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Effects of State Non-Group Health Insurance Market Reforms on Market Stability and Effectiveness

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Ten states enacted guaranteed issue and community rating laws prior to the Patient Protection and Affordable Care Act (PPACA). Massachusetts was the only state to also enact and fully implement an individual mandate. The remaining 9 states that implemented guaranteed issue and community rating reforms without an individual mandate did not achieve their market participation or insurance coverage goals. Most reform states experienced (1) political pushback that added uncertainty to the regulatory environment, (2) a flight of insurers from the individual market, (3) increased premiums, (4) declining or stagnating enrollment in insurance plans, and (5) adverse selection.[1–4] Researchers attribute these overall negative market outcomes to the absence of an individual mandate and insufficient subsidies to support individuals to purchase insurance.[3,5,6] Specific policies that states enacted and the status of their pre-reform markets significantly affected how each state's insurance market reacted to reform.

Variation in state reforms

No two states enacted the same set of insurance reform policies, and the pre-reform status and condition of insurance markets differed across states. In addition to guaranteed issue and community rating, state reform policies included risk adjustment mechanisms, standard benefits, and individual subsidies.

Political instability introduces insurance market uncertainty

Most states experienced intense politicking after enacting reforms, and ultimately repealed or rolled back reforms; in many cases these rollbacks occurred before reforms could take full effect.[2,4] These rollbacks increased uncertainty in the marketplace, causing insurers to leave the individual market. Several states phased-in their health insurance reforms over a number of years, which created additional market uncertainty.

Key Terms

Guaranteed issue: Guaranteed issue laws mandate that insurers issue health care plans to all individuals regardless of health status.[4]

Community rating: Community rating laws restrict the amount insurers can vary rates based on health status, or individual or community characteristics (e.g., age, gender, location).[4]

Adverse selection: Adverse selection (from the perspective of an insurer) is when an insurance pool (e.g., for a specific insurance product or insurance company) has too many people who need care and too few healthy people.

Moral hazard: Moral hazard refers to the risk assessment healthy vs. unhealthy individuals make when they determine whether it is in their best interest to purchase insurance. People who expect to use more medical services are more likely to buy health insurance than those who expect to not need services.[1]

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Director: Michelle Garrison, PhD

Evidence about state insurance market reforms

Studies indicate that the individual insurance market in each reform state deteriorated after the introduction of guaranteed issue and community rating policies.[2,4,5] These laws destabilized states' direct-purchase markets: premiums increased, enrollment declined, and insurers exited the market.[2,4] While it is unclear whether the number of insurers in a market is an accurate measure of market health, the exit of insurers was an unintended effect of health reform in these states. Most insurance companies chose to stop selling individual insurance after reforms, decreasing competition and choice in the individual market. Most reform states experienced a significant loss in the number of individual insurers post-reform. Kentucky, for example, which enacted reforms in 1994, lost more than 40 insurers by January of 1998; prior to Kentucky's 1998 and 2001 reform repeals, only two insurers remained in the individual market.[3,4]

Adverse selection is more evident in non-group insurance markets in states that implemented community rating in the 1990s. Charging all policyholders similar rates regardless of health and age increases the rates for younger or healthier individuals and decreases the rates for older or less healthy individuals. The idea is that this cross-subsidy is "fair" over the long term, as young and healthy insureds tend to become old and sick insureds. State experience shows that more individuals with lower health status and higher care costs purchased insurance in the reformed market, while fewer healthy and less costly individuals did.[7] Guaranteed issue can have similar effects.[4] Figure 1 illustrates how in reform states with community rating the rate of covered unhealthy individuals increased while the rate of covered healthy individuals decreased.[7]

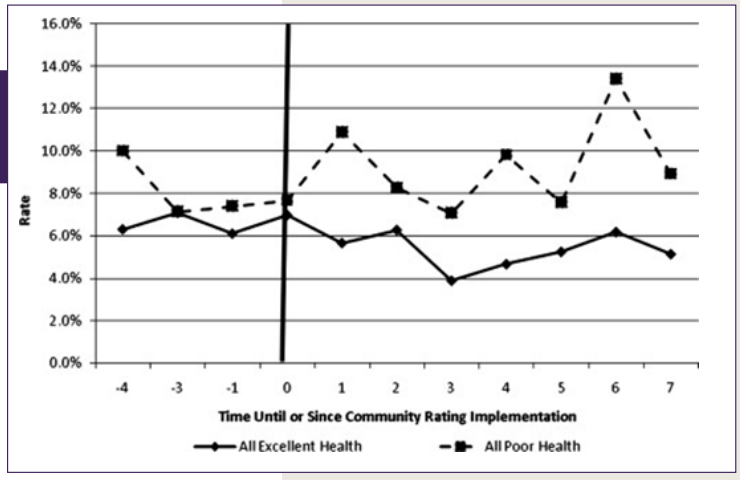


Figure 1:
Adverse selection in non-group coverage in community rated states[7]

