopted comprehensive bi-partisan legislation aimed at expanding health insurance coverage to the state's uninsured residents. Among the key provisions impacting the individual market are an individual mandate requiring individuals to purchase insurance or face fines, a merger of the individual and small group markets (including new products such as a low cost plan aimed at 19- to 26-year-olds and HSA-qualified plans from HMOs), and the creation of the Commonwealth Health Insurance Connector, a government-run clearinghouse or exchange for individual and small group insurance.

An actuarial study[24] on the impact of merging the individual and small group markets was completed in accordance with the requirements of the 2006 law. The commission study was based on detailed data from 2003 to 2005 in the small group and individual markets. Approximately 92.1% of the small group market was represented in the sample, and 99.8% of the individual market. Based on this data, the commission report found that:

- Average per member per month (PMPM) costs in the individual market was approximately 40% higher than in the small group market. Individual market members were older on average and generally had less rich benefit sets than small group members.

- The average loss ratio in the individual market increased from 83% in 2003 to 91% in 2005.

- Average member months in the individual market in 2005 were approximately 10% lower than in 2003.

Taken together, these figures appear to confirm that the individual market in Massachusetts contained significantly higher risk members than the small group market at the time.

Various reports indicate a reduction of the individual market average premium, due to the merger with the small group market, ranging from 20% to 33%. More recently, as health insurance premium growth continues to outpace inflation, concern has focused on the issue of affordability. On the other hand, Massachusetts health care reform has been successful in achieving its goal of near universal coverage, with over 98% of residents having insurance

[24] Gorman Actuarial, LLC (December 26, 2006) "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets." Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission.

coverage in 2010.[25] This estimate is based on the results of state funded survey and includes all ages.

As described by the Health Connector Agency, the expansion of coverage was achieved via two programs: Commonwealth Care and Commonwealth Choice. The first program offers subsidized coverage to those who are not offered employer sponsored insurance and earn up to 300% of the federal poverty level (FPL). On the other hand, Commonwealth Choice offers unsubsidized private coverage, which the Connector selects by competitive bidding. The program approves health plans to offer a range of benefits options which are categorized as bronze, silver and gold based on the level of benefits and member cost share. The Connector also offers a lower cost plan for Young Adults Plan available to individuals between 18 and 26.[26]

[25] MASSACHUSETTS HEALTH REFORM: A FIVE-YEAR PROGRESS REPORT" BCBS Massachusetts Foundation.
[26] Health Connector: Health Care Reform. Health Reform Facts and Figures: Winter 2011/2012. Retrieved February 15, 2012, from https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf.

LAW

Citation(s):
P.L. 1996 c. 203
Mass.Gen.Laws.Ann.Ch. 176M §§ 2 and 4

Enactment Date: June 1996.
Effective Date: First open enrollment was to begin June 1, 1997.
Repeal Date: N/A

Original GI Provisions

- Guaranteed issue required for insurers with at least 5,000 small group members.

Original CR Provisions

- Modified community rating: rates were allowed to vary based on age (2:1 rate band), geographic region (1.5:1 rate band), and family composition.
- Only standardized plans could be offered.

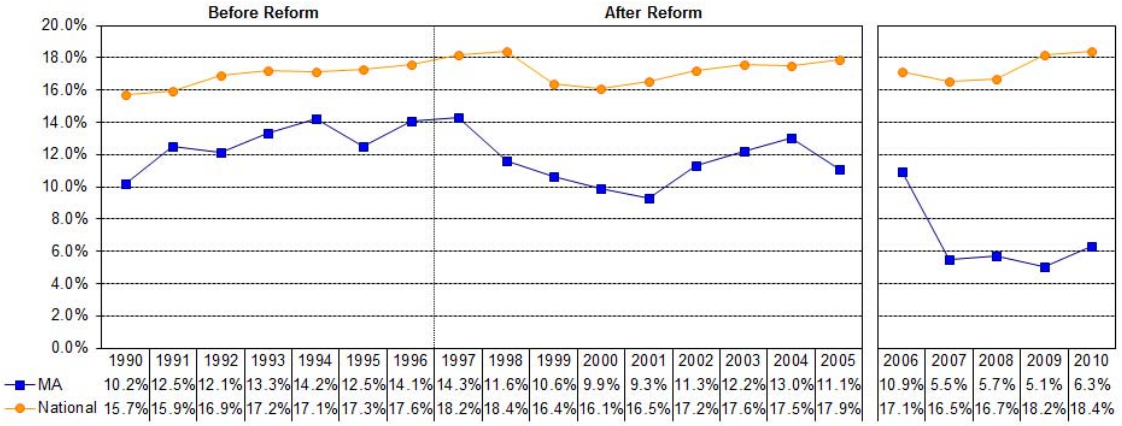
Subsequent History

- **1999**: Age bands kept at 2:1 (initially, they were to narrow to 1.5:1).
- **2000**: Insurers allowed to offer a second plan in addition to the standard plan subject to the Commissioner's approval; open enrollment period made continuous; modified state laws to comply with HIPAA.
- **2006**: Chapter 58 of the Acts of 2006 established sweeping reforms. Among other things, it included an individual mandate with subsidies for the poor, encouraged employers to offer health insurance, and merged the individual and small group markets.

Current status: GI and modified CR still in effect.

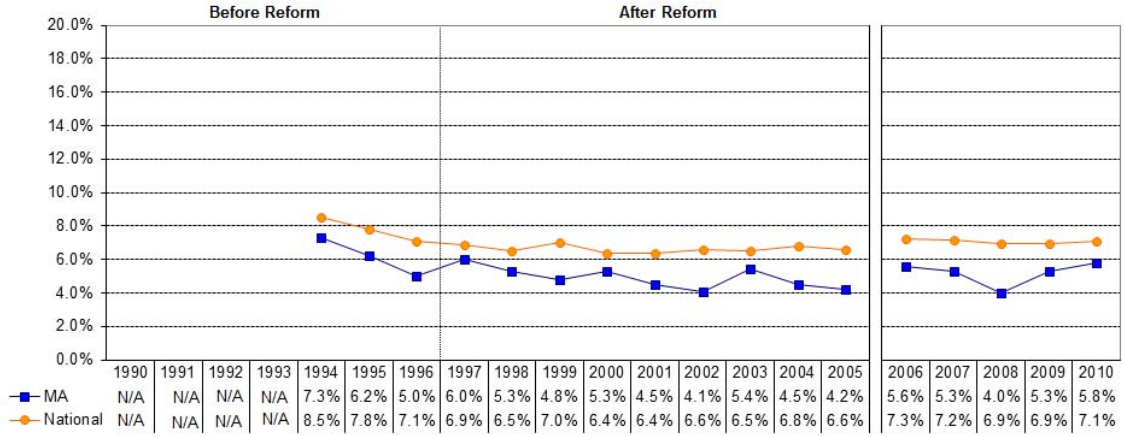
MASSACHUSETTS FACTS*

Percentage of Uninsured Under Age 65



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
MA	10.2%	12.5%	12.1%	13.3%	14.2%	12.5%	14.1%	14.3%	11.6%	10.6%	9.9%	9.3%	11.3%	12.2%	13.0%	11.1%	10.9%	5.5%	5.7%	5.1%	6.3%
National	15.7%	15.9%	16.9%	17.2%	17.1%	17.3%	17.6%	18.2%	18.4%	16.4%	16.1%	16.5%	17.2%	17.6%	17.5%	17.9%	17.1%	16.5%	16.7%	18.2%	18.4%

Percentage of Direct Purchasers Under Age 65



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
MA	N/A	N/A	N/A	N/A	7.3%	6.2%	5.0%	6.0%	5.3%	4.8%	5.3%	4.5%	4.1%	5.4%	4.5%	4.2%	5.6%	5.3%	4.0%	5.3%	5.8%
National	N/A	N/A	N/A	N/A	8.5%	7.8%	7.1%	6.9%	6.5%	7.0%	6.4%	6.4%	6.6%	6.5%	6.8%	6.6%	7.3%	7.2%	6.9%	6.9%	7.1%

Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994.

The data show that the uninsured percentage of the nonelderly population in Massachusetts was well below national averages from 1994 through 2005. For the most part, this percentage moved similarly to national trends, until 2007 when Massachusetts implemented its individual mandate and subsidies. At that point, the uninsured rate was cut in half to 5.5%. It remained near that level through 2010.

However, the percentage of the nonelderly population purchasing insurance directly was also below national averages throughout the same period, and exhibited a slight decline over time. The rate had a significant drop from 5.3% to 4.0% in 2008, but quickly recovered and by 2010 it was back at 5.8%, still below the national average but at its highest level since 1997. That the percentage of direct purchasers under age 65 did not rise with the drop in the rate of uninsured after 2007 may indicate that many newly insured members are obtaining coverage in the group market or that direct purchasers through the Connector are not being counted in the census data.

Overall, the statistics suggest that the original individual market reforms of the 1990s did not

have a significant impact on individual insurance enrollment. However, the 2006 reforms do appear to have significantly reduced the numbers of uninsured.

