



HEALTH INSURANCE - COMMUNITY RATING & GUARANTEED ISSUE A BRIEFING PAPER

NOVEMBER 2008



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INTRODUCTION

According to the U.S. Census Bureau, 5.3 percent or 45.7 million people in the United States did not have health insurance in 2007. Using a three year average from 2005 to 2007, 21.9 percent of New Mexicans did not have health insurance. New Mexico had the second highest rate of people without health insurance in the nation.

State policymakers utilize regulatory approaches in an attempt to increase access to health insurance. Without legislative intervention, in a private health insurance market, insurers adopt practices that minimize their risk in order to avoid losses, including denial of coverage for high-risk individuals (e.g., older individual or those with health conditions).

This paper focuses on community rating and guaranteed issue regulations at the state level. Both types of regulations attempt to increase access to health insurance by ensuring that high-risk individuals are not denied coverage or charged premiums higher than they can afford. Presented in this paper are the findings of three studies conducted by three diverse entities, which examine the impacts of these state regulations on the individual health insurance market.

COMMUNITY RATING & GAURANTEED ISSUE DEFINED

Community Rating¹

Community rating requires everyone in the same “community” to be charged the same rate for health insurance and requires health insurers to ignore such cost factors as:

- Geography - Doctors and hospitals in different cities may charge different rates for the same services;
- Age - As their health needs increase with age, older people tend to be more expensive to insure;
- Sex - Women and men have different costs, depending on their age; and
- Health status - Those with health conditions cost more to insure.

There may also be other factors that are disallowed for consideration. The result is a single rate for all applicants. Adjusted community rating or modified community rating typically allows variation based on some or all demographic factors but not based on health status.

¹ Council for Affordable Health Insurance. (February 2008). *Short Cuts: Community Rating & Adjusted Community Rating*. Retrieved October 17, 2008, at http://www.cahi.org/cahi_content/resources/pdf/SCn101CommunityRating.pdf

Guaranteed Issue²

Guaranteed issue requires health insurers to accept any applicant for health insurance coverage even if the applicant has a serious medical condition. In the individual market, health insurers are not usually required to provide coverage on a guaranteed issue basis. There are some exceptions as outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and specific state laws. However, most people receive their health insurance from either government sources (around 27%) or employer sources (more than 60%). Health insurance coverage provided by government and to employees is almost always issued on a guaranteed issue basis. As a result, it is only the relatively small individual health insurance market (around 9%) that does not provide guaranteed issue rights.

In most states, community rating and guaranteed issue regulations are combined.

NEW MEXICO'S ADJUSTED COMMUNITY RATING

New Mexico imposes an adjusted community rating regulation on insurers. Section 59A-18-13.1. NMSA 1978 requires that every health insurer that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, gender, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment.

In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than 20 percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than 250 percent of the lower rate, except that the rates for children under the age of 19 or children aged 19 to 25 who are full-time students may be lower than the bottom rates in the 250 percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.

STUDIES ON THE IMPACTS OF STATE REFORMS ON THE INDIVIDUAL HEALTH INSURANCE MARKET

The following information is taken from three studies conducted by America's Health Insurance Plans in 2007; the U.S. Department of Health and Human Services in 2006;

2 Council for Affordable Health Insurance. (October 2007). *Short Cuts: Guaranteed Issue*. Retrieved October 17, 2008, at http://www.cahi.org/cahi_content/resources/pdf/SCN100GuaranteedIssue.pdf

and the Heritage Foundation in 2005. Each of these studies examined the impacts of state regulations on the individual health insurance market.

U.S. Department of Health and Human Services³

An August 2006 U.S. Department of Health and Human Services study entitled, *Effects of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market*, examined the relationship between expected medical expenses, individual insurance premiums, and the likelihood of obtaining individual insurance. The study tested for differences in these relationships between states with both community rating and guaranteed issue and states with no such regulations.