With the increase of adverse selection, most reform states experienced a rise in premiums. In the period 3-7 years after New Jersey's reforms, older, more costly individuals enrolled in coverage, and premiums rose by 155%. Overall enrollment declined by 41 percent during that same period.[8,9] Maine experienced an annual rate increase of at least 25% in 1998-1999, five years after reform, and increases between 30% and 64% in 2000.[4] New York also experienced substantial and continuing rate hikes; rates remained high until the PPACA. Some major New York insurers increased premium rates 35-40% following reforms; one carrier in New York City was charging $1,299 a month for individual coverage in 2012, "nearly three times the unsubsidized price of the 2017 PPACA benchmark plan."[3]

Findings

PEOPLE WITH HDHPs ARE SIGNIFICANTLY MORE LIKELY TO REPORT EXPERIENCING HEALTH CARE-RELATED FINANCIAL BURDEN THAN PEOPLE IN TRADITIONAL INSURANCE PLANS.

Many states implemented reforms with the goal of increasing the number of individual health insurance policyholders.[4] Although the average share of uninsured individuals in reform states trended lower than the national average, this difference was not significant.[4] Most states saw nonelderly uninsured rates similar to pre-reform levels. Several reform states saw significant declines in enrollment,[4] likely due to premium increases.

Figure 2:
New York State percent uninsured under the age of 65 before and after reforms.[4]

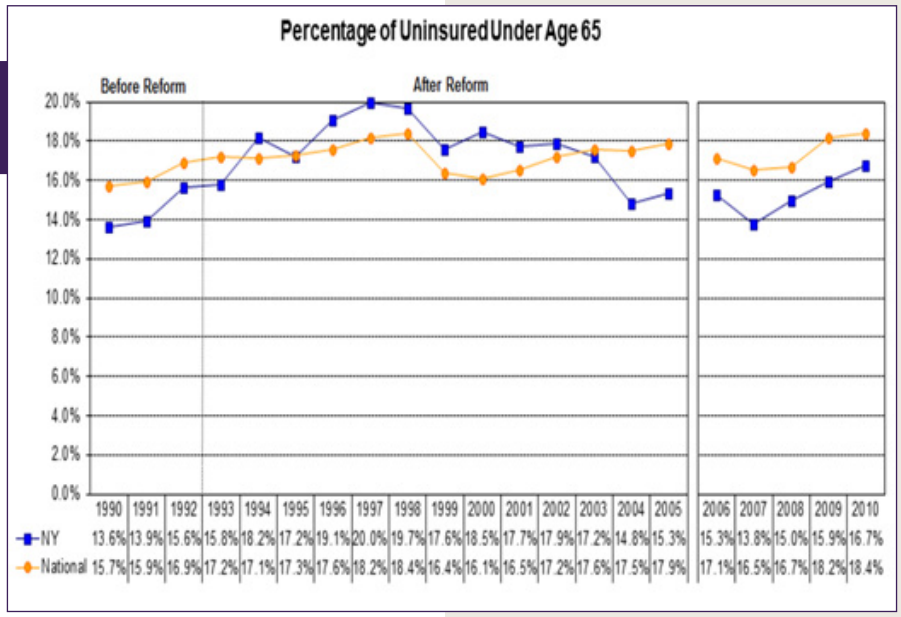


Figure 3:
Vermont percent uninsured under the age of 65 before and after reforms.[4]