*Note: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

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2. Current and session laws accessible at http://www.mass.gov/legis/. Accessed June 7, 2007.
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7. "Massachusetts Health Reform: A five year progress report". Alan G. Raymond. BCBS Massachusetts Foundation, November 2011

DISCUSSION

New Hampshire passed guaranteed issue and community rating laws for its individual and small group markets in 1994. Under the original community rating laws, limited premium variation by age was allowed, but no variation was allowed for other case characteristics.

Prior to the 1994 reforms, there were about a dozen insurers participating in the individual market in New Hampshire, although the majority of the market was concentrated in two companies. As in several other states, one of the companies was already using community rating methods prior to reform, a fact that may have dampened the impact of the reforms.

Moreover, the New Hampshire Insurance Department did not require individual policies that had been issued before the reforms to comply with the new laws. Self-employed individuals were allowed to purchase insurance in the small group market. Both of these exemptions in the individual market would also tend to significantly slow or diminish the impact of the reforms. Keeping the pre-reform business exempt would tend to reduce the number of good risks leaving the individual market due to rate shocks, and if high-risk self-employed individuals are able to find lower cost coverage in the small group market, adverse selection against the individual market may be dampened.

According to a 2000 commentary[27] by two New Hampshire regulators, although only one company "aggressively enter[ed] the reform market," its individual block "continued its pre-reform adverse selection spiral, culminating in their decision to exit the market as of the end of 1997." Despite the introduction of premium subsidies for the individual market in 1998 assessed against all group insurance writers, by 2000 only two indemnity insurers based outside of New Hampshire were actively participating in New Hampshire's individual market. The lowest deductible offered by these carriers was $2,000.

On the other hand, the regulators report that in the years following reform, the small group market in New Hampshire experienced "steady growth" and "an expansion in the number of carriers writing insurance in the state."

Further declines in enrollment eventually led to the repeal of guaranteed issue and community rating reforms in the individual market effective in 2002. In place of guaranteed issue, a high risk pool was created. As of November 2011, the New Hampshire Insurance Department lists two companies marketing individual policies.

[27] Feldvebel and Sky, ibid.

LAW

Citation(s):
P.L. 1994, c. 294
N.H.Rev.Stat.Ann. §420-G

Enactment Date: June 6, 1994
Effective Date: January 1, 1995
Repeal Date: 2002

Original GI Provisions

- All carriers must guarantee issue of all products.

Original CR Provisions

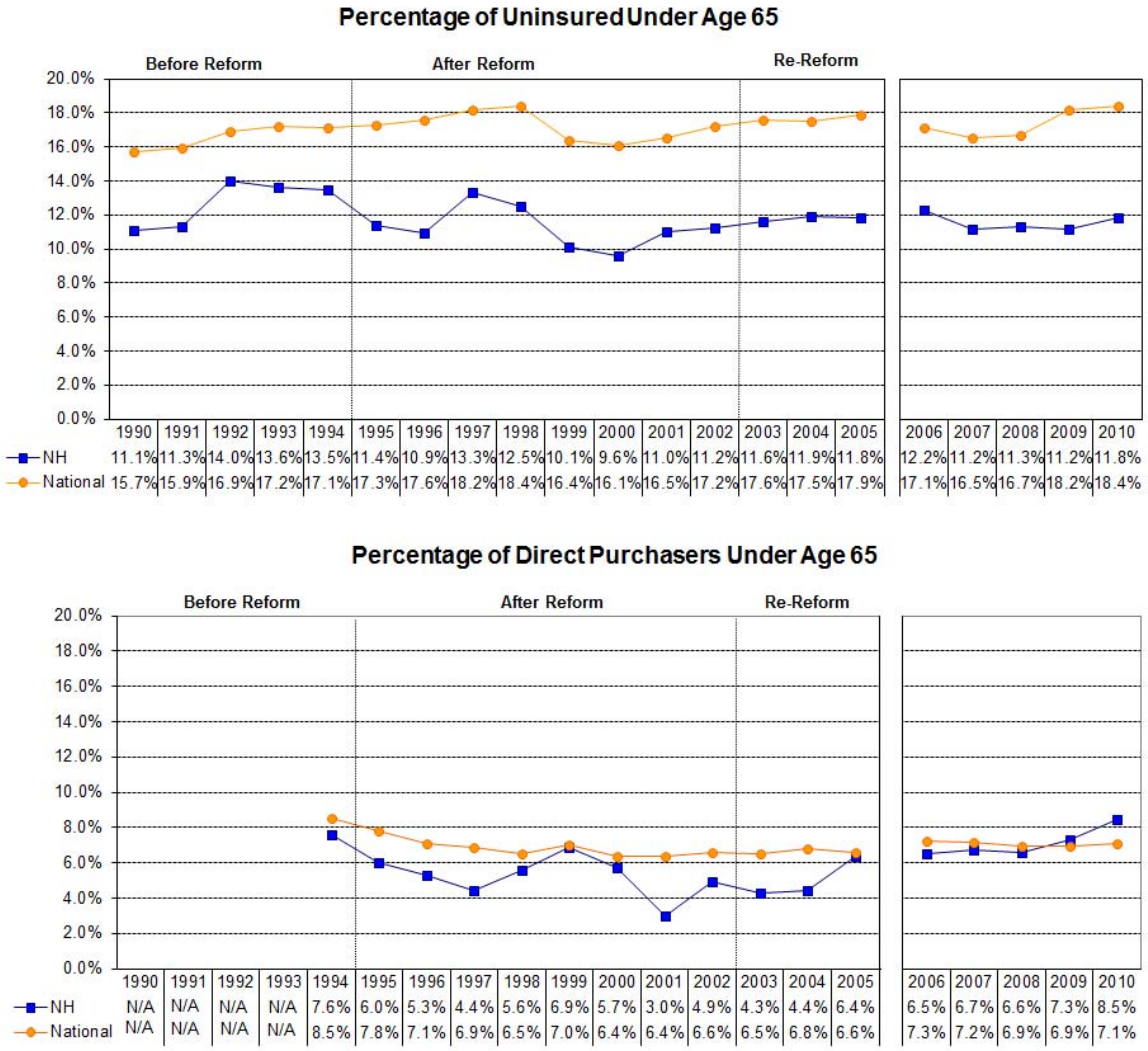
- Modified community rating.
- Rates may only vary by age and family composition.
- Rates may vary by age no more than 4:1 in the first year, narrowing to 3:1 in following years.

Subsequent History

- **1998**: Subsidization mechanism implemented for carriers writing individual insurance.
- **2002**: GI and CR repealed in individual market, high risk pool established.

Current status: GI and CR have both been repealed.

NEW HAMPSHIRE FACTS*



Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994.

The percentage of the nonelderly population without health insurance in New Hampshire was lower than national averages from 1990 to the present. The data also showed a decline in 1995 and 1996 that did not occur in national averages. This may suggest that market reforms did initially have an impact on the level of uninsured residents of the state, although it may also reflect expansions of Medicaid that occurred at about the same time. In any event, in 1997 the level returned to approximately the same value as in 1994, and since then has exhibited trends similar to the national average.

The percentage of nonelderly people directly purchasing health insurance in New Hampshire fell from 7.6% in 1994 to 6.0% in 1995. This drop was steeper than the decline in the national average over the same period, and may reflect the impact of individual reforms.

From 1996 to the 2005, the percentage of direct purchasers in New Hampshire fluctuated considerably, reaching a peak of 6.9% in 1999 and a low of 3.0% in 2001. The peak in 1999 may reflect a temporary market stabilization following the introduction of the subsidization rules in 1998. Since 2001, the percentage has generally increased, and by 2005 it had nearly reached the national average. Finally, in 2009 and 2010 the rate has exceeded the national average. In 2010 it reached its highest level since 1994 at 8.5% versus a national average of 7.1%.

*Note: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

ADDITIONAL STATISTICS*

	Re-Reform		
	2002	**2003**	**2004**
Individual Market			
Covered Lives	7,119	17,831	36,143
Avg. Premium PMPM	$144.34	$179.38	$141.85
Avg. Loss Ratio	63%	66%	63%
Groups of Size One			
Covered Lives	29,759	22,464	9,670
Avg. Premium PMPM	$173.38	$223.09	$417.47
Avg. Loss Ratio	87%	92%	89%
Entire Fully Insured Small Group Market			
Covered Lives	192,844	183,288	148,678
Avg. Premium PMPM	$215.57	$253.83	$289.69
Avg. Loss Ratio	78%	76%	83%

Figures from supplemental reports produced by the New Hampshire Department of Insurance are included in the "Additional Statistics" table above. Starting in 2002, the Department requested data from carriers selling health insurance in the state. Although data was also collected for 2001, it was not collected from all carriers and is not comparable with later reports. Moreover, the Department reports acknowledge that there may be inconsistencies in the data, particularly for 2002. Finally, these figures also reflect changes in benefit levels and other variables, which must be kept in mind when reviewing year to year trends in the data.