The results of the study indicate that the state community rating and guaranteed issue regulations in the individual market limited variation in premiums and coverage due to health conditions-related expense. In states with no such regulations, there was a negative effect of condition related expense on coverage and a positive effect on premiums. In states with these regulations, there was no significant effect of condition-related expense on either coverage or premiums. The study indicates that regulations made high-risk people relatively more likely to obtain coverage and pay lower premiums.

The main finding in the study was the extent of pooling of risks in the individual market in unregulated states. According to the study, the effect of doubling a household's condition-related expense implied, at most, a 15 percent increase in premiums. A low-risk person at the 10th percentile of risk was about 1.029-1.045 times as likely as an average-risk person to obtain coverage, while a high-risk person at the 90th percentile of risk was about 0.915-0.929 times as likely as an average-risk person to obtain coverage. The results implied a significant amount of pooling of health risks in unregulated markets.

The study did not find significant adverse consequences resulting from the implementation of community rating and guaranteed issue regulations; however, the study did find evidence supporting the substitution of some high-risk people with coverage for a larger number of low-risk people with coverage. According to the study, this could imply an overall increase in the number of uninsureds in the individual market as high as about 7.4 percent.

Overall, the results of the study indicate that the regulations produce a slight increase in the number of uninsured because increases in low-risk uninsureds more than offset decreases in high-risk uninsureds. Further, community rating and guaranteed issue regulations produce only small changes in risk pooling because the extent of pooling in the absence of regulation is substantial.

³ Herring, Bradley & Pauly, Mark. (August 2006). *The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market*. Retrieved October 20, 2008, from The U.S. Department of Health and Human Services at <http://aspe.hhs.gov/daltcp/reports/2006/HIMregs.pdf>

According to the authors, there are two problems with the current individual market that deserve more attention:

- 1.) The high administrative loading in the individual market results in high premiums for both high-risk and low-risk individuals alike.
- 2.) The tax subsidy available to employment based insurance but not generally available to those in the individual market results in an inherent instability of the latter since people will almost always prefer to obtain their coverage in the former.

The authors recommend that policymakers consider making the incentives for obtaining individual versus group insurance neutral. Consumers should obtain their insurance where it is more efficient for them to do so. An increase in the number of people actually using the individual market that could result from eliminating this inequity will likely have then byproduct of reducing its high administrative loading as the market grows in size.

The Heritage Foundation⁴

The Heritage Foundation is a research and educational institute whose mission is to formulate and promote conservative public policies based on the principles of free enterprise, limited government, individual freedom, traditional American values, and a strong national defense.

An October 2005 study by The Heritage Foundation entitled, *The Effect of State Regulations on Health Insurance Premiums: A Preliminary Analysis*, looked at the costs of identical health insurance plans across various states and analyzed a wide range of insurance regulations. The study focused on four sets of regulations that affect health insurance premiums: mandated benefits, health plan liability, direct-access-to-specialists, and provider due process. The average health insurance premiums in states that have these types of regulations were compared to the average premiums in states without such regulations. Since the average state has 26 mandated benefits, health premiums in states with more than 26 mandated benefits were compared to insurance premiums in states with 26 or fewer mandated benefits.

The study found that premiums tended to be higher in states that regulate more heavily. On average, states with health plan liability laws, direct-access-to-specialist laws, and provider due process mandates had higher health insurance premiums than states without these regulations. States with more than 26 mandated benefits had higher premiums than states with 26 or fewer benefits.

⁴ New, Michael. (October 2005). *The Effect of State Regulations on Health Insurance Premiums: A Preliminary Analysis*. Retrieved October 20, 2008, from The Heritage Foundation, at <http://www.heritage.org/Research/HealthCare/cda05-07.cfm>

The study was furthered through regression analysis, which allowed for the isolation of the effects of each individual type of regulation by “holding constant” other factors. Four sets of regressions were run. In each regression, indicator variables were included to hold constant the price differences among the different types of plans.

Overall, the results provided solid evidence that state-level regulations of health insurance are correlated with higher premiums. The regression model estimated that the presence of health plan liability laws increased monthly premiums by \$26.72. Laws that give subscribers direct access to specialists increased monthly premiums by \$33.10. Provider due process laws increased premiums by \$22.49. Finally, each additional mandated benefit increased monthly premiums by \$0.89.

