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Market and Regulatory Reforms to Expand Health Insurance Coverage

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Executive Summary

Health insurance markets for small businesses and individual purchasers not eligible for group coverage are susceptible to forces that limit access to and increase the cost of coverage. Public policy options for improving accessibility and affordability in these markets include:

- Pooling risk among insurance carriers through market regulation
- Lowering costs through reducing benefit mandates
- Separating the highest costs or highest-risk users from the overall market through high-risk pools or a universal catastrophic coverage program outside the private market

Studies of market regulation, benefit mandates, and high-risk pools offer little evidence that these strategies decrease the number of uninsured persons. However, regulatory reforms in the individual and small group markets have been shown to stabilize faltering markets, thereby sustaining coverage that otherwise may not have been provided. Research has not found the predicted adverse effect of insurers exiting the market. The most comprehensive regulations in the individual market, i.e., pure community rating, may be an exception, with trends indicating adverse risk selection, rising premiums and declining coverage. Research on benefit mandates is mixed but does not generally suggest that regulatory relief would significantly lower costs or increase coverage. High-risk pools have been shown to be costly but nevertheless to provide some relief for those at greatest risk of being excluded from private coverage. Universal catastrophic coverage, an extension of high-risk pools, is a novel approach that has yet to be tested.

This report is presented to the program staff of the Washington State Planning Grant on Access to Health Insurance. It represents the research findings and opinions of the consultant team.

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Problem Definition

The individual (sometimes called the non-group or direct-purchase) and small-group health insurance markets are vulnerable to financial instability resulting from the highly skewed distribution of population health risk. Since a very small share of the population accounts for a very large share of spending, those who expect to be high-cost enrollees are more likely to purchase insurance. Insurers are generally not able to identify such high-cost persons a priori. As a result, they are unable to set appropriate risk-adjusted premiums that reflect the increased risk of these enrollees. This asymmetry of information between individuals and insurers regarding enrollee health risk (e.g., potential enrollees know whether they are high risk; insurers do not) creates a situation known as adverse selection. Adverse selection is most serious when the risks are spread across fewer insured people, as occurs among policies sold to individual and small groups. To counter adverse selection, unregulated insurance markets are subject to segmentation, where insurers select out high-risk cases, redline certain high-risk industries where possible or charge higher prices to higher-cost groups, making coverage unaffordable for the sickest individuals. The large-group market generally avoids such excluding practices because high expenditure cases are averaged over a larger number of enrolled persons.

Unlike the large-group market in which many businesses self-fund (i.e., take financial risk for) employee health coverage, the coverage in the individual and small-group markets is purchased from state-regulated insurance carriers. State regulations can address problems in these markets. Insurance benefit mandates (i.e., the requirement that insurers cover specific services or types of providers) are intended to assure access to selected services or to correct for insurance market failure (e.g., the incentive to manipulate benefit packages to encourage low-risk persons to enroll). Such mandates have increased in recent years, (Jensen & Morrisey, 1999a; Jensen & Gabel, 1992) raising questions about their impact on premiums and rates of coverage in the regulated segments of the market.

Other kinds of regulations (described in the Appendix) affect whom carriers must cover and what they can be charged in these markets. These regulations compensate for market forces that exclude or lead to higher premiums for high-risk persons. In competitive individual and small-group coverage market without regulatory prohibitions to the contrary, insurers limit their risk exposure through risk-rated premiums, medical underwriting, waiting periods for coverage, and exclusion of pre-existing conditions. These practices tend to fragment rather than pool risk and lead to high premiums for or exclude from coverage entirely the sickest persons. Market regulations are intended to develop an inclusive market that provides affordable coverage to the people with the greatest needs.

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On the other hand, regulations that strictly prohibit carriers from managing the financial risk through rating or underwriting practices can also undermine the viability of these markets, by reducing affordability for some low-risk groups. Thus, states that regulate premium rating and enrollment practices also use mechanisms to ensure that the costs of high-risk cases are shared among carriers or subsidized in some way (described in the Appendix).

The fundamental tension in individual and small group market reforms is between inclusiveness and affordability/market viability. Regulatory interventions seek to protect sick individuals from being excluded from coverage, but in doing so, they may increase the cost of coverage to other groups, which in turn may decrease coverage. The negative financial effect on the risk pool and on rates when sick people participate in risk pools is a direct result of the positive effect affordable rates have on access for those most at risk. State regulations seek a balance between these two competing priorities.

