THE REGULATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET

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Introduction

Although the majority of Americans with health insurance obtain their coverage through group health plans offered through their employers, many individuals obtain their coverage through the nongroup (or individual) insurance market. Currently almost 18 million persons, or almost seven percent of the United States nonelderly (under age 65) population, obtain coverage through individual plans purchased directly from insurance issuers.

Several initiatives at the state and federal level, as well as policy proposals involving health system reforms, have proposed utilizing the individual health insurance market as a means of expanding access to affordable health insurance policies. While health insurance purchased in the individual market has the advantages of being portable (not tied to a person's employment) and potentially being a better match to a person's preferences for health coverage than policies purchased through group plans, it does have aspects of significant concern. Among these concerns is how laws and regulations surrounding the individual health insurance market affect its ability to meet various population needs. It is necessary to understand these issues to determine how market reforms would interact with these policies.

Insurers marketing health plans in the individual market use approaches different from those used in the group insurance market to examine insurance applicants. One such approach is that of medical underwriting to identify applicants according to their health status. Some applicants may be categorized as likely to cost the insurer more in claims than a healthier person, resulting in insurers charging them higher premiums or restricting or denying coverage. Other differences between the group and individual market involve the application of different state versus federal regulations in the marketing of products, and other accountability requirements of entities selling individual policies.

In reviewing how insurance is regulated, it is important to keep in mind an understanding of what insurance is and why it is regulated. This has been expressed rather succinctly in an introduction to a recent paper on insurance regulation (Kofman and Pollitz, 2006):

> Health insurance serves several public policy goals: it enables consumers to spread the risk of health care expenses and provides them access to medical services that they might otherwise not be able to obtain. Because of the importance of health insurance to the general public welfare, states have been regulating private health insurance companies and products since the

late 19th century. State insurance regulation has sought to promote several policy objectives, such as ensuring the financial solvency of insurance companies, promoting the spread of risk, protecting consumers against fraud and ensuring that consumers are paid the benefits that they are promised.

Health reform initiatives can choose to work within these constraints or change the rules to facilitate the success of health policy options.

Background

The business of insurance, including health insurance, has traditionally been regulated at the state level. States license entities that offer health insurance coverage and have established laws that control their structure, finances, and obligations to the people that they insure. However, a number of federal laws also have an impact on private insurance coverage, most notably the Employee Retirement Income Security Act (ERISA) of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[1]

In 1945, preceding ERISA and HIPAA, the McCarran-Ferguson Act restored the primary role of states in regulating the business of insurance. Passage of McCarran-Ferguson was prompted by state and industry concern over a U.S. Supreme Court decision rendered in 1944 (U.S. v. South-Eastern Underwriters Assn., 322 U.S. 533 (1944)) which held that insurers that conducted a substantial part of their business across state lines were engaged in interstate commerce and thereby subject to federal antitrust laws. McCarran-Ferguson provided that the "business of insurance, and every person engaged therein, shall be subject to the laws of the several States…" The act specified that federal law that does not specifically regulate the business of insurance will not preempt a state law enacted for that purpose. States regulate individual insurance products differently from group insurance products. Additionally, the regulation of small group business policies may be subject to some regulations that do not apply to larger groups.

[1] ERISA outlines minimum federal standards for private employer-sponsored benefits such as requiring a plan administrator to provide a summary of plan benefits to employees, file annual reports, maintain procedures for claiming benefits and provide administrative and judicial remedies for beneficiaries. HIPAA was enacted to address concerns that insured persons have about losing their coverage if they change jobs or health plans. HIPAA established federal requirements to ensure the availability and renewability of coverage for certain employees and other persons under certain circumstances.

This paper will concentrate on individual health insurance regulations, with reference to the group market where necessary to differentiate practices and/or processes. The paper will discuss some of the major areas of state regulation, trends in the number of states with various regulations, and some of the effects of these regulations on health insurance coverage, costs and access.