America’s Health Insurance Plans⁵

America’s Health Insurance Plans (AHIP) is a national association representing nearly 1,300 member companies providing health insurance coverage to more than 200 million Americans. Member companies offer medical insurance, long-term care insurance, disability income insurance, dental insurance, supplemental insurance, stop-loss insurance and reinsurance to consumers, employers and public purchasers.

An August 2007 study by AHIP entitled, *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*, looked at guaranteed issue and community rating reforms adopted in eight states (Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont and Washington) in the 1990s. The study also looked at the impact of these reforms on the individual insurance market.

Most of the eight states studied enacted various versions of guaranteed issue and community rating reforms. The goal of such reforms in the individual market was 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. According to the study, however, the reforms often resulted in unintended consequences.

AHIP’s study indicates that 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. As a result, younger or healthier individuals may choose not to purchase health insurance.

According to the study, in an environment with such reforms, individuals that purchase insurance can have higher than average medical costs. As a result, the insurance pool

⁵ Wachenheim, Leigh & Leida, Hans. (August 2007). *The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets*. Retrieved October 20, 2008, from America’s Health Insurance Plans at <http://www.ahip.org/content/default.aspx?docid=20736>

will have higher costs per member, and premiums tend to increase. Increasing premium rates drive low risk policyholders from the insurance pool, which leads to further rate increases. If the trend continues, it results in an antiselection spiral where the pool or market shrinks to include only the higher risk population.

Overall, the study indicates that although results varied among the eight states, in general, individual health insurance markets deteriorated after the introduction of guaranteed issue and community rating 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 tended to decrease, and premium rates tended to increase. The study did not observe any significant decreases in the level of uninsured as a result of the market reforms.

STATE EXPERIENCES WITH COMMUNITY RATING AND GUARANTEED ISSUE REGULATIONS

As indicated by the AHIP study, Kentucky and New Hampshire have since repealed their guaranteed issue and community rating laws, and Washington has significantly weakened its laws. The experiences of these three states are set forth below.

Kentucky

According to a 1998 research memorandum by the Kentucky Legislative Research Commission, in 1994, the Kentucky General Assembly passed legislation to increase access to health insurance. The legislation primarily affected health insurance policies sold directly to individuals and employer groups with fewer than 100 employees. The most significant provisions of the legislation required health insurers to sell a policy to anyone who applied for coverage (guaranteed issue), prohibited rating on health status and gender (modified community rating) mandated standard benefit plans, and created a state health purchasing alliance to expand buyer power.

The legislation did not affect everyone insured under an individual or small-group policy. An executive order from Governor Paul Patton temporarily allowed holders of any individual or small-group policy prior to July 1995 the right to renew their existing benefit plan at the existing price. Therefore, these policies did not come under the reforms of the 1994 legislation. Initially, the freeze was to last until July of 1996; however, additional orders were issued that extended the freeze until December of 1997.

During the 1996 regular session, the Kentucky General Assembly made further changes to the 1994 reforms. The 1996 legislation redefined small groups so that employers with 50 to 99 employees were no longer considered small groups. Policies sold to these groups were no longer subject to guaranteed issue or restrictions on rating. The 1996 legislation also changed the rating restrictions imposed by the initial reforms. Companies providing individual and small group policies could now rate on gender. Also, the rating spread for age was increased. However, the most substantial change to

the reforms was the exclusion of insurance policies sold through associations from the rating restrictions.

In June and July of 1995, most of the health insurance carriers stopped selling individual policies in Kentucky. Over 40 companies were said to have left the market. As of January 1998, individual coverage was only available through Kentucky Kare3 and Blue Cross /Blue Shield in Kentucky. Although most of the insurance companies left the individual market, they accounted for a relatively small share of the covered lives in the individual market. The most common explanation for why companies left the market was that companies were not making a profit in the individual market. Low profits may have been caused by the rating restrictions limiting premiums or the regulatory constraints increasing costs.⁶

In 1998, Kentucky passed legislation that allowed more rating flexibility. The legislature was not in session in 1999, but in 2000, legislation was passed, which amongst other things, established a high-risk pool, eliminated the guaranteed-issue mandate, and broadened the rate band.