Description of Design Options

States have sought to encourage inclusive but stable individual and small-group markets by regulating insurance practices, reallocating or subsidizing the cost of high-risk cases among insurance carriers, or by offering coverage to high-risk persons outside the traditional private insurance system. The following four options are potentially available to Washington to enhance the functioning of these coverage markets:

- *Relief from benefit mandates*—Reduce state requirements that insurers cover specific services or types of providers in order to reduce premiums and, ultimately, improve the affordability of coverage.
- *Individual and small-group market regulations*—Restructure the distribution of risk in the individual and small-group markets. These regulations can take a number of forms and include restricting insurance carrier practices that limit coverage of or charge higher premiums to high-risk individuals or groups, and pooling of risk by encouraging or requiring carriers to participate in or otherwise share risk in these markets (see Appendix). These changes could potentially affect the 40 percent of workers in small businesses and 6 percent of state residents with individual insurance.*
- *High-risk pool expansion*—Modify the state high-risk pool to remove more high-risk individuals from the private insurance market. State-managed high-risk pools are generally structured to cover persons rejected from private insurance for medical reasons. Some states, including Washington, permit individuals who are not eligible for small group coverage to participate in pools; others allow pools to cover individual high-risk members who have been excluded from small-group plans (United States General Accounting Office, 1992). Although Washington already has a high-risk pool, potential modifications to the pool include expanding eligibility to include small groups of fewer than 10 or 25, which includes as many as 40 percent of all workers*, making the product more affordable by lowering the allowable cost of standard-risk policies or basing them on HMO/PPO rates, and facilitating entry through an auto-enrollment process. About 15 percent of those in fair or poor health are uninsured.*

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* Washington State Planning Grant on Access to Insurance. Research Deliverable 3.0. *Targeting the Uninsured in Washington State.*

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- *Universal catastrophic coverage*—Create a universal catastrophic benefit for residents under 65 that separates liability for the cost of catastrophic care from the existing insurance system, replaces the current high-risk pool, and provides a minimum level of coverage to all eligible state residents. This novel approach would create a new statewide managed plan to cover all or substantial segments of Washington residents for catastrophic medical expenses (e.g., above $7,000-$10,000 a year). Enrollment in the plan would be mandatory, and substantial state financing would be required. The approach, which could be coupled with modifications to systems for payment for charity care or other reforms, could potentially provide coverage for all 308,000 uninsured Washington residents with incomes less than 200% FPL*.

Financing Considerations

Many regulatory approaches require only minimal state funding and are generally funded through surcharges on private carriers or premiums charged to program participants. Risk may be distributed through pay-or-play mechanisms or mandatory reinsurance mechanisms that are also financed through the private market through carrier premiums or assessments. Even in financing through private market assessments, the state needs to consider what the market will bear. Since federal law prohibits states from taxing or placing other targeted levies on self-insured employee benefit plans, reforms must be funded through the individual and small business portions of the market or with general revenues. In considering risk-distribution strategies and imposing additional assessments, the state needs to be cognizant of the potential effect of carriers exiting the market or of increasing premiums to other purchasers.

Policies to extend the state's high-risk pool or to provide universal catastrophic coverage are likely to require significant additional state funding. Although Washington's high-risk pool is currently funded solely by premiums and assessments on carriers, decreasing the consumer premium will result in higher assessments to carriers. Again, depending on the level of assessment, the state may opt to subsidize an expansion of the pool, which would require an additional source of funding. Under a universal catastrophic coverage model the state would need to consider a variety of sources of revenues to fund the coverage. Employers that currently offer coverage would realize large savings in health premiums that could be recaptured through new or existing business taxes. Charity care and bad debt for hospitals would be significantly reduced under a universal catastrophic plan, and uncompensated care reimbursement systems could be modified to capture savings (or to reallocate these subsidies to primary care).

Administrative Considerations

Market and regulatory reform options entail many design decisions that could be implemented in some combination. For individual and small group reforms, for instance, studies have found the effect of extending guaranteed issue is severely hampered without accompanying rating restrictions that keep insurance affordable. In addition, the complexity of rating reforms require careful construction of rules and ongoing monitoring to eliminate possible avenues for circumvention (Hall, 2000-2001). This should be taken into consideration when developing individual and small group reforms.