Major Regulations

Every state has adopted certain basic standards for health insurance that apply to all types of health insurance products. These standards protect consumers by requiring insurers to be financially solvent and capable of paying claims, pay claims promptly, and adhere to certain market conduct requirements. Regulation begins with the licensing of entities that sell insurance within the state. Licensing involves reviews of finances, management, and business practices to ensure an entity can provide coverage promised to policyholders. States also license agents and brokers who sell insurance within the state.

Examples of several financial standards include periodic financial reporting and minimum capital requirements, or amount of net worth that an insuring organization must have in order to operate. This minimum must be available to pay for claims submitted by policyholders. States also examine investment practices and may perform on-site financial examinations. As another measure of financial protection for policyholders, states have established guaranty funds which are non-profit organizations set up to pay claims of insurers that become insolvent. These non-profit organizations are created by statute and financed by imposing assessments on insurers in the market.

Market conduct requirements relate to claims and underwriting practices, advertising, marketing, rescissions of coverage, and payment of claims. These allow states to address unfair trade and claims practices, such as failure to pay claims fairly or promptly, and perform market conduct examinations to make sure insurers are complying with state regulations such as describing products accurately, avoiding deceptive advertising, and using sound actuarial principles to price products. Insurers must adhere to requirements of prompt claim payment and claims appeals processes. They must also have policy forms (i.e. the documents that establish the contractual relationship between the insurer and purchaser) reviewed and/or approved by the state to conform to standards of definition and

content. Most often, states review forms issued to individuals and small groups, presuming larger groups are more knowledgeable and need less state oversight.

Other aspects of regulating the business of insurance vary by state and by type of coverage. Although most states have instituted patient protection laws like access to emergency services and specialists, these standards vary by state. An example of state variation exists with external review laws[2]; while most states have external review laws, different standards exist as to the types of disputes eligible for review, the amount of applicable fees, filing time frames, etc.

Other types of health insurance regulations that can vary by state can be grouped into several major areas including access to health insurance, rating, and covered benefits. The following paragraphs describe these regulations as they apply to the individual insurance market.

Access

States have sought to improve access to insurance policies through several regulatory approaches. Absent state individual insurance regulation, insurers in the individual insurance market adopt practices that seek to minimize risk to avoid losses, including denial of coverage for applicants who have health conditions or a history of health problems. Because most health care expenses are concentrated in a relatively small percentage of individuals, even a small number of high cost individuals can substantially impact overall insurance results (benefit costs, administration, profitability, etc.) in a particular group of individuals with the same insurance policy. As a result, an estimated 10 percent of individual insurance applicants are denied coverage for some medical reason(s) (AHIP, 2007).

[2] External review laws provide consumers with a mechanism to resolve coverage disputes when a health insurance plan determines that a proposed service or treatment does not meet medical necessity criteria or is experimental or investigational. Typically, external review programs are operated by a state's Department of Insurance, and apply to health insurance plans regulated by the state. While state regulators usually determine the eligibility of an external review appeal, almost all states select an independent review organization (IRO) to evaluate cases. In all states, the IROs' reviewers are health care professionals who are board certified and have an expertise in the specialty under review and cannot have a conflict of interest that would impair their ability to perform an unbiased review. Typically, external review laws also require that consumers exhaust all internal appeals processes before submitting a case for review.

Standards relating to access address when, and on what terms, health insurers must accept an applicant for coverage. While most states require insurers to provide coverage to small employers, few apply these requirements to the individual insurance market. State regulations addressing access involve requirements for guaranteed issue and/or guaranteed renewability of health insurance policies. Federal law also includes requirements for access under HIPAA.

Guaranteed Issue

Guaranteed issue laws prohibit insurers from denying coverage to applicants based on their health status. While all health policies sold in the small group market (generally employers of 2 to 50 employees) must be sold on a guaranteed issue basis, only a handful of states require insurers to sell coverage on this basis in the individual health insurance market. Some states require limited guaranteed access based on HIPAA eligibility[3] and some require open enrollment periods during which insurers may not deny coverage due to a medical condition. Because these requirements vary by state, this results in consumers in some states having more protections than consumers in other states.