New Hampshire⁷

In 1994, in response to concerns about access to, and fairness in rating of, health insurance for small employer groups the New Hampshire Legislature passed legislation that required, for employer groups with up to 100 employees:

- **Guaranteed issue:** no group could be denied insurance from any insurer selling in the small group market.
- **Guaranteed renewability:** once a health policy was purchased, the insurer was generally required to renew the policy at the option of the insured.
- **Portability:** Anyone with a preexisting condition who changed employers and therefore insurers would have his or her period of coverage with the previous carrier applied as a credit against the succeeding carrier's preexisting condition exclusion period.
- **Limitations on preexisting condition exclusion periods:** benefits had to be provided for all preexisting conditions for an insured whose policy had been in effect for at least nine months.
- **Modified community rating:** insurers were allowed to use only age and size of group to differentiate prices between employer groups.

The legislature later became concerned that the 1994 legislation may have gone too far in restricting health insurer practices and in spreading costs to younger, healthier individuals and groups. Another consequence of the law was that a number of insurers had exited the New Hampshire market, as they saw it as less desirable for doing

6 Clark, Mike & Wilson, Ginny. (January 1998). *Status of the Health Insurance Market in Kentucky*. Research Memorandum No. 480, Legislative Research Commission. Retrieved November 17, 2008 from The Kentucky Legislative Research Commission at <http://www.lrc.state.ky.us/lrcpubs/Rm480.pdf>

7 Rhode Island Office of the Health Insurance Commissioner. (February 2006). Report to Joint Committee on Health Care Oversight. Retrieved November 19, 2008, at http://www.dbr.state.ri.us/documents/divisions/healthinsurance/HI-060227_NH_Reforms.pdf

business. As a result, in 2003, the New Hampshire legislature passed legislation, which re-introduced underwriting practices that had been prohibited since 1994 and reduced the scope of the earlier reforms to groups of up to 50. The effect of the legislation was to allow greater segregation of the insured market and less spreading of costs.

Again, the New Hampshire legislature became concerned with the effect of the reforms on variation in small group health insurance rates. Legislators saw increases in rates paid by older, less healthy groups as unacceptable. As a result, in 2005, the New Hampshire legislature passed legislation, which scaled back permissible underwriting practices. In addition, they created a reinsurance mechanism to address carrier concerns about risk exposure in an environment that required guaranteed issue and greatly limited carrier rate flexibility. The reinsurance mechanisms allowed for the costs of the highest-risk cases to be spread across all carriers.

Washington⁸

The Washington Policy Center (WPC) is an independent, non-partisan, research and education organization located in Seattle, Washington.

According to the WPC, in 1993, the Washington State legislature passed health care reform legislation called the Washington State Health Plan. The intent of the health plan was to provide universal coverage for all Washington residents. The plan required all state residents that were not in the Medicare program to join a managed competition plan. The plan included caps on insurance premiums, community ratings and universal access, mandates on employers and individuals, a guaranteed issue law, and increased emphasis on public health and prevention.

The guaranteed issue law required insurers to sell their product to anyone, regardless of medical risk or pre-existing health conditions. The community rating law required premiums charged by an insurance company to be an average of all premiums (for sick and healthy, young and old, etc.) in a given region. Exceptions were allowed for some factors, such as age, but the required community rating bands worked as a price control.

As a result of the 1993 health care reform, 14 health insurance carriers left the state and the few remaining insurance companies were forced to raise their rates by up to 40 percent. The number of uninsured in Washington rose by 20 percent, as people were forced to drop policies they could no longer afford. The state began attracting sick patients from all over the country because of the guaranteed issue provision.

Most elements of the reform plan were repealed; however, the guaranteed issue law, though modified, remains in place.