The universal catastrophic model has not been previously attempted by a state and would require the consideration of significant range of design issues. This model would require many fundamental

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changes in the organization of health care financing in the state. Decisions would have to be made about levels of expenditures that would be considered eligible for catastrophic reimbursement, the sources of revenue to finance coverage, and mechanisms for administering the program. In addition, eligibility rules would need to be agreed upon, such as whether to exclude the Medicare and Medicaid populations or require residency of one or more years to avoid in-migration and associated adverse selection. This model presumes that supplemental or "wrap-around" policies would be provided through the employer and individual market, and coordination-of-benefits mechanisms would have to be developed. If the state wants also to encourage prevention, it could either add these services to the catastrophic benefit or, to ensure access for low-income persons, directly fund necessary preventive services through community health centers or local health departments.

Target Population

Individual and small-group markets (defined in Washington as groups of 50 or fewer employees) are important parts of the continuum of coverage in Washington, covering 6.4 and 25.5 percent of the non-elderly, respectively. Instability in these markets can lead to greater levels of uninsurance—67 percent of the uninsured (about 324,000 people) are workers or dependents of workers in small firms that may or may not offer coverage. Of the uninsured, 16 percent, or about 77,000 people, (7 percent are self-employed or not working and 9 percent are employed but are ineligible or are not offered health insurance through their employer) have incomes more than 350 percent of the federal poverty level*, making coverage through the individual market potentially affordable.

The target population for the universal catastrophic option is much broader, possibly including all Washington residents or excluding only those enrolled in Medicaid, Medicare, or other federal programs. In total, the universal catastrophic option could affect up to 85.3 percent of Washington's non-elderly population, including nearly all 484,000 uninsured people.[†]

Evidence

Relief from Benefit Mandates

Benefit mandate laws are becoming increasingly common; in 1999, more than 1,000 mandates were in place across the states, compared to 399 in 1979 and 827 in 1989 (Jensen & Morrisey, 1999a; Jensen & Gabel, 1992). Presently, Washington State has 22 mandated benefit laws: 10 of these affect group coverage; 12 affect both individual and group insurance products (Office of Insurance Commissioner, 2001). These benefit mandates include coverage of specific services (e.g., treatment of chemical dependency and mammograms) and access to certain providers (e.g. chiropractors and podiatrists). The state also has administrative mandates that establish eligibility (e.g., coverage for adopted children) or rules for continued coverage (e.g., guaranteed issue). Although proponents of mandate relief argue that mandates increase the cost of insurance both by increasing the cost of coverage and by encouraging firms to self-insure, the research literature does not offer clear evidence on the likely effect of offering regulatory relief from mandates.

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*Washington State Population Survey, 2000

[†] Washington State Planning Grant on Access to Insurance. Research Deliverable 3.0. *Targeting the Uninsured.*

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Mixed Results on the Impact on Insurance Offer Rates or the Number of Uninsured

Several studies evaluating the effect of small group reforms using different approaches have found that benefit mandates significantly reduce the probability of having insurance and the likelihood that small firms will offer coverage. (Jensen & Morrisey, 1999b; Sloan & Conover, 1998; Jensen and Gabel, 1992). Sloan and Conover (1998) found that state mandates are associated with a 0.4 percent increase in uninsurance among adults for each additional mandate, that 20-25 percent of uninsurance is due to benefit mandates, and that these negative effects were strongest among small employers. Similarly, Jensen and Gabel (1992) found that mandates accounted for 19 percent and 43 percent of non-coverage in small firms in 1985 and 1988, respectively. In general, these studies focused on the number of benefits rather than the specific type of benefit. The limitation of this research is that it does not permit analysis of the effects of particular benefit mandates either in terms of the individual cost effect or the added benefits to individual's health resulting from this service being required.

Other research and evidence from state's experiences selling "bare-bones" plans, which exempt small employers from some or all benefit mandates, suggest that these numbers may be overstated. Gruber found that insurance mandates have little effect on uninsurance in the small employer market (Gruber, 1994b), and companies that have been exempted from benefit mandates are only slightly more likely to offer health insurance to their employees (United States General Accounting Office, 1992).