Another means of access to health coverage is through *high-risk pools*. Approximately two-thirds of states have implemented high-risk pools as a safety net for the "medically uninsurable" population. These are people who have been denied health insurance coverage because of a pre-existing health condition, or who can only access private coverage that is restricted or has extremely high rates. Risk pools are not created expressly to serve the indigent or poor who cannot afford health insurance. The indigent can access coverage through state medical assistance, Medicaid or similar programs. Risk pools are designed to serve people who would not otherwise have the right to purchase health insurance protection. However, some state risk pools do have a subsidy for lower income, medically uninsurable people.

Though differing by state, risk pools operate as a state-created non-profit association overseen by a board of directors made up of industry, consumer and state insurance department representatives. The board contracts with an established insurance company to collect premiums and pay claims and administer the program on a day-to-day basis. Insurance benefits vary, but risk pools typically offer benefits

[3] An individual must have had 18 months of prior continuous coverage (without a 63 day break); the most recent coverage must be through a group health plan; the individual may not be eligible for other coverage including Medicare or Medicaid; and must have exhausted COBRA coverage if eligible.

that are comparable to basic private market plans. Generally, there are no exclusions. However, risk pools do have waiting periods for coverage of pre-existing conditions. Risk pool insurance generally costs more than regular individual insurance, but the premiums are capped by law in each state. The caps range from as low as 125 percent of the average for comparable private coverage, up to 200 percent of the average or more.

Risk pools are not a panacea for coverage of the uninsured because of their higher premiums and typical funding concerns. All state risk pools inherently lose money and need to be subsidized at roughly 40 percent of overall operating costs. Subsidy arrangements include assessments levied on insurance carriers, HMO's and other insurance providers; appropriations from state general tax revenue; special funding sources, such as a tobacco tax, or a hospital or health care provider surcharge; or a combination of these. Because of these funding concerns, access in some states is limited by waiting lists. There are currently less than 200,000 people enrolled in high-risk pools.

Guaranteed renewability

Guaranteed renewability laws prohibit insurers from canceling or not renewing coverage based on medical claims or diagnosis of an illness. This is a protection afforded to policyholders once coverage is obtained. Following the passage of HIPAA, all group and individual health insurance policies must be guaranteed renewable.

While guaranteed renewability is at the option of the policyholder, the insurer may increase premiums based on the claims experience of the group of individuals with the same policy. Insurers are generally prohibited from singling out policyholders for premium increases, called re-underwriting, because they got sick after buying coverage. However, insurers are not prohibited from canceling all their policies and leaving the market, though there is a time penalty on market re-entry.

Other protections for access to individual private health insurance coverage implemented by states include guaranteed access for special populations such as continued coverage for dependent handicapped adults who were covered by their parents' policies as minors and automatic coverage of newborns for 30 days under their parents' policy provided the policy covers dependents.

Rating Practices

With some variation, there are two distinct approaches to rating methods, or the process by which insurers calculate policy premiums, allowed by states. Insurers in a handful of states must offer policies to all applicants (guaranteed issue) and are limited to rates that are similar regardless of health status. This is called adjusted community rating. For these states, rates will generally vary by age and gender but not with health conditions. In states that do not require community rating, individual health insurance policies are underwritten, meaning that past health conditions of individuals are examined and rates are set according to the health risk of the applicant. A number of other factors are also considered in determining the rates charged.

Factors Utilized in Rating Practices in the Absence of State Regulation

Medical underwriting (examining health status) is the process that insurers use to evaluate an application for insurance. An insurance application is an offer, by the applicant to the insurer, to enter into an insurance contract. In states that allow medical underwriting, the insurer may evaluate an applicant's health status and then accept that offer, decline it, or make a counteroffer with different benefits, a different premium, or both. Insurers use information reported by the individual, as well as medical records. Based on this examination, there are generally three possible outcomes:

- An applicant answers a variety of health status questions and is underwritten as a "standard risk" and receives an offer of insurance at standard rates that are generally lower than those for an employee or dependent in the group market. This occurs because the person is found to be healthy at time of policy issue, rather than being of "average health" typical of an employee or dependent of an employee that is covered by a group plan offered through their employer.
- An applicant with some past or current health conditions might be offered a policy at higher rates than average (called a "rate up" offer) or with coverage of certain specified conditions excluded for a period of time (called a "pre-ex" offer, for a pre-existing condition). Some applicants may be offered a policy with an elimination rider which specifies that coverage is

provided except for the particular condition(s) that existed prior to the issuance of the policy.