⁸ Stark, Roger. (August 2008). *What Works and What Doesn't: A Review of Health Care Reforms in the States*. Retrieved November 18, 2008, from The Washington Policy Center at <http://www.washingtonpolicy.org/Centers/healthcare/policybrief/StateHealthCareReforms.pdf>

GUARANTEED ISSUE REGULATIONS BY STATE⁹

Health insurance sold on a guaranteed issue basis cannot turn applicants down based on health or risk status. According to the Henry J. Kaiser Family Foundation (Kaiser), as of December 2007, Maine, Massachusetts, New Jersey, New York, and Vermont required that all individual health insurance policies be offered to all residents on a guaranteed issue basis. Kaiser reported the following guaranteed issue regulations by state.

Individual Market Guaranteed Issue (Not Applicable to HIPPA Eligible Individuals), 2007					
	All Insurers Must Guaranteed Issue All Products?	All Insurers Must Guaranteed Issue Some Products?	Insurers of Last Resort?	High-risk Pool for Medically Eligible?	Guaranteed Issue Comments
United States	NA	NA	NA	NA	NA
Alabama	No	No	No	No	
Alaska	No	No	No	Yes	
Arizona	No	No	No	No	
Arkansas	No	No	No	Yes	
California	No	Yes, continuously for some individuals	No	Yes	Individual market insurers and HMOs must guarantee issue a standardized policy to those exhausting High-risk Pool coverage (36 months).
Colorado	No	No	No	Yes	
Connecticut	No	No	No	Yes	The high-risk pool is available for all qualified applicants, not just those that are medically eligible.
Delaware	No	No	No	No	
District of Columbia	No	No	Blue Cross Blue Shield	No	
Florida	No	No	No	No	
Georgia	No	No	No	No	
Hawaii	No	No	No	No	
Idaho	No	Yes, continuously for some individuals	No	No	Individual market insurers must guarantee issue standardized policies to the medically uninsurable. Insurers must offer basic, standard and catastrophic policies. These policies are called High-risk Pool Policies.
Illinois	No	No	No	Yes	
Indiana	No	No	No	Yes	
Iowa	No	No	No	Yes	
Kansas	No	No	No	Yes	
Kentucky	No	No	No	Yes	
Louisiana	No	No	No	Yes	
Maine	Continuous for all individuals	No	No	No	
Maryland	No	No	No	Yes	
Massachusetts	Continuous for all individuals	No	No	No	
Michigan	No	Yes, periodically for some plans and for all individuals	Blue Cross Blue Shield	No	HMOs, after 24 months in existence, are required to guarantee issue to a limited number of applicants during one, 30 day open enrollment per year.
Minnesota	No	No	No	Yes	

⁹ Henry J. Kaiser Family Foundation. (December 2007). State Health Facts, Individual Market Guaranteed Issue. Retrieved October 27, 2008, at <http://www.statehealthfacts.org/comparetable.jsp?ind=353&cat=7&sub=87&yr=18&typ=5&sort=567>