The Department figures show a substantial increase in individual enrollment from 2002 through 2004. Over the same time period, the small group market was decreasing in size. However, if we consider groups of size one (sole proprietors purchasing through the small group market), we see evidence that these members of the small group market may have shifted to the individual market, as the drop in groups of size one each year is similar in size to the increase in covered lives in the individual market.

Since the GI and CR reforms were repealed in 2002, it seems likely that healthy groups of one were migrating to the individual market in order to escape community rating. The sharp increase in per member premiums for groups of one and the decrease in premiums and loss ratios in the individual market in 2004 are also consistent with this scenario.

*Source: New Hampshire Department of Insurance Supplemental Reports, 2001-2004. http://www.nh.gov/insurance/lifehealth/supp_report.htm. Accessed June 12, 2007.
Note: Entire Fully Insured Small Group Market excludes self-insured small group business.

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1. Westlaw. http://www.westlaw.com. Thompson West.
2. Current laws accessible at http://www.gencourt.state.nh.us/rsa/html/nhtoc.htm. Accessed June 12, 2007.
3. Previous legislation accessible at http://www.gencourt.state.nh.us/ns/billstatus/default.asp. Accessed June 12, 2007.
4. New Hampshire Insurance Department web site, http://www.nh.gov/insurance//lah/index.htm. Accessed February 14, 2012.

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1. "A Regulator's Perspective on Other States' Experiences." Alexander K. Feldvebel and David Sky. Journal of Health Politics, Policy and Law Vol. 25, No. 1. Duke University Press, February 2000.
2. "Small Group Health Insurance Reform in New Hampshire." Report of the Office of the Health Insurance Commissioner of Rhode Island to the Joint Committee on Health Care Oversight. February, 2006. Accessed at http://www.dbr.state.ri.us/documents/divisions/healthinsurance/HI-060227_NH_Reforms.pdf on June 12, 2007.
3. "The Small Group Health Insurance Market. White Paper, New Hampshire Insurance Department. February 16, 2005. http://www.nh.gov/insurance/lifehealth/lah_news/documents/small_group_market_white_paper_021605.pdf. Accessed June 12, 2007.
4. New Hampshire Department of Insurance Supplemental Reports, 2001 - 2004. http://www.nh.gov/insurance/lifehealth/supp_report.htm. Accessed June 12, 2007.
5. Fifty State Profiles: Health Care Reform, 1995. Intergovernmental Health Policy Project at The George Washington University. Fourth Edition, October 1995.

DISCUSSION

New Jersey enacted both guaranteed issue and pure community rating for individual health plans in 1992. At the same time, standardized benefit plans, a loss pooling process, and minimum loss ratios were also mandated. One direct cause of the legislation was a state judge's ruling that hospital surcharges used to subsidize Blue Cross Blue Shield of New Jersey (BCBS-NJ), the state's insurer of last resort prior to GI, could no longer be levied on self-funded plans under ERISA.

Under the original legislation, indemnity carriers could only offer five standard plans: a basic plan (Plan A) and four plans with increasing coinsurance levels (Plans B through E). HMOs had to offer a standard HMO package. These standard plans made up the New Jersey Individual Health Coverage Program (IHCP). Riders could be offered if they were priced separately. Although some changes to the standard plans have been made over the years, all individual business in New Jersey is still regulated by the IHCP.

If an insurer chose not to offer the standard plans (or if it failed to enroll a target number of policyholders proportionate to its share of business in the state), it would be subject to an assessment used to help cover losses (the "loss pool") sustained by those carriers that did participate in the reformed individual market.

The 1992 law also replaced the previous individual rate increase approval process with a loss ratio standard, giving insurers the ability to adjust rates without prior approval provided that they maintain a 75% loss ratio. In the event that insurers achieve a loss ratio lower than 75%, the difference must be refunded to policyholders.

One early effect on the individual market was a decrease in the market share of one carrier, from around 90% before reform to about 50% in 1995.[28] The number of carriers also increased dramatically over this period, from 5 to 29. However, several subsequent studies[29] have suggested that this increase in the number of carriers was actually due to flaws in the loss assessment mechanism. Essentially, insurers with smaller market shares could more easily force other carriers to share their losses because they had to sell fewer policies to qualify for participation in the loss pool. In 1996, eight of these small insurers reported losses of $43.5 million to be shared by all insurers in proportion to their market shares.

From 1996 through 1998, carriers with small market shares were raising rates significantly (in one instance, by 415% over the two years), losing enrollment, and exiting the market. In 1997, the legislature changed the risk pooling mechanism to a two-year retrospective methodology and required losses eligible for reimbursement to exceed 115% of income, adding a further incentive for these carriers to leave. By 2000, only one small market share carrier remained. At present, there are only six companies selling individual insurance in New Jersey.[30]

[28] Institute for Health Policy Solutions (September 1995). State Experiences with Community Rating and Related Reforms, pp 24-29.
[29] See Swartz and Garnick (1999) and Monheit et al. (2004) referenced below.
[30] New Jersey Department of Banking & Insurance. Individual Health Coverage Program. Retrieved February 15, 2012, from http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcmain.htm.

In a 2004 study, Monheit et al. described the IHCP as "a market that is heading for collapse." They found that enrollment in the program had declined much more rapidly than national trends, and that premiums had increased more rapidly than in the group market.

Overall, the study reports that these trends "appear consistent with a marketwide adverse-selection death spiral spurred by open enrollment and pure community rating," although the authors note that several other factors (including interactions with the small group market and the loss assessment mechanism) also likely played a role.

Rate histories for the standard plans provided by one insurer with experience in the state show dramatic rate increases from 1994 until 2002. New business rates were actually increased twice in 1994 for the standard plans, once in August and again in December. Between August and December, adult rates for Plans B through E more than doubled for many deductible options. Moreover, among the 12 combinations of product and deductible level available, only three had less than a 50% rate increase. Rates generally increased by 50% or more each year until 2002, though there was no rate increase in 2001. Rate increases were constrained to some degree by the 75% guaranteed minimum loss ratio requirement for this business.

The Agency for Healthcare Research and Quality has reported[31] that the average nationwide premium for an individual health insurance policy increased by a total of 44% over the entire six year period from 1996 to 2002. This average increase is not necessarily directly comparable to the increases described above, as it reflects the impact of factors such as changes in nationwide average demographics and benefit levels over this time period. However, it can be used as a general point of reference when reviewing the impact of the individual market reforms in New Jersey.

Overall, available data suggest that the individual market reform in New Jersey in the 1990s was not successful in maintaining enrollment in the individual marketplace, compared to national average enrollment percentages. Given national trends, it also does not appear that the reforms have increased the number of people with health insurance in the state.

In 2008, a new package of reforms was enacted with the goal of expanding access to affordable care. The new law mandated that all children have coverage, expanded coverage to low income parents, adopted various reforms to the individual and small group insurance markets and makes other adjustments to eligibility criteria.[32] In particular, the reform allowed adjusted community rating based on age by up to 3.5 to 1. It also reduced the number of standard plans from five to at least three and allowed plans to offer additional riders to add benefits or increase the actuarial value of any of the standard plans. In addition, it required carriers in the small group market to offer and make a good faith effort to market individual policies.

[31] Bernard, D.M., Statistical Brief #72, ibid.
[32] New Jersey Assembly Budget Committee Statement (June 19, 2008). Retrieved February 15, 2012, from http://www.njleg.state.nj.us/2008/Bills/A3000/2624_S1.PDF.

LAW

Citation(s):
P.L.1992 c. 161
NJ ST 17B:27A

Enactment Date: November 30, 1992
Effective Date: August 1, 1993
Repeal Date: N/A

Notes: Created New Jersey Individual Health Coverage Program (IHCP)

Required Participation: Any carrier offering health benefits must offer individual policies or pay an assessment.

Original GI Provisions

- Guaranteed issue/guaranteed renewal required.
- Limited preexisting condition exclusions allowed (6 mo. / 12 mos.)

Original CR Provisions

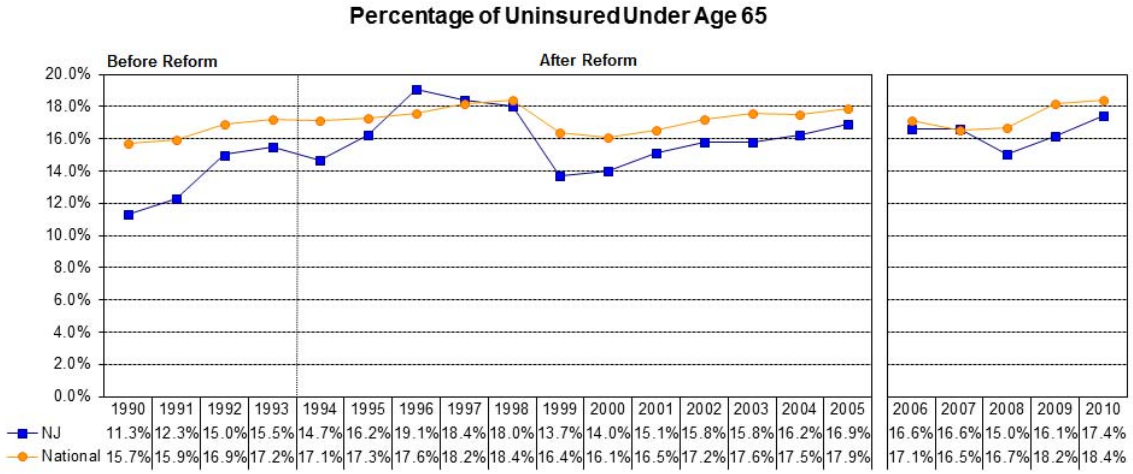
- Pure community rating.
- Standardized plan designs: five indemnity plans and one HMO.