- Some applicants with more serious health conditions will be denied coverage since the insurer would not be able to charge a sufficient premium in an underwritten market to pay for the average claims for these individuals.

Prior health care claims are examined to determine if premiums need to be adjusted to sufficiently cover expected claims in the future. As mentioned above, insurers are generally prohibited from singling out policyholders for premium increases, but will look at the experience of the class of individuals with the same policy when considering rate changes.

Age can be used in determining premiums with insurers usually charging older people higher premiums than younger people. Premiums also generally rise as the group of policyholders gets older.

Gender is a factor in some policies with insurers often setting higher premiums for women of childbearing age than they do for men. However, for older individuals, insurers may charge more for men than women.

Particular types of business or industry present higher or lower risk to the individuals working within them. Insurers often charge people in higher-risk occupations, such as the construction trades, higher premiums than they charge to people in lower-risk occupations, such as office workers.

Geographical location is taken into consideration because higher premiums are charged for residents and workers in locations where health care expenses are typically higher.

Family composition is more important than the number of persons in the family when determining health insurance policy premiums. Insurers often set lower premiums for a parent with a child than they do for a couple. Similarly, they may set different premiums for other kinds of families.

Lifestyle or participation in wellness activities has become more important in recent times as interest in cost containment has increased. Insurers have long charged higher premiums to smokers than nonsmokers, but have recently also begun to charge higher

premiums for obese enrollees and lower rates to people who participate in health plan "wellness programs."

State Rate Reforms

A handful of states have enacted rating reforms for the individual health insurance market, prohibiting or restricting insurers from charging higher premiums based on health status or the risk of having future medical claims. These rating restrictions are generally of two types: rate bands and community/adjusted community rating.

Rate bands limit how much insurers can vary premiums for each policyholder based on the health and claims of the policyholder. These limits force insurers to spread some of the risk more broadly across all policyholders. The extent to which premiums can vary depends on the size of the rate band and the factors that insurers can consider when setting premiums.

The rate band sets an upper and lower limit around an "average" premium. For example, if an average individual premium is $200 a month and a state allows an insurer to vary premiums by plus or minus 50 percent from the average premium, this allows a three-fold variation in premium from $100 (50 percent of the average) to $300 (150 percent of the average). Some states that use rate bands also allow variation based on factors other than health status, such as age and geographic location.

States that use rate bands also often limit price increases for individuals who renew their policies. In such a state, an individual whose health has deteriorated will not suddenly be charged significantly higher premiums. This limit is based on the health status and past claims experience of the individual and may be in addition to any increase that would otherwise apply to all policyholders due to increases in the cost of medical care.

Community rating, sometimes called pure community rating, requires insurers to charge the same premiums for everyone with the same policy. Insurers are not allowed to vary rates based on the health status or claims of the person. In theory, the price reflects the value of the benefits and not the risk factors of the people who purchase the policy. The community rate may be different for different insurers based on the claims experience (and other factors such as administrative costs) of people enrolled with that insurer. At the time of renewal, premiums are based on the claims experience of all people

with the policy, so that people who had claims for health expenditures are not charged higher rates than others with the same policy who may not have submitted any claims. Variation is allowed depending on the family composition of the person(s) applying for the policy.

Adjusted or modified community rating likewise prohibits insurers from varying premiums based on health status. All persons in the same community are charged the same premiums, but premiums can vary by geography. Additional variation may be allowed for age, but adjustments for gender are usually not allowed.

The amount of variability among states in the extent of regulation surrounding insurers' premium rates reflects states' attempts to balance the challenges of greater access to private health coverage with the policies' affordability. Additionally, states change rating practices over time in response to changing markets and political circumstances.