In Washington no insurers currently offer a mandate-free product, and few employers have shown interest in such a product. (Office of Insurance Commission Policy Division, 2001). According to a GAO report in the early 1990s, elimination of mandated benefits has not lowered premiums enough to make a difference in affordability and also often included other restrictions that limit such products' attractiveness such as higher cost-sharing or pre-existing condition clauses. Similarly in the late 1990s, Riley and Yondorf (2000) concluded that bare-bones plans are even less attractive due to three developments. First, national attention to women's health issues has made policy makers and insurers less inclined to waive benefits such as mammograms, complications of pregnancy, or breast reconstruction. Second, employers have increasingly shifted away from traditional indemnity plans toward less expensive HMO plans that have no interest in excluding some of the preventive care mandated benefits that are an integral part of the HMO concept of care. Finally, the passage of HIPAA reduced insurers' interest in selling bare bones plans both because HIPAA established some federal mandates (e.g., 48-hour maternity length of stay and breast reconstruction) and imposed pre-existing condition regulations that would potentially increase insurers' liability when employers switch from a bare-bones to a comprehensive plan.

Mandates Do Not Encourage Firms to Self-Fund

Premiums and benefits in exempted self-funded plans are similar to those of state-regulated plans, suggesting that few firms self-fund to avoid benefit mandates (Acs, Long, Marquis, & Short, 1996; Gruber, 1994a; Morrisey, Jensen, & Morlock, 1994). Taken together, this evidence suggests that competition in the labor market would likely mitigate any major benefit from regulatory relief.

Individual and Small-Group Market Regulations

The past decade has witnessed a great deal of experimentation among states with insurance market regulation, and a body of research literature has begun to emerge on the effects of these reforms. However, the evidence of the effects of specific reforms (e.g., imposing minimum loss ratios or mandating reinsurance) is limited.

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Small Group Reforms Have Little Effect on Coverage and Number of Uninsured

Despite variations in study approach and time period, the preponderance of evidence suggests that guaranteed access and rating reforms in the small-group market have not led to serious adverse selection or declines in enrollment or offer rates that opponents had predicted, nor have they resulted in considerable increases in coverage (Marquis & Long, 2001; Zuckerman & Rajan, 1999; Buchmueller & DiNardo, 1999; Sloan & Conover, 1998). Early studies that relied on Current Population Survey data found some improvements in coverage in some states that had imposed guaranteed issue and rating reforms, but decreases in other states (Institute for Health Policy Solutions, 1995). A study of New York's individual and small-group market reforms that controlled for state-specific effects, found that declines in coverage were not attributable to regulatory reforms. (Buchmueller & DiNardo, 1999) Similarly, studies utilizing employer surveys to measure the effect of small-group reforms, found the effects of small-group market reforms taken individually or together on the small firms' provision of health insurance were statistically insignificant. This was true even for small firms and during both the early 1990s and in the mid-1990s when rating and guaranteed issue reforms were tightened. Marquis and Long also looked at the effect on turnover in offer decisions, enrollment rates overall, and in HMO plans and also found no significant effect (Jensen & Morrisey, 1999a; Marquis and Long, 2001).

Some recent evidence does suggest that reforms may have had some unintended consequences for low-risk small-firm employees. In states with stringent reforms (e.g., guaranteed issue and rating reforms), coverage for high-risk employees has increased relative to that for low-risk employees (Simon, 1999; Monheit & Schone, 2002). However it's unclear from results whether this is being driven by the behavior of low-risk small-firm employees or the behavior of low-risk large-firm employees.

Community Rating in the Individual Market May Lead to Decline in Number of Lives Covered

Early studies of pure community rating and guaranteed issue in the individual market in New Jersey found that the reforms stabilized a seriously flawed market without adverse selection (Swartz & Garnick, 1999). However, an early study of community-rating in New York's individual market found a modest decline in the number of total persons covered and an increase in the proportion of near-elderly purchasing non-group coverage in that state, suggesting a shift toward higher-risk, and higher-cost individuals as the policy intended (Thorpe, 1999). The experience of Vermont, the other state with community rating (although some demographic variation is allowed by non-HMO carriers other than Blue Cross), does not provide evidence that rating reforms led to serious adverse selection, although the available data make this experience more difficult to evaluate (Hall, 2000a; Hall, 2000b).