Subsequent History

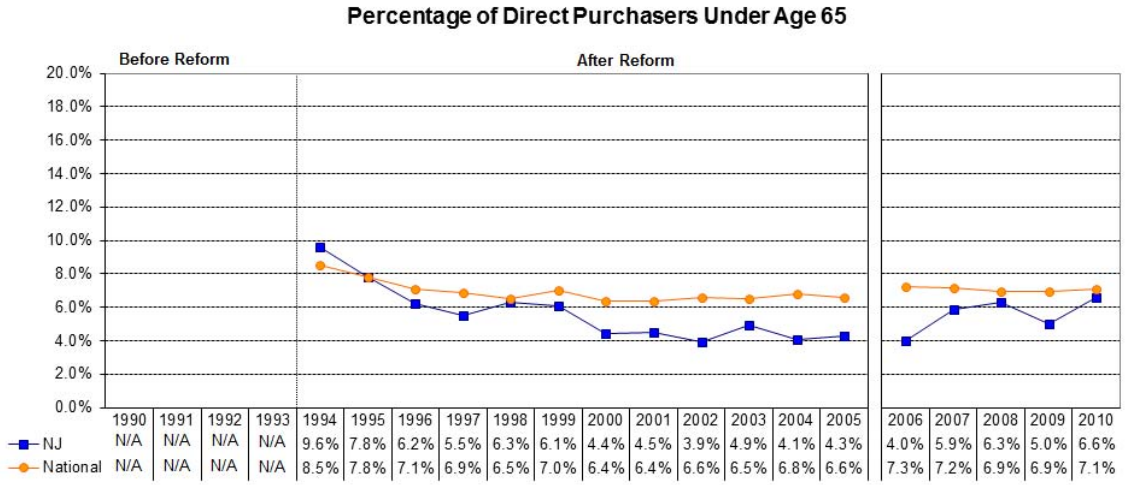
- **1997**: Changed loss assessment process and added HDHP to list of standard plans.
- **2001**: Allowed carriers to sell PPO versions of standard plans, required a revised basic plan.
- **2008**: Mandated insurance coverage for all children and expanded subsidies; reduced the number of standard plans and allowed insurers to offer additional benefit riders. Also allowed adjusted community rating and required small group carriers to offer and make a good faith effort to market individual policies.

Current status: GI and CR still in effect.

NEW JERSEY FACTS*



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
NJ	11.3%	12.3%	15.0%	15.5%	14.7%	16.2%	19.1%	18.4%	18.0%	13.7%	14.0%	15.1%	15.8%	15.8%	16.2%	16.9%	16.6%	16.6%	15.0%	16.1%	17.4%
National	15.7%	15.9%	16.9%	17.2%	17.1%	17.3%	17.6%	18.2%	18.4%	16.4%	16.1%	16.5%	17.2%	17.6%	17.5%	17.9%	17.1%	16.5%	16.7%	18.2%	18.4%



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
NJ	N/A	N/A	N/A	N/A	9.6%	7.8%	6.2%	5.5%	6.3%	6.1%	4.4%	4.5%	3.9%	4.9%	4.1%	4.3%	4.0%	5.9%	6.3%	5.0%	6.6%
National	N/A	N/A	N/A	N/A	8.5%	7.8%	7.1%	6.9%	6.5%	7.0%	6.4%	6.4%	6.6%	6.5%	6.8%	6.6%	7.3%	7.2%	6.9%	6.9%	7.1%

Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994.

The number of uninsured under age 65 in New Jersey has exhibited substantial variation since 1992, reaching a peak of 19.1% of the nonelderly population in 1996 and a low of 13.7% in 1999. Generally, the percentage of nonelderly uninsured in New Jersey has been lower than national averages. However, the spike of 19.1% in 1996 significantly exceeded the national average of 17.6%, and after that New Jersey remained close to national levels through 1998. It seems likely that the 1996 spike of uninsured levels was at least in part due to market turmoil stemming from the guaranteed issue, community rating, and loss pooling regulations.

The rate of uninsured did decrease in 2008 and 2009 which may be partially attributable to more recent reforms, although it increased again in 2010. The economic crisis of the past few years may also have contributed to the changes in coverage level.

Census figures for nonelderly direct purchasers of private health insurance in New Jersey fell from 9.6% of the nonelderly population in 1994 to between 3.9% and 4.9% for 2000 through 2005. Nationwide, the percentage was 8.5% in 1994 and ranged from of 6.4% to 6.8%

during 2000 through 2005. Therefore, the census data indicates a significant decline in the size of the New Jersey individual market since the implementation of reforms in the 1990s. More recently, it appears that the 2008 market regulation reforms may have contributed to an increase in direct purchasers and an initial drop in the overall level of uninsured.

*Notes: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

ADDITIONAL STATISTICS

	Before Reform		After Reform			
	1993	**1994**	**1995**	**1997**	**2000**	**2005**
Total IHCP Enrollment** (entire individual market)	157 K	211 K	220 K	161 K	101 K	78 K

2006	**2007**	**2008**	**2009**	**2010**
83 K	88 K	96 K	112 K	129 K

	1996	**2000**	**Change**
Annual Single Premium†			
IHCP Indemnity Plan B	$1,792	$3,797	111.9%
IHCP Indemnity Plan C	2,063	5,254	154.7%
IHCP Indemnity Plan D	4,245	10,231	141.0%
IHCP HMO Plan	2,702	4,001	48.1%
Employer-sponsored Insurance	2,354	2,911	23.7%

Based on data provided by the Department of Banking and Insurance (DOBI), enrollment in the New Jersey individual market declined significantly since the implementation of reform. Enrollment in the Individual Health Coverage Program started at 156,565 covered lives at the end of 1993, reached a peak of 220,384 in 1995, and has since declined. Enrollment has been in the neighborhood of 80,000 members since 2001. The market shows enrollment growth starting in 2006, with increases over 15% for 2009 and 2010, very likely resulting from the 2008 market reforms.

Data for selected years appears above in the table of Additional Statistics. Note that the IHCP membership represents the entire individual market in New Jersey, because all individual health plans must be regulated by the program.

The number of people directly purchasing health insurance as reported in the census data (referenced above) substantially exceeds the IHCP enrollment figures provided by the DOBI. The DOBI figures are derived from enrollment reports provided to the DOBI by carriers, whereas the census figures are based on a survey of the general population. Because the census questionnaire does not ask people detailed questions about the type of health policy they have, it is likely that the census figures include people with non-comprehensive health plans, such as hospital indemnity policies. Also, the census figures represent those with coverage at any time during the year, whereas the DOBI figures represent average enrollment over the fourth quarter of each year.

**Notes: K=thousands. IHCP Enrollments as of fourth quarter of each year. Source: Department of Banking and Insurance web site, http://www.state.nj.us/dobi/ihcseh/4q06historical.pdf accessed February 13, 2012.
† Source: Monheit et al. 2004 study (see reference below).

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3. New Jersey Department of Banking and Insurance web pages accessed February 13, 2012.
    a. http://www.state.nj.us/dobi/index.htm
    b. Life and Health Actuarial, http://www.state.nj.us/dobi/ /division_insurance/lhactuar.htm
    c. Individual Health Coverage Program, http://www.state.nj.us/dobi/ /division_insurance/ /ihcseh/ihcmain.htm

History:

1. Fifty State Profiles: Health Care Reform, 1995. Intergovernmental Health Policy Project at The George Washington University. Fourth Edition, October 1995.
2. State Experiences with Community Rating and Related Reforms. Institute for Health Policy Solutions, September 1995.
3. "Hidden Assets: Health Insurance Reform in New Jersey." Katherine Swartz and Deborah W. Garnick. Health Affairs Vol. 18 No. 4. 1999.
4. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey." Alan C. Monheit et al. Health Affairs Vol. 23 No. 4. 2004.

DISCUSSION

Effective April 1, 1993, New York implemented both pure community rating and guaranteed issue reforms in the individual market. Widely regarded as the most far reaching package of reforms enacted during this time period, the reforms have generated much debate and controversy.

The impact of the reforms was likely dampened by the fact that one carrier holding about two thirds of the combined individual and small group market was already voluntarily operating under a substantially similar rating methodology.[33]

The 1993 reforms also included two risk adjustment mechanisms. The first was based on demographics; each insurer paid or received money from the demographic pool according to market share and a comparison of its average demographic factor with the overall average in each of seven regions. The second pool reimbursed insurers specific amounts for certain high cost medical conditions, such as AIDS.