Covered Benefits

While almost all health insurance policies cover the usual medical expenses associated with hospital, surgical and out-patient care received from licensed facilities and medical personnel, other requirements for coverage can be implemented through state regulations. One way to spread the cost of a medical condition or treatment among a broad population, making it less expensive for the group of people who need such coverage, is through a benefit mandate. It is also a way to encourage people to seek certain care that otherwise may not be received.

Mandates are laws that require health insurers to offer or include coverage for certain benefits or services. These required benefits may include coverage for certain providers such as chiropractors and social workers, certain benefits such as well child care and acupuncture, and certain populations such as adopted and non-custodial children. The number and type of mandates varies considerably across states. States may apply these mandates to certain markets, differentiating between group and individual policies, and between types of plans such as health maintenance organizations (HMOs) versus other health insurance policy types.

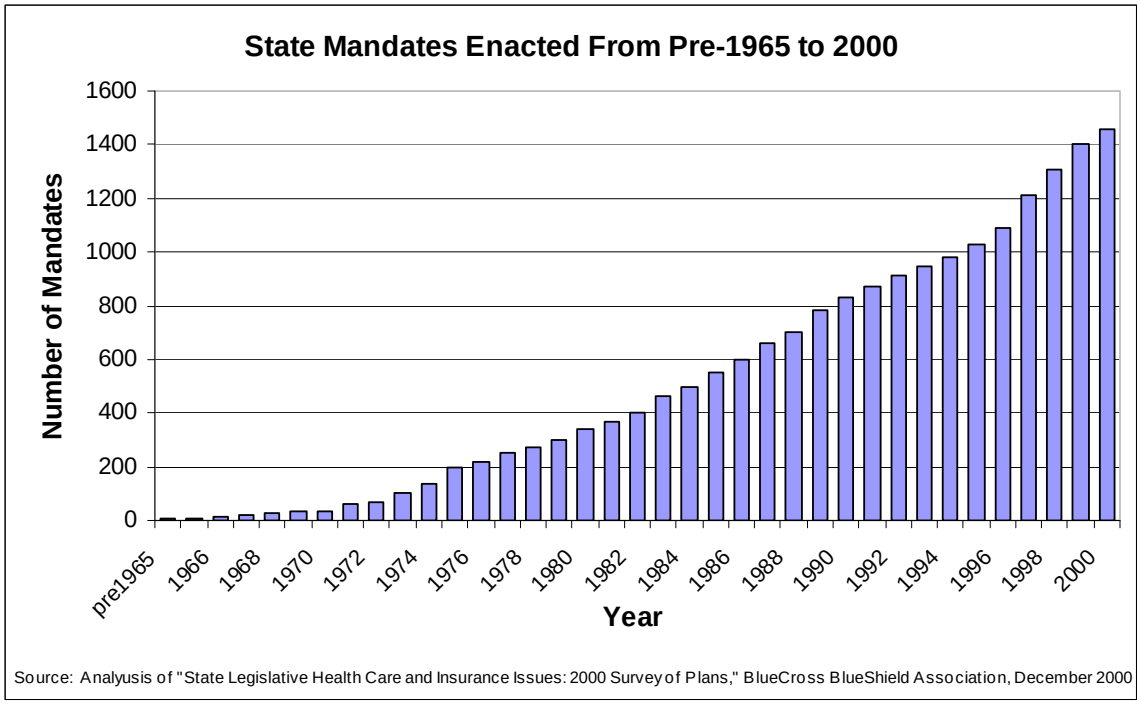
It is sometimes difficult to determine whether a mandate in a particular state applies to only the group health insurance market or to individually purchased policies as well because some states allow

health insurance coverage issued to “groups of one” (i.e., one person is considered a group) to be classified as a small group.

While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets. However, in the absence of mandates, adding optional benefits to a policy may distort premiums if only those people who need the benefit select the coverage.

Policymakers make tradeoffs, balancing higher premiums with the need to help finance certain illnesses. Many times mandates are implemented due to the strength of a particular advocacy group representing a particular constituency (advocates for coverage of diabetic self management and disposable testing materials) or because an instance of a denial of benefits caused some harm to a constituent patient (non-coverage of cancer medications). However, because mandates increase the cost of health insurance, states have begun to consider costs before passing new legislation with some states requiring a cost impact study before mandates would be approved.