More recent anecdotal observations about these markets suggest that over time strong regulations may lead to market dysfunction. The number of persons covered through the individual market in both New Jersey and New York has roughly halved since those states' reforms, while premiums and medical payments have continued to rise (unpublished data from the New Jersey Individual Health Coverage Board, 2001; Hall, 2000a; and Hall, 2000b). Some of this decline may be associated with the increase in economic growth and employment (and hence access to employment-based coverage) during the latter part of the 1990s. However, national Current Population Survey data reveal that the proportion of people covered in the individual market has remained fairly stable during the past decade, suggesting that the declines in these states are reform-related (United States Census Bureau, 1995-1999). Both New Jersey and New York use mechanisms to buffer carrier losses in the individual market. New Jersey's "play-or-pay" mechanism assures that losses are shared among

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carriers, and New York's Health Care Reform Act of 2000 allocated $20 million in annual subsidies for individual market carriers (Haslanger, 2000; and Healthcare Association of New York State, 2000). However, recent trends put in doubt the likelihood that these mechanisms will be sufficient to ensure vigorous and stable individual markets under community rating and guaranteed issue over the longer haul.

Small-group rating reforms have gradually tightened in states that have implemented them, but most have still maintained loose reforms, with many states allowing a 2:1 rating band between groups based on health status (Curtis, Lewis, Haugh, & Forland, 1999). Most states have been reluctant to impose pure community rating, and those that phased in community rating eventually backed off due to the strong opposition of employers that expected to pay higher prices as a result.

Impact on Premiums Is Unclear

There is very limited empirical literature demonstrating the relationship between small-group reforms and premiums. Early studies showed that rate restrictions and guaranteed issue of policies have raised the cost of insurance policies (IHPS, 1995; AAA, 1993). Another study found some evidence that extensive small-group reforms (e.g., guaranteed issue and renewal, rating reforms, and pre-existing condition constraints) may have been associated with premium increases of between 4 and 6 percent in small firms (Simon, 1999). However, a more recent study comparing states that had adopted small-group market reforms with those that had not, found no effect on premiums, variability in premiums, or the rate of change in premiums (Marquis and Long, 2001).

Reforms Have Not Led to an Increase in Self-insurance in Small-group Market

Marquis and Long found that tight small-group regulations did not cause an increase in self-insurance among small employers between 1993-1997, during which these reforms were legislated and implemented. The percent of small establishments that self-insure is fairly constant regardless of whether they are located in states with low, medium, or high degrees of small-group reform. The study concluded that market changes, such as the availability of low-cost HMO plans, were more important than regulatory changes as a determinant of self-insurance decisions (Marquis & Long, 1999).

Reforms Generally Do Not Lead to Reduced Competition Among Carriers in the Market

Early case studies of state insurance market reforms found that few carriers left the market after reform. In New Jersey, for example, health plans did not exit from the small-group market as a result of its pay-or-play requirement, and the number of carriers in the individual market increased significantly. In Minnesota, 43 percent of carriers exited the small group market the year following the implementation of reform, leaving 27 carriers, but most of those that left had small books of business (Institute for Health Policy Solutions, 1995). Two studies found a significant increase in HMO market share in the small-group and individual markets, suggesting a higher level of cost consciousness (Buchmueller & DiNardo, 1999; Institute for Health Policy Solutions, 1995).

Limited Evidence on Effect of Stop-Loss Provisions or Mandated Reinsurance

Reinsurance pools are state-sponsored mechanisms that reduce risk associated with providing coverage to high-risk individuals or groups. They allow individual insurers to group the high-risk people and their excess medical costs in a separate pool. Implemented in only a few states, they are funded by all insurers contributing a small fee for each person covered, which is then set aside to cover the costs of high-risk persons across plans. Stop-loss limits liability of coverage for single

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persons to a fixed amount. The separate effect of these components of insurance reform has not been studied (United States General Accounting Office, 1992).

High-Risk Pool Expansion

Rigorous studies evaluating the effectiveness of high-risk pools have not been conducted, yet some descriptive studies are informative. Twenty-nine states operate high-risk pools for three broad categories of individuals: the medically uninsurable, those eligible for coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Medicare beneficiaries who want supplemental insurance. Washington has the largest proportion of Medicare beneficiaries in its high-risk pool, as of June 30, 2000, 43 percent compared to 7.9 percent nationally, but is one of only six states that do not include HIPAA-eligibles (Achman & Chollet, 2001).