These risk adjustment mechanisms proved controversial, and were revised in 1996. The demographic pool was phased out over five years. The medical conditions pool, which had been running large surpluses due to the extensive administrative effort required in submitting claims, was to be retooled by an Insurance Department task force.

Beginning in 2007, the risk adjustment mechanism was further modified to focus on pooling of variations of costs attributable to high cost claims. Predetermined funding amounts were set for the new pool for the next few years: $80 million in 2007, $120 million in 2008, and $160 million in 2009. These amounts (which apply to the small group and individual markets combined) were assessed from insurers with lower dollar amounts paid in high claims and distributed to insurers with higher dollar amounts paid in high claims.

A 2000 study by Buchmueller and DiNardo compared experience in New York following the reforms to experiences in Pennsylvania and Connecticut. These two states are similar to New York demographically, but differ in their health insurance reform strategies (Pennsylvania enacted no reforms, and Connecticut only enacted small group reforms).

Buchmueller and DiNardo found that while private insurance coverage declined and average ages of insureds increased in New York from 1993 to 1996, these shifts were not statistically different from similar shifts in the two neighboring states.[34] They concluded that the main impact of the reforms in New York was a significant shift from traditional indemnity plans towards managed care plans, as this shift did not occur in the two control states.

Buchmueller and DiNardo only studied the period from 1987 to 1996, which may not have provided enough time for the impacts of reform to become apparent. Effects of selection spirals occur over time with the pace dependent on the particular situation.

[33] Institute for Health Policy Solutions, ibid.
[34] Buchmueller, Thomas C. & DiNardo, John (March 2000). Implications for California of New York's Recent Health Insurance Reforms. California Policy Research Center Brief Series. Accessed at http://www.ucop.edu/cprc/buchbrief.html on May 22, 2007.

By 1996, the GI and CR requirements effectively eliminated the commercial individual indemnity market in New York with the largest individual health insurer exiting the market. In response to this market exodus, a new law was passed that required all HMOs to offer two standard plans: a traditional managed care plan and a point of service (POS) plan.

The stated intent of this law was to ensure access and make comparison shopping easier for consumers. However, premiums for the two standard plans increased rapidly. For the less expensive of the two plans, 2007 monthly premiums for a single contract are in excess of $1,000 per month with many carriers, and they are more than $500 per month with all carriers.[35]

As part of the Health Care Reform Act of 2000 (HCRA 2000), state-funded stop loss reimbursement mechanisms were established for the two standard HMO plans. Although such reinsurance programs can help stabilize the market to some degree, they can prove costly. According to the Insurance Superintendent's 2006 report, $130 million was initially allocated to the reinsurance programs for the standard HMO plans over the three and a half year period ending in the middle of 2003. Funding was renewed at $40 million per year through the middle of 2007. In 2005, these funds were able to reimburse approximately one third of the costs submitted for the standard HMO plan and a little under half of the submitted costs for the standard POS plan.

A 2000 study by Mark A. Hall[36] concluded that:

> Following reform, the overall percentage of the population with insurance has worsened, and enrollment in the individual market has steadily diminished. Prices have increased substantially more than in other portions of the market, due to adverse selection. Also, reform resulted in the demise of comprehensive indemnity products and the withdrawal of all commercial indemnity insurers.

Hall found that there were "substantial and continuing price increases" in the individual market, particularly for indemnity business in the years just after reform. Some major insurers increased premium rates 35-40% in this period.

These increases are markedly greater than the increases seen in the small group market, and may have been dampened by regulation, since New York required approval for rate increases exceeding 10% and gave the superintendent the authority to conduct rate hearings. Hall notes that in 1998, several insurers, including the two largest carriers in the individual market, requested very substantial rate increases between 50 and 80%, citing mounting losses. Except for three small HMOs, these increases were denied, despite the fact that some companies' reserves had fallen below required levels.

Hall also investigated adverse selection in the individual market by obtaining data on risk characteristics from several large insurers. He found that average ages increased more quickly after reforms, and also that per member claim costs and hospital utilization were both two to three times higher in the individual market when compared to group subscribers with similar coverage. The incidence of high cost conditions was also several times greater among individual subscribers than among groups.

While the results of the 1993 reforms in New York did not conform to the worst-case scenarios envisioned by their opponents, neither did they result in appreciable gains in

[35] New York Department of Insurance. Premium Rates for HMO Standard Individual Health Plans by County. http://www.ins.state.ny.us/ihmoindx.htm. Accessed May 23, 2007.
[36] Hall, Mark A. (February 2000). An evaluation of New York's reform law." *Journal of Health Politics, Policy and Law* Vol. 25, No. 1. Duke University Press.

insurance coverage. Despite repeated legislative intervention in subsequent years and shifts towards managed care, premiums increased following reform and enrollment decreased in New York's individual market at a rate greater than the national average in the years immediately following reform.

LAW

Citation(s):
NY INS §3231
P.L. 1992 c. 501
11 NYCRR Parts 360-362

Enactment Date: July 17, 1992
Effective Date: April 1, 1993
Repeal Date: N/A

Original GI Provisions

- Guaranteed issue required for all individual products.

Original CR Provisions

- Pure community rating.
- Variations only allowed for benefit plan design, family type, and geographic region.

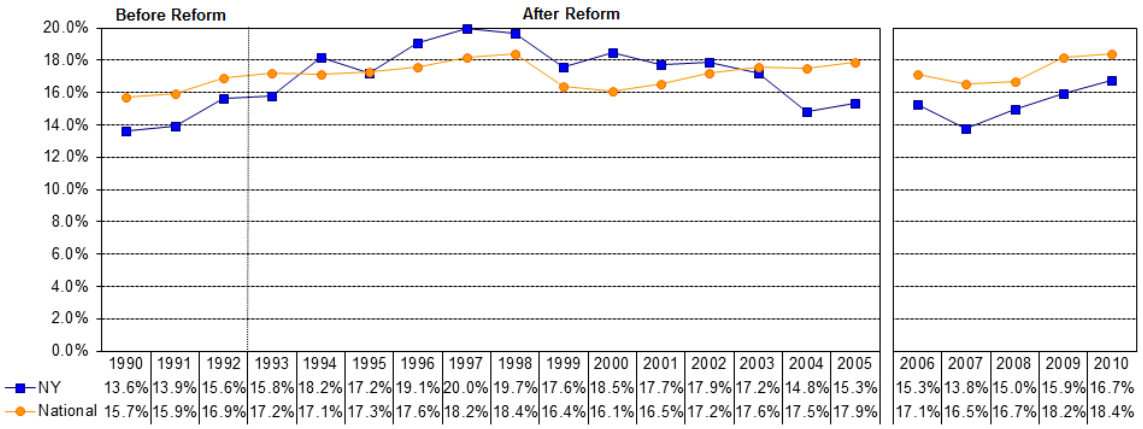
Subsequent History

- **1995:** Legislation enacted requiring HMOs to offer two standardized benefit plans, modifies risk adjustment mechanism over the next five years.
- **2000:** Reinsurance program established for standardized benefit plans.

Current status: GI and pure CR still in force.

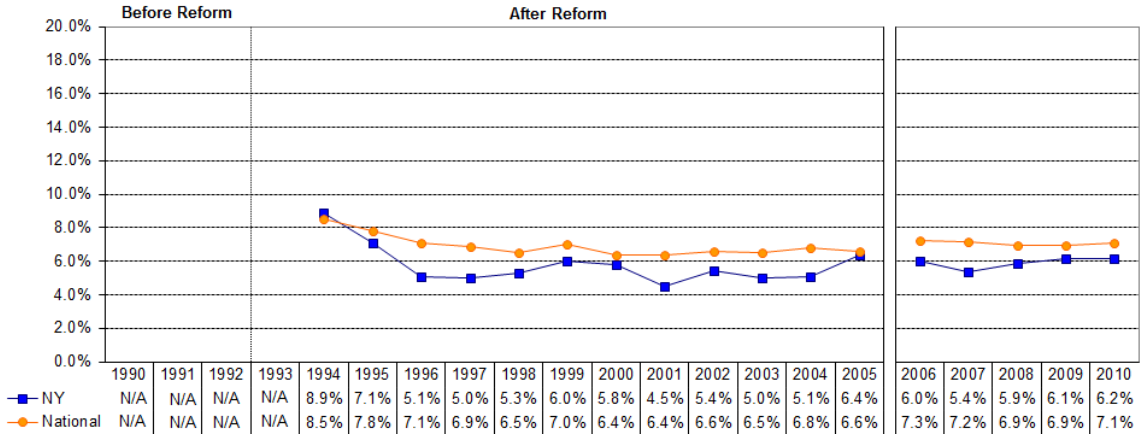
NEW YORK FACTS*

Percentage of Uninsured Under Age 65



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
NY	13.6%	13.9%	15.6%	15.8%	18.2%	17.2%	19.1%	20.0%	19.7%	17.6%	18.5%	17.7%	17.9%	17.2%	14.8%	15.3%	15.3%	13.8%	15.0%	15.9%	16.7%
National	15.7%	15.9%	16.9%	17.2%	17.1%	17.3%	17.6%	18.2%	18.4%	16.4%	16.1%	16.5%	17.2%	17.6%	17.5%	17.9%	17.1%	16.5%	16.7%	18.2%	18.4%

Percentage of Direct Purchasers Under Age 65



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
NY	N/A	N/A	N/A	N/A	8.9%	7.1%	5.1%	5.0%	5.3%	6.0%	5.8%	4.5%	5.4%	5.0%	5.1%	6.4%	6.0%	5.4%	5.9%	6.1%	6.2%
National	N/A	N/A	N/A	N/A	8.5%	7.8%	7.1%	6.9%	6.5%	7.0%	6.4%	6.4%	6.6%	6.5%	6.8%	6.6%	7.3%	7.2%	6.9%	6.9%	7.1%

Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994. The percentage of nonelderly uninsured people in New York generally moved similarly to the national averages from 1990 through 2003. However, it is notable that the percentage of uninsureds in New York was below national averages from 1990 through 1993, and above national averages for all but one of the following years through 2002. Since 2002, the New York average has once more fallen below the national level.