Mississippi	No	No	No	Yes	
Missouri	No	No	No	Yes	
Montana	No	No	No	Yes	
Nebraska	No	No	No	Yes	
Nevada	No	No	No	No	
New Hampshire	No	No	No	Yes	
New Jersey	Continuous for all individuals	No	No	No	
New Mexico	No	No	No	Yes	
New York	Continuous for all individuals	No	No	No	
North Carolina	No	No	Blue Cross Blue Shield	No	
North Dakota	No	No	No	Yes	
Ohio	No	Yes, periodically for all individuals	No	No	Individual market insurers must guarantee issue standardized policies on a periodic basis. Non-HMOs are required to guarantee issue standardized policies (up to a limited number determined of enrollees as determined by the state) for one 30 day period, annually. HMOs are required to guarantee issue standardized policies annually until reaching a state determined limited number. For HMOs, this period could extend beyond 30 days.
Oklahoma	No	No	No	Yes	
Oregon	No	Yes, continuously for some individuals	No	Yes	Individual market insurers must guaranteed issue portability policies to individuals with 6 months of prior coverage.
Pennsylvania	No	No	Blue Cross Blue Shield	No	
Rhode Island	No	Yes, continuously for some individuals	Blue Cross Blue Shield	No	Individual market insurers must guarantee issue all products to those with 12 months of continuous creditable coverage, provided the applicant is not eligible for alternative group coverage, Medicare or any other state health insurance plan.
South Carolina	No	No	No	Yes	
South Dakota	No	No	No	Yes	
Tennessee	No	No	No	Yes	
Texas	No	No	No	Yes	
Utah	No	Yes, continuously for some individuals	No	Yes	Individual market insurers that have not met enrollment cap must guarantee issue at least one individual market policy to those that are otherwise not eligible for any other type of health insurance coverage (i.e. group, HRP, etc..)
Vermont	Continuous for all individuals	No	No	No	
Virginia	No	No	Blue Cross Blue Shield	No	
Washington	Continuous for some individuals	No	No	Yes	Insurers in the individual market must guarantee issue all products to applicants achieving a minimum score on a state mandated health status questionnaire (or health screen). Those applicants, not eligible for guaranteed issue plans, are referred to the high-risk pool.
West Virginia	No	Yes, periodically for some plans for all individuals	No	Yes	HMOs with greater than 5 years in the market or with enrollment not less than 50,000, must guarantee issue during annual 30 day open enrollment period.
Wisconsin	No	No	No	Yes	
Note: This chart is not applicable to HIPAA eligible individuals. For rules that apply to HIPAA eligible individuals refer to HIPAA Rules.					
Source: Data as of December 2007. Data compiled through review of state laws and regulations and interviews with state health insurance regulatory staff.					
http://www.statehealthfacts.org/comparetable.jsp?ind=353&cat=7&sub=87&yr=18&typ=5&sort=567					

CONCLUDING LESSONS FROM STATE REFORMS OF THE 1990s¹⁰

As stated earlier in this paper, in the 1990s, states enacted individual market reforms 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.

In 2004, the Robert Wood Johnson Foundation (RWJF) produced a research synthesis entitled, *Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s*. The synthesis weighs available research findings, draws conclusions based on those findings, and notes where evidence is lacking or inconclusive. The synthesis draws primarily from studies that meet professionally accepted standards for social science research; however, other studies that may not be as strong methodologically but have helped influence how people think about state insurance reforms are also examined. The following are lessons or findings from RWJF's research synthesis on the state reforms of the 1990's:

- In states with comprehensive underwriting reforms (guaranteed issue combined with guaranteed renewability and strict limits on pre-existing condition exclusions), individual insurance became more available for purchase.
- Comprehensive reforms resulted in some carriers leaving the individual market, particularly in states where guaranteed issue was combined with community rating, and possibly fueled faster HMO penetration.
- Coverage was not necessarily available to everyone, even in states with guaranteed issue. Most states did not require guaranteed issue of every policy an insurer offered and some permitted insurers to impose a prior coverage requirement.
- Average premiums and premiums paid by healthier people increased in states with comprehensive reforms (community rating combined with guaranteed issue), while premiums paid by unhealthy or high-risk people decreased. Premium increases were more modest when reforms were phased in. Less aggressive reforms, such as rating bands, had no clear effect on premiums.
- Reforms that make insurance more available and affordable for high-risk people can increase adverse selection problems for insurers. Adverse selection did occur after community rating was introduced, but not as much as expected, in part due to risk-spreading mechanisms and because many unhealthy or high-risk people still could not afford coverage.

¹⁰ Fuchs, Beth. (June 2004). *Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s*. Retrieved November 13, 2008, from The Robert Wood Johnson Foundation at <http://www.rwjf.org/pr/product.jsp?id=20114>

- Although policies were more available for purchase, more people did not necessarily buy them. States with comprehensive reforms (including a combination of guaranteed issue, community rating and other rating restrictions) experienced a decrease, not an increase, in overall coverage rates.
- States with less comprehensive reforms experienced modest or no changes in coverage rates. Limited evidence suggests that high-risk people were more likely to obtain coverage in states with reforms.

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