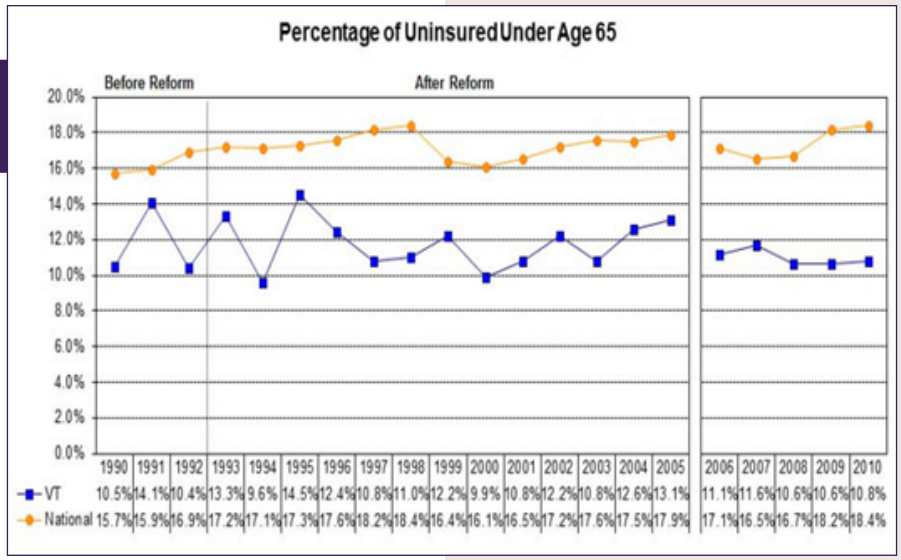


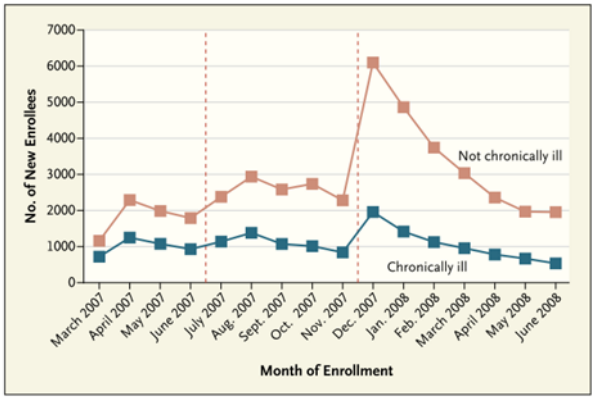
Figure 2 (New York) and Figure 3 (Vermont) illustrate how the percentage of uninsured under the age of 65 differed from the national average. In New York, similar to New Jersey, the percentage uninsured spiked above the national average after reforms, and in the long term trended just below the national average. In Maine, similar to Vermont and New Hampshire, the percentage uninsured was much lower than the national average before and after reforms, and they experienced spikes and turbulent uninsured rates directly after reforms.

For the most part, reforms did not significantly affect uninsured rates. By 2010 Maine and Massachusetts were the only reform states to decrease uninsured rates from pre-reform levels.[4]

Massachusetts – Added value of the individual mandate and subsidies

The evidence from states that instituted individual insurance market reforms shows that healthy people are key to market stability.[4]

Figure 4:
Number of healthy versus unhealthy new enrollees in Massachusetts' Commonwealth Care[5]



Number of New Enrollees in Commonwealth Care, According to Chronic-Illness Status.
The two vertical dashed lines represent the start of the mandate phase-in period (from July through November 2007) and the start of the period when the mandate became fully operational (from December 2007 onward)

Massachusetts presents a unique case study given that its individual mandate did not take effect until after the implementation of guaranteed issue and community rating. With just guaranteed issue and community rating laws, Massachusetts' least healthy individuals enrolled first. These individuals were "on average four years older, almost 50% more likely to be chronically ill, and had about 45% higher costs than those who enrolled after the mandate was fully implemented."[9]

The Massachusetts individual mandate by itself contributed most to increasing enrollment and coverage.[10] Massachusetts, however, also heavily subsidized insurance for nearly a year before mandating insurance coverage. Massachusetts offered substantially more subsidies to individuals than the PPACA. Adults with incomes between 150 and 200% of the poverty level were asked to contribute $35 per month, at 200- 250% of the poverty level monthly contributions were $70, and at 250- 300% of the poverty level contributions were $105 per month.[5]

Healthy individuals increasingly enrolled as subsidies became available. However, the large jump in healthy enrollees that occurred when the program was fully implemented suggests that the mandate had a causal role in healthy individuals' enrollment.[5] Figure 4 illustrates the number of healthy versus unhealthy new enrollees in Massachusetts' Commonwealth Care.[5] When the mandate fully took effect the bump in unhealthy enrollees was much smaller than healthy enrollees. Massachusetts enrollment outcomes suggest that the smaller the subsidy, the more important the mandate. The individual mandate and subsidies for individuals to buy insurance are critical for encouraging market participation.[5,9]

Conclusion

Guaranteed issue laws ensure the availability of health care plans to all individuals regardless of health status. Community rating laws ensure health care plans are equitably priced. Most states that reformed their health care insurance markets prior to the PPACA to include these policies experienced neutral or negative individual market outcomes. The Massachusetts example strongly suggests that individual mandate and individual subsidies are critical to the success of these health insurance reforms. Repealing the PPACA's individual mandate or eliminating or reducing individual subsidies may result in adverse selection, enrollment declines, insurers exiting the individual market, and premium increases. Policy and market uncertainty alone could contribute to similar outcomes.

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