The percentage of direct purchasers under age 65 in New York fell much more steeply than national averages from 1994 through 1996. New York started at 8.9% in 1994, which was 0.4 percentage points above the national average. By 1996, New York was at 5.1%, two percentage points below national levels. It has remained below national levels ever since, although it nearly matched national levels in 2005.

*Note: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

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DISCUSSION

Vermont passed guaranteed issue and community rating reforms for its individual (or "non-group") market in 1992. These followed the implementation of GI and CR reforms of the small group market enacted in 1991. All insurers choosing to participate in the individual market were required to guarantee issue all products, and HMOs were required to participate in the market.

Commercial insurers were originally allowed to vary rates +/-40% for demographic and other case characteristics, excluding health status. This rate band was narrowed to +/-20% two years later. Non profit HMOs and Blue Cross Blue Shield of Vermont (BCBS-VT) are subject to pure community rating, while for profit insurers can use adjusted community rating[37]. Close to 90% of the individual members are enrolled in plans that require community rating[38]. Effective in 2009, Vermont allowed insurers to provide discounts of up to 15% for those participating in programs intended to improve health.

The 1991-1992 legislature also set up a commission to develop a comprehensive health care reform plan, but this effort did not result in any new legislation.[39] A reinsurance mechanism was also authorized by the 1992 legislation, but it was never implemented.

In his 2000 study[40] of Vermont's individual market reforms, Mark A. Hall points out that this lack of reinsurance or risk adjustment mechanisms made Vermont unique among the states that tried community rating and/or guaranteed issue reforms. Vermont also did not require insurers to offer a standard set of benefits in the individual market.

Hall found "no clear evidence that Vermont's individual market reforms have significantly increased enrollment or decreased the overall level of the uninsured, either statewide or in the individual market." Based on figures reported by the Vermont Department of Banking, Insurance, Securities, and Health Care Administration (Insurance Department), Hall found a 17% decline in covered lives in the individual market from 1994 to 1997.

Rate increases for the two leading indemnity insurers averaged 14-18% per year for the two years following the reforms. Subsequent increases were generally comparable between the small group and individual markets, and although double digit increases occurred regularly throughout the 1990s, rate increases generally were not as extreme as some opponents of reform had predicted.

On the other hand, several factors may have served to dampen the impact of the reforms on rate increases. First, BCBS-VT, which held a large portion of the individual market, was already operating under community rating and guaranteed issue prior to reforms. Additionally, the small size of the Vermont market led some insurers to make rate increase

[37] Kapel, Steven, Policy Integrity, LLC (March 25, 2011). Community Rating: The Basics. Vermont Legislative Joint Fiscal Office.

[38] Annual Statement Supplement Reports 2010. Comprehensive Major Medical, Non Group. Department of Banking, Insurance, Securities, and Health Care Administration

[39] See Leichter's 1993 and 1994 papers (referenced below) for a detailed history.

[40] Hall, Mark A. (February 2000). An evaluation of Vermont's reform law. *Journal of Health Politics, Policy and Law* Vol.25 No. 1. Duke University Press.

decisions for their individual and small group blocks together, in which case the small group block may have effectively subsidized the individual block. Also, the reform law limited rate increases to a maximum of 20% annually unless doing so would endanger the financial safety and soundness of the insurer.

Another key factor in delaying the impact of reform was the safety net program created by the 1992 law. Correctly anticipating that several insurers would leave the individual market due to the reforms, the law required BCBS-VT to continue the coverage of subscribers of such companies at the same rates, and without increasing rates more than 15% annually.

Hall reports that enrollment in the safety net rose to 5,000 lives, or about one sixth of the individual market at the time. Although it may have slowed any impact of adverse selection in the market, the safety net proved problematic for several reasons. Many subscribers in this pool had been subject to exclusionary riders for specific conditions under their previous coverage, but such riders were illegal under reform. Thus BCBS-VT became obliged to cover these lives at artificially low rates. Eventually, in 1995, BCBS-VT was allowed a one-time extraordinary rate increase of 37% on this business.

The availability of richer benefit plans declined in the years following reform. Prior to reform, indemnity insurance with deductibles as low as $50 was available. In 1998, the lowest indemnity deductible was $1,000, and in 2006 it was $3,500.

In 1999 (the end of the period covered by Hall's study), the two insurers with the largest individual market share after BCBS-VT both decided to leave the individual market. After that, the individual market continued to decline. A December 2006 study[41] commissioned by the Vermont Insurance Department concluded that "the individual market seems to be performing badly: the number of people buying such coverage is falling drastically; coverage is unaffordable for many; and the only coverage that is available has very high cost sharing."

The Insurance Department study further found that community rating was effectively being circumvented, with good risks from both the individual and small group markets finding their way into employer association plans not subject to community rating, so that the individual market "has in essence become a high risk pool."

In 2006, Vermont passed a large health reform package, much of which was to be phased in over the next five years. Key provisions relating to the individual market include:

- Creation of the Catamount Health Plan, a separate insurance pool offering lower cost health insurance for uninsured Vermonters, with subsidies for the poor;
- Requirement for the legislature to consider an individual mandate if less than 96% of the Vermont population is insured in 2010;
- Creation of the Non-group Market Security Trust, a state reinsurance fund whose purpose is to reduce premiums in the non-group (individual) market by at least 5%; and
- Commission of a study of further individual market reforms, including changes to market rules, consolidation into a single risk pool, and/or merger of the small group and individual markets.

In its December 2006 study, the Insurance Department recommended several possible courses of legislative action, including phasing out the safety net pool and creating uniform

[41] Wicks, Elliot K. (December 2006). The Individual Market in Vermont: Problems and Possible Solutions. Prepared for the Vermont Department of Banking, Insurance, Securities, and Health Care Administration.

rating rules for all carriers. Since then, Vermont has undertaken numerous health care reform initiatives intended to increase access, improve quality, and contain cost. However, as of 2008, the Non-group Market Security Trust fund had not been implemented due to lack of funding.[42]

In 2011, Act 48 of the state legislature put Vermont on the path to a single payer system. However, the law requires the development of a financing system that assures the model will cost less than the current system.[43] Act 48 also creates a framework to establish the Exchange requirements of the federal Affordable Care Act by 2014, with an eventual conversion to Green Mountain Care, which would be the universal and unified health system for the state.[44]

LAW

Citation(s):
1991 Adj. Sess., No. 160
Title 8 V.S.A. §4080b

Enactment Date: Spring of 1992
Effective Date: July 1, 1993
Repeal Date: N/A

Original GI Provisions

- All companies must guarantee issue all products.
- HMOs required to participate in the individual market.

Original CR Provisions

- BCBS-VT and HMOs must use pure community rating (rates may only vary by family size and benefit level).
- Commercial insurers were originally allowed a +/-40% rating band for risk factors other than health status.
- Preexisting conditions may be excluded for 12 months.