High-Risk Pools Represent Only a Small Portion of the Individual Insurance Market

A total of 1,897 individuals were enrolled in Washington's high risk pool as of 1999, which represented 0.3 percent of those enrolled in the individual insurance market. Some states have closed enrollment, and most states have waiting lists (Achman & Chollet, 2001). As a result of its small market share, any innovations in this area usually have only a very small effect on uninsurance rates (Riley & Yondorf, 2000). In addition, their small market share makes it difficult to detect the effects of high-risk pools on other health insurance markets using existing data sources.

High-Cost of Coverage May Be Barrier to Enrollment

Across states that have high-risk pools, approximately half of the high-risk pool claim costs are supported by beneficiary premiums, which range from 125-200 percent of the cost of standard-risk policies and may be unaffordable for many high-risk persons (Achman & Chollet, 2001). The remaining costs are typically covered by assessments on small group or all insurers based on their share of the private market, although some states also provide support through general funds or tobacco taxes. In 1999, the national annual average premium for high-risk pools was $3,083. Washington's high-risk pool had the lowest average annual premium of any state, at $1,832, or 4 percent of median household incomes. Although lower than the national average, this may still be unaffordable for many. Some states have provided income-related subsidies to reduce the financial burden for enrollees, but many have subsequently abandoned these programs (United States General Accounting Office, 1992). As of 2001, Washington has added special discounts to its high-risk pool program for enrollees aged 50-64 with incomes less than 300 percent of the federal poverty level and for those enrolled for more than three years.

Pools Are Expensive

In 1999, all state high-risk pools were operating at a loss, with a medical loss ratio ranging from 1.14 in Oklahoma to a high of 4.84 in Washington, indicating that the premiums collected from enrollees are not enough to cover the expense of their claims. The total cost per enrollee ranged from $3,610 to $11,145, with administrative costs accounting for less than 10 percent of total costs in the vast majority of pools. States need to creatively finance these pools, because they operate at a loss; Washington's financing has been highlighted as innovative because it assesses stop-loss and re-insurance carriers along with traditional health insurers (Achman & Chollet, 2001).

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Universal Catastrophic Coverage

There is no documented experience with a state-based universal catastrophic coverage program. The closest parallel is the Medicare program, which provides close to universal eligibility for the target population, no premiums for basic coverage in Medicare Part A, substantial deductibles, and group and individual supplemental markets with member premiums for non-covered expenses.

In the private sector, voluntary catastrophic coverage is a necessary component of medical savings account (MSA) programs, which have been tried on a limited basis. Although little empirical evidence is available on the success of these programs, early evaluation of the voluntary small-group and individual worker demonstrations that were authorized under HIPAA suggest that these models have had low rates of participation (United States General Accounting Office, 1997). The HIPAA demonstration model differs significantly from the universal catastrophic coverage option in that it was offered on a voluntary basis as one among several insurance options. The voluntary model leads to greater risk segmentation as the low-cost employees choose this option, increasing the cost of other plans offered. Estimates indicate that this voluntary model could increase premiums for high-risk persons remaining in their health plans by 60 percent (Thorpe, 1995). A universal state-subsidized model would avert this problem by offering the same coverage to all residents of the state. The state universal catastrophic model would enable Washington residents to choose from among a variety of approaches to covering non-catastrophic expenses, including possibly an MSA or more comprehensive coverage.

Depending on the specific design decisions made in implementing a universal catastrophic approach (e.g., scope of benefits and financing), the cost of health plans purchased by employers and families might be significantly reduced, making basic coverage more affordable and leading to a decline in the number of persons without coverage.

In Washington, the closest comparison is the state high-risk pool (WSHIP), which is also intended to make the commercial market viable and focuses on high-costs. However, this option differs significantly from the WSHIP in that it would cover high costs for almost all residents as opposed to covering all costs of a small, self-selected high-risk pool. Due to its limited benefit package and universality (that is, not a self-selected, high-risk population), the universal catastrophic model should offer a low cost per person compared to more comprehensive plans or plans that cover only high-risk persons (such as the WSHIP). The total cost to the state of the universal catastrophic model would depend on the financing mechanism and on the size of the population required to enroll.