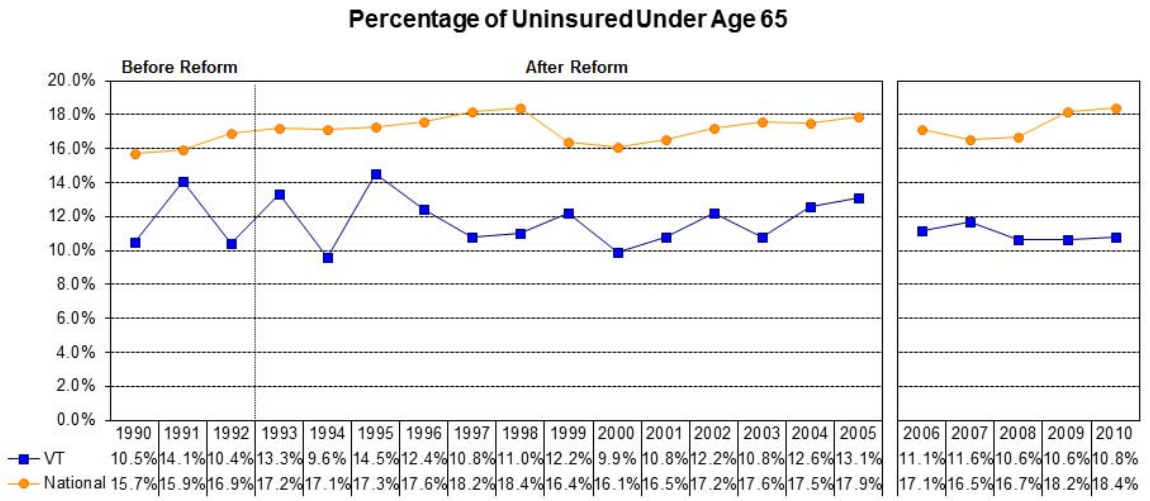
Subsequent History

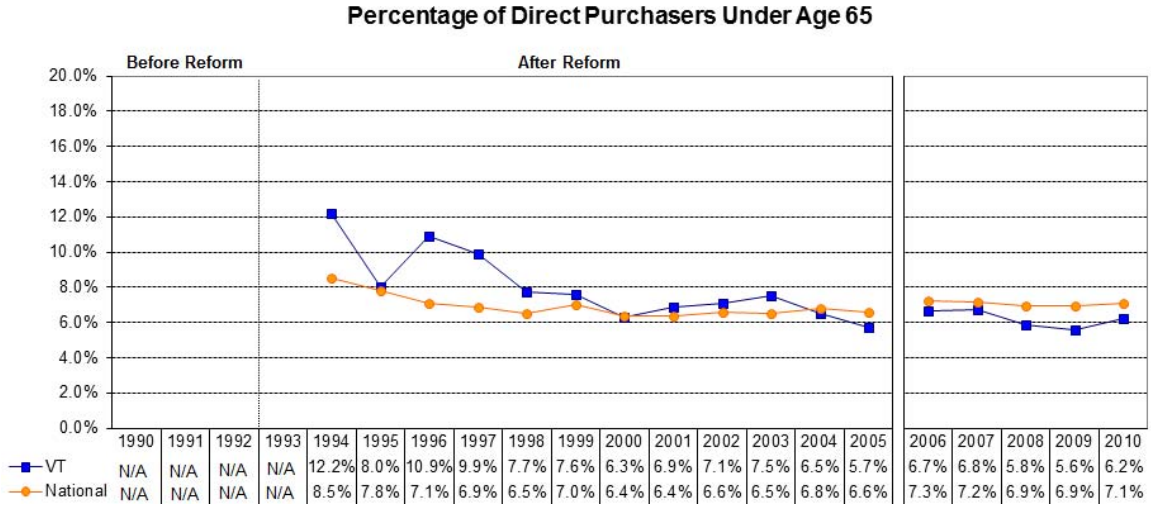
- **1995**: Rate bands for commercial insurers narrowed to +/-20%.
- **1999**: Rate bands for commercial insurers phased out in small group market.
- **2006**: Broad health care reforms enacted.
- **2011**: Reform enacted to convert to single payer system, after a series of steps are completed.

Current status: Both CR and GI still in effect.

[42] Overview of Vermont's Health Care Reform, State of Vermont October, 2008.
[43] Vermont's Health Care Reform Agency of Administration (http://hcr.vermont.gov/home) accessed February 10, 2012.
[44] Agency of Administration (January 17, 2012). Act 48 Integration Report: The Exchange. Senate Committee on Health and Wellfare.

VERMONT FACTS*





Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994.

Since 1994 the percentage of direct purchasers under age 65 in Vermont has fallen steadily. Originally considerably above national averages, Vermont was nearly a full percentage point below the national average of 6.6% in 2005. The percentage of nonelderly uninsured in Vermont has fluctuated somewhat immediately following the implementation of reforms, but has remained fairly flat since then at levels lower than national averages.

From 1994 to 1997, the percentage of direct purchasers was considerably above national averages (with the exception of 1995), but it fell fairly steadily until 2005, when Vermont was nearly a full percentage point below the national average of 6.6%. The rate has fluctuated from 5.6% to 6.8% since then but has stayed below the national average.

*Note: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

ADDITIONAL STATISTICS*

	After Reform						
	1994	**1997**	**2000**	**2002**	**2003**	**2004**	**2005**
Individual Market Total Covered Lives	31,257	26,099	16,007	17,718	15,635	10,266	9,422
Individual Market Avg. Annual Premium	$806	$1,043	$1,435	$1,680	$2,082	$2,860	$2,769
CR Sm. Grp. Market Total Covered Lives	N/A	N/A	46,349	33,048	29,046	24,325	22,014
CR Sm. Grp. Market Avg. Annual Premium	N/A	N/A	$1,996	$2,764	$3,032	$3,410	$3,628
Association Market Total Covered Lives	N/A	N/A	74,131	82,443	86,560	96,282	114,384
Association Market Avg. Annual Premium	N/A	N/A	$2,134	$2,631	$2,948	$3,151	$3,218

	After 2006 Reform				
	2006	**2007**	**2008**	**2009**	**2010**
Individual Market (Excluding Catamount) Total Covered Lives	8,304	7,482	6,092	5,222	4,872
Individual Market Avg. Annual Premium	$3,080	$3,456	$3,835	$3,882	$3,683
Catamount Health Insurance Total Covered Lives	N/A	1,482	7,780	11,300	12,607
Catamount Health Avg. Annual Premium	N/A	Effective 3QTR	$3,210	$4,035	$4,796
CR Sm. Grp. Market Total Covered Lives	17,498	19,681	16,321	19,201	23,688
CR Sm. Grp. Market Avg. Annual Premium	$4009	$4436	$4,663	$4,261	$4,154
Association Market Total Covered Lives	104,883	95,666	88,184	79,491	74,693
Association Market Avg. Annual Premium	3,617	3,799	$4,006	$4,366	$4,608

Annual report figures obtained from Hall's study and the Insurance Department are included in the "Additional Statistics" table above. They represent actual covered lives, and hence will differ from figures generated by the census surveys, which ask people whether or not they directly purchased coverage at any time in the previous year. It is important to note that the average premium levels in this table also reflect changes in benefit levels or other characteristics over time and between markets.

The Insurance Department figures confirm that enrollment in the individual market continues to shrink, while average premium levels are increasing. Corresponding figures for the small

group and association markets are also included for recent years. They reveal a decline in the community rated small group market and a simultaneous increase in enrollment in the association market up to 2005. After 2006, the association market has begun to shrink, while the Catamount Health Insurance program reached over 12,000 lives as of 2010.

Average premiums for the small group and association markets are both higher than in the individual market, reflecting the high levels of cost sharing in the individual market. Over the five year period from 2000 to 2005, average premium rates increased by an average of 14% annually in the individual market, 13% annually in the small group market, and 9% annually in the association market. For the four year period from 2006 to 2010, the equivalent values are about 5% for individual, less than 1% for small group and over 6% for associations. Please note that this excludes the impact of the Catamount program. This suggests that the associations, the vast majority of which are exempt from community rating, may be attracting the better risks from the other two markets, most notably prior to the 2006 reforms. It may also reflect the impact of rate increase limits in the individual market.

*Source: Values for individual market prior to 2000 taken from Hall (2000) p. 108. Values after 2000 calculated from Annual Statement Supplement Reports 2000-2010, Department of Banking, Insurance, Securities, and Health Care Administration. Accessed at http://www.bishca.state.vt.us/health-care/health-insurers/market-share-reports-earned-premiums-year on 2/10/2012.

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DISCUSSION

In 1993, Washington reformed the individual market with the Washington Health Services Act (Act). The Act was modeled after the proposed Clinton reforms on the federal level. In the individual market, the Act instituted guaranteed issue, set tight limits on preexisting condition exclusions (including mandatory maternity coverage), and gave the insurance commissioner strong powers to regulate rates. It also capped premium rates, aimed to phase in mandatory basic individual and employer coverage, and required pure community rating and risk adjustment; however, these provisions were repealed in 1995 before they took full effect.

The 1995 legislation also required insurers selling individual insurance to offer a Basic Health Plan "look-alike." The Basic Health Plan, which predates the 1993 reforms, is a program funded by the state for low-income individuals who are ineligible for Medicaid.

Over the next few years, the commissioner reduced rate increases from the level requested by carriers on individual business.

In the late 1990s, the three largest carriers closed their individual blocks to new business, citing mounting losses. Smaller carriers had also been leaving the market, and individual health insurance became unavailable in many counties. In 1999, the legislature responded in several ways. First, guaranteed issue was modified so that carriers were allowed to deny coverage to high risk individuals identified by a standard state questionnaire. These high risk individuals (intended to be the most costly 8% of the population) were then eligible for the state's high risk pool.

The second major reform enacted in 1999 was the replacement of the commissioner's approval authority for individual premium rate increases with a 72% guaranteed loss ratio standard (74% less the 2% premium tax). On the other hand, if the carrier's actual loss ratio is less than 72%, the difference goes to fund the high risk pool. Finally, the allowable preexisting condition exclusion limitation period was increased from three months to nine.