Washington State Experience

Reforms affecting the individual and small-group markets in Washington have been largely incremental over the last decade and a half and focus primarily on the individual market, which has been particularly volatile. The state has taken some of the policy approaches indicated above to stabilize the individual market or to protect access to persons with high risk, including the creation of the WSHIP high-risk pool in the late 1980s and the imposition of guaranteed access and adjusted community-rating regulations for the individual and small-group market in the mid-1990s. In addition, Washington authorized "value" health insurance products by exempting some small-group products from state benefit mandates in the early 1990s. In its modified community rating for small groups, Washington has been more conservative in setting rating bands, allowing a 4:1 rating band

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between groups, based on health status, compared to the average of 2:1 in other states. With the exception of this and the three month pre-existing condition exclusion in effect until 2000, Washington regulations were not different from those found elsewhere, but the regulations are not linked across markets as in most other states. Most other states require that at least some categories of insurers participating in the state-regulated group market offer non-group coverage or contribute toward reimbursing the losses of carriers offering non-group products (Nichols, 1999).

The insurance market reforms of the 1990s contributed to a highly unstable individual market. By January 2000, private individual health insurance was unavailable in many of Washington's 39 counties. High and rapidly rising insurance premiums and health care expenditures loomed large after a brief period of respite, with growing losses among the larger carriers. The passage of the Health Insurance Reform Act in 2000 was intended to entice insurers back into the individual market by allowing health plans to screen out up to 8 percent of applicants deemed too sick to insure. These regulatory reforms have resulted in some health plans and carriers re-entering the market, but the premiums in the individual market have not fallen much as plans continue to set rates for new enrollees based on existing enrollee experience (Holahan & Pohl, 2002). In addition, the "screen-out" provision reinforces rather than reduces market segmentation, limiting the highest-risk individuals access to affordable coverage.

The critical issue for the state has been the ongoing difference of opinion between regulators and the industry in diagnosing the problem, which has made it difficult for the state to reach a consensus solution. These disagreements and clashing viewpoints doomed attempts in 1996 and 1997 to "fix" the individual market problem: to impose a pay-or-play requirement on all insurers in the group market to offer a BH-like product in the individual and small-group markets (rates not to exceed 105 percent of small group rates); to set up a reinsurance mechanism through the high-risk pool by assessing all health insurers, including stop-loss carriers; to dismantle modified community rating in the individual market; and to limit the Insurance Commissioner's power to set loss-ratio rules.

The instability in Washington's individual market has been attributed by insurers to adverse selection. Although the evidence is limited, some markers suggest that adverse selection was occurring. For example, the state's non-subsidized Basic Health (BH) plan, which covered maternity care after most commercial products had eliminated it, had maternity admissions about 2.5-3 times higher than the subsidized BH or state employees during the 1999-2000 period*. Basic Health is not technically part of the individual market segment. Nonetheless, the fact that BH non-subsidized premiums are comparable to those charged in the individual market under the reforms may indicate that adverse selection could also have driven up costs in the individual market.

Although the causes of dysfunction in the individual market are difficult to identify, one observer suggested that Washington's problems might stem in part from the de-linking of the individual and small-group markets: "Since the two states with no cross-market compulsion, Kentucky and Washington, unambiguously performed the worst under market reforms, one may reasonably infer that most states believed and found that requiring group insurers to offer individual coverage, even if only HMOs, imparts a stability to the individual market that may be prerequisite for reforms to be able to demonstrate how well they might work in the long run" (Nichols, 1999). Another observer identifies Washington's failure to use regulatory means to decrease market segmentation by benefit design as another fatal flaw (Kirk, 2000).

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* Interview with Dennis Martin, Washington State Health Care Authority, 2000.

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Implications

Some market and regulatory reform strategies, such as guaranteed issue and rating reforms, have been successful in protecting access to health insurance for high-risk groups but have had little documented effect on rates of health insurance coverage overall. Although expanding access for some groups, most of these strategies have had minimal effect on reducing the cost of coverage, a primary reason individuals or small groups do not purchase insurance. In general, based on the evidence it appears that:

- Benefit mandate relief is not likely to significantly reduce costs of insurance or increase coverage.
- Rating and enrollment regulations may improve access for high-risk persons and groups but have not reduced rates of uninsurance overall. These regulations appear to stabilize faltering markets and have provided affordable coverage to high-risk persons without serious adverse selection (except perhaps in the case of pure community rating in the individual market). Rating and enrollment regulations need to be coupled with mechanisms for fairly distributing risk in order for these reforms to be effective.
- In Washington, guaranteed access reforms did not result in the stabilization of the individual market, as measured by the number of carriers willing to participate in the market. Reasons for this are unclear, but some have suggested the lack of cross-market compulsion or failure to standardize benefit packages (thus decreasing market segmentation by benefit design). With the recent passage of HIRA in 2000, some carriers have reentered the market, but it is too early to assess the full effect on individual market stability.
- High-risk pools protect some high-risk individuals, but still exclude many because they are unaffordable. In Washington, the pool at its peak covered about 5,000 people; as of 2000 included approximately 2,200. The State's Health Insurance Reform Act of 2000 allows health insurers to screen out 8 percent of applicants for individual insurance who are deemed too sick to insure, with the expectation that excluded applicants may enroll in WSHIP. If WSHIP is unaffordable, this system could result in increased uninsurance rates in the future. In fact, since the screening program began in January 2001, only 240 of the 1,448 individuals rejected from individual coverage had signed up for the WSHIP pool as of June 2001 (Holahan and Pohl, 2002).
- Universal catastrophic coverage is a departure from existing approaches but has the potential to remove high-risk cases from insurance markets across the board. This option would likely significantly improve the affordability of basic coverage and reduce the number of uninsured. This approach would require significant new funding, enforcement mechanisms, and mechanisms to "capture" savings that it would generate for employers and safety net providers in order to provide subsidies for low-income families. Additional work assessing design options for a universal coverage option would more clearly identify the potential benefits and costs of this approach.

In summary, states have a range of regulatory options, including relief from mandated benefits, rating and enrollment reforms, high-risk pools, and other approaches. The evidence on reforms of these types suggests that they are not likely to have a major effect on the number of uninsured, but that some reforms are useful for stabilizing coverage markets and offering affordable coverage to high-risk persons. More sweeping, but untried approaches, such as universal, publicly financed,

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catastrophic coverage have the potential, in theory, to significantly reduce the number of uninsured, but the financing and design issues of such approaches are considerable.

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Appendix

Figure1. Individual and Small-Group Insurance Market Regulations

Reform	Description	Main Objectives
Regulation of whom carriers must cover		
Guaranteed Issue*	Policies must be open to all regardless of risk.	Increase access for high-risk persons.
Guaranteed Renewal*	Policies may not be canceled, except for cause (failure to pay premiums).	Increase access for high-risk persons and improve continuity of coverage.
Pre-existing Condition Restrictions*	Limits on the length of waiting periods that may be imposed for coverage of any medical condition	Increase access for high-risk persons.
Portability Protections	Special case of guaranteed issue and limitations of pre-existing condition limits for persons changing plans.	Increase access for high-risk persons and improve continuity of coverage.
Regulation of what carriers may charge		
Premium Rating Restrictions (i.e., rating bands, modified and pure community rating)	Limits or prohibits premium variation based on factors such as age, sex, or medical history.	Improve affordability of coverage for high-risk persons.
Minimum Loss Ratios	Requires carriers to pay a defined percentage of premiums collected on medical benefits.	Limit carrier profits.
Regulation of the distribution of risk among carriers		
Reinsurance Pools and Stop-loss Coverage	Insures carriers against large losses from high-risk clients by sharing losses across a large group of insurers. States may mandate participation, financed with insurer premiums or surcharges on covered lives.	Encourage or requires risk sharing among carriers.
Carrier Play-or-Pay Requirement	Requires carriers that sell coverage in the state to cover a share of persons in individual or small-group markets in proportion to their overall market share or pay to cover losses by other carriers.	Encourage competition and risk sharing among carriers.
Regulation to facilitate consumer choice and price competition		
Standardized Benefit Packages	Specified benefit package options, states may or may not restrict the market to standard plans.	Simplify consumer comparison shopping, encourage price competition, reduce risk selection.
Carrier Play-or-Pay Requirement	See above	See above

Sources: Adapted from Tapay and Feder 1999; Pauly and Percy 2000; and Swartz and Garnick 2000, GAO 1992.*

* Following state governments' lead, the federal government enacted comprehensive access reforms through the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA addresses only the availability of coverage not affordability, thus state rating rules have taken on increased importance (Curtis, 1999).

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