After this new legislation went into effect on January 1, 2000, major carriers returned to the market. Over the years, several bills were introduced in the State Legislature to reinstate the commissioner's authority to regulate rate increases. Finally, in 2008, the commissioner's authority to review premium rate increases was reinstated for the individual market and subsequently for small groups as well.

It is clear that individual insurance reforms in Washington directly caused many insurers to leave the individual market. It also appears that the individual insurance market decreased in size faster than the national average after the enactment of reform.

LAW

Citation(s):
L. 1993 c. 492
RCW 48.43

Enactment Date: May 17, 1993
Effective Date: July 1, 1993
Repeal Date: N/A

Original GI Provisions

- GI required.
- Preexisting conditions could only be excluded for three months.

Original CR Provisions

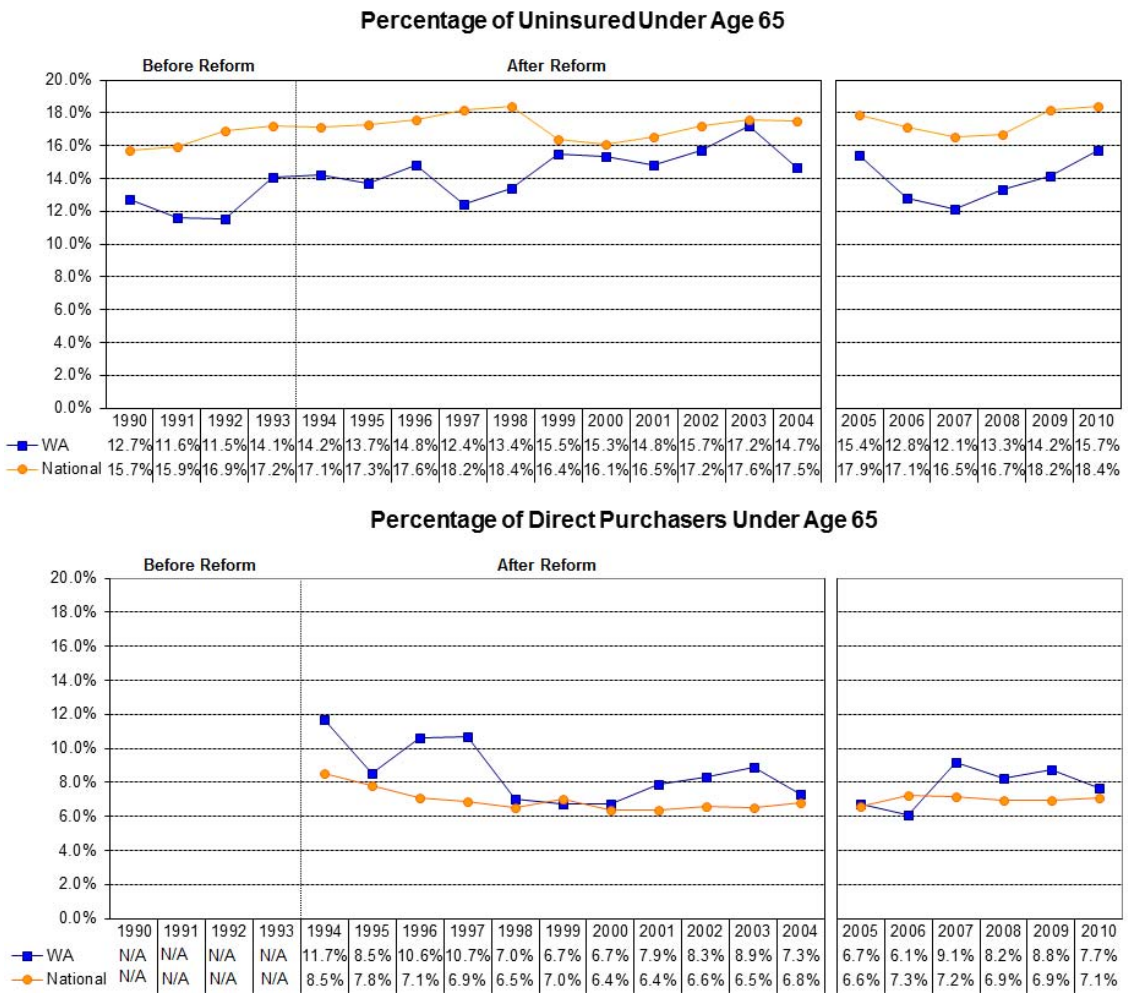
- Original pure, capped CR was replaced with a weak form of modified, uncapped CR before it took full effect.
- Rates may vary by geographic area, family size, age, tenure discounts, and wellness activities.
- Some limitations apply to age and tenure rating.

Subsequent History

- **1995**: Repeal of much of 1993 law (GI and modified CR not repealed).
- **2000**: Health Insurance Reform Act replaces commissioner rating authority with 72% loss ratio requirement, allows for health screen to assign applicants to high risk pool, increases preexisting conditions exclusion period to 9 months, adds portability consistent with HIPAA.
- **2008**: Insurance commissioner's rate approval authority reinstated.

Current status: GI still in effect except for those referred to high risk pool, modified CR.

WASHINGTON FACTS*



Census figures are included in the graphs above. The census did not collect information on individual insurance prior to 1994.

The data indicates that the percentage of the nonelderly, noninstitutionalized population directly purchasing health insurance fell from 11.7% to 6.7% over the period from 1994 to 1999, a relatively large drop compared to the national average decline from 8.5% to 6.7%. A large increase in direct purchasers occurred in 2007, up to 9.1%, with a subsequent decrease to 7.7% by 2010.

In 1992, census data indicated that Washington state, at 11.5%, had a much lower percentage of nonelderly uninsured than the national average of 16.9%. By 2000, that gap of 5.4 percentage points had narrowed to 0.8 percentage points, and Washington remained close to the national level until 2003. Sharp decreases in 2004 and 2006 lowered Washington's uninsured rate to 12.1% in 2007, 4.5 points below the national average.

*Note: All percentages relative to the total state population under age 65.
Source: U.S. Census Bureau, Current Population Survey, 1988 to 2010 Annual Social and Economic Supplements. HI-6 (Original Series) used for 1990 to 2005 and HIB-6 used for 2006 to 2010. Accessed at http://www.census.gov/hhes/www/hlthins/data/index.html on February 1, 2012.

ADDITIONAL STATISTICS

	After Reform					
	1998	**2000**	**2002**	**2004**	**2006**	**2008**
Uninsured under age 65*	10.3%	8.6%	9.4%	11.0%	11.9%	12.3%
Individual Insurance under age 65*	8.4%	6.1%	4.9%	5.6%	5.4%	5.4%
Percent of Total Population Insured by Basic Health Plan**	4.7%	4.3%	2.1%	1.9%	2.2%	1.9%

The Washington State Population Survey (WSPS) has been published biennially since 1998. It provides additional estimates of some of these statistics. However, due to differences in survey methodologies, these data are not directly comparable to the census data. These figures are included in the table of Additional Statistics above.

Since 2000, the WSPS individual coverage percentages remain relatively steady (with the exception of a continued decline in enrollment in the state-subsidized Basic Health Plan), consistent with the census figures. This steady coverage is counter-intuitive, given that insurers stopped issuing new individual policies in the late 1990s and began again after the reforms of 2000. However, many other factors may also influence these rates, including, for instance, unemployment levels.

*Source: Charts 1-1 and 3-1, Access to Health Insurance Chartbook. Office of Financial Management, State of Washington. Based on WSPS data. Available at http://www.ofm.wa.gov/healthcare/spg/chartbook/default.asp. Accessed April 30, 2007.
**Source: Washington State Population Survey. Available at http://www.ofm.wa.gov/sps/. Accessed April 30, 2007.

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Appendix A: Glossary of Selected Terms

The following are definitions of these terms as used in this report. Other sources may use slightly different definitions.

Case Characteristic. A demographic, health status, or lifestyle factor used by insurers to set health insurance premium rates, such as age or tobacco use.

Community Rating (CR). A rating methodology prohibiting insurers from varying rates based on health status and restricting the amount by which premium rates may vary based on case characteristics such as age and gender.

Individual health insurance. Insurance purchased directly from an insurance company, as opposed to insurance obtained through an employer or under a government program.

Guaranteed Issue (GI). Laws requiring insurers to issue insurance to any eligible applicant without regard for current health status or other factors.

Loss Ratio (LR). The fraction of premiums returned as claims, generally calculated as incurred claims divided by earned premiums.

Modified Community Rating. Community rating where limited variation for some case characteristics, such as age, is allowed.

Pure Community Rating. A rating methodology where each policyholder is charged the same average (or community) rate, with adjustments allowed only for family size or benefit plan design. Occasionally, limited variation by geographic area is also included in this category

Rate Band. A limited amount by which premium rates may vary, typically for claims experience and health status. In some cases variations for case characteristics are also included.