An analysis of the number of mandates that have been enacted over the past decades is shown below. This chart indicates that there were over 1400 mandates in effect in the year 2000. A more recent report on mandates compiled by the Council for Affordable Health Insurance (CAHI) (Bunce and Wieske, 2008) indicates that as of early 2008 that number had risen to almost 2000.



A grid developed by CAHI which shows the number and types of mandates by state for 2008 is shown in Appendix A. As this grid demonstrates, some of the more frequently state-mandated services are breast reconstruction, diabetic supplies, and mental health parity (even before federal legislation was considered). Frequently, mandated providers include chiropractors, optometrists, and psychologists, with coverage of adopted, handicapped, and newborn children among categories of frequently covered persons.

Other State Insurance Regulations

States have issued other types of regulations to ensure access to the individual private health insurance market. Among the more common are pre-existing condition limitations and medical loss ratios.

Pre-existing conditions are those conditions for which a policyholder was diagnosed, sought advice, sought treatment, or received care during a specific period of time prior to an application for insurance. Some insurers use pre-existing condition limitations to manage insurance costs by limiting or eliminating coverage of these conditions for some defined period of time after the initial purchase of a policy. Most states have implemented limitations on how far an insurer can go back to find prior claims for conditions (the look-back period) and how much time can elapse before coverage of these conditions begins (the

exclusionary period). (See the subsequent section on Variation in Regulations within States for examples.)

A *medical loss ratio* is the percentage of dollars paid out as benefits to policyholders in relation to the premiums collected for the policies. For example, a state may require that an insurer spend at least 75 percent of the premiums they collect on medical claims. Loss ratios can be calculated for a particular policy form or design, a line of business, or a health insurer's overall business. Only a handful of states require all insurers in the individual market to spend at least 75 percent of every premium dollar on medical care (Families USA, June 2008). Some states establish minimum loss ratios and reserve the right to review or approve the rates submitted by state-licensed insuring organizations. Insurers must estimate what they will spend on medical claims over the course of a year and set their premiums accordingly.

Because premiums must be set at the start of a policy year, actual claims may be more or less than anticipated. If an insurer has underestimated or overestimated the amount of claims, it may adjust the policy premiums in the following year to make up for the discrepancy. In some states, if claims are lower than expected and medical claim expenses do not meet the loss ratio, the insurer must refund the excess premium to policyholders at the end of the year.

Variation in Regulations within States

The previous sections of this report describe some of the types of regulations that states can implement in their governance of the individual insurance market. However, within each of the major areas of regulation there is wide variation in the requirements that have been implemented. For example, within a rating structure that may be imposed on health insurance premiums, there are state actions that range from no rating requirements to pure community rating with various levels of rate bands in between. Similarly, states have a range of requirements for regulating pre-existing condition limitations from no restrictions to very tight time frames of a six-month look back and six-month exclusionary period.

To illustrate this variation, Appendix B displays a chart of states and their market reforms compiled by the National Association of Health Underwriters (NAHU, 2007). Though individual market reforms are the focus of this report, the chart displays both individual and small group policy regulations.

A majority of states (27) have no requirement for guaranteed issue (GI) of individual insurance policies and no rating structure for variation in premiums. Where states have implemented some form of GI (11 states), this is often accompanied by some rating requirement, usually pure or modified community rating. Several states (12) use the HIPAA requirements to grant access to the individual insurance policies, but this applies to persons with prior group insurance coverage and there are usually no rate restrictions on the amount of premiums insurers can charge for these policies, depending on the health status of the applicant. Most states (37) allow policy elimination riders (policy provisions that eliminate coverage for particular conditions).

Almost all states have some limitation on the pre-existing condition look-back/exclusionary periods. While some states indicate they have none, this usually applies to persons exercising their group to individual portability rights under HIPAA (persons whose pre-existing limitations are eliminated because of previous coverage). The most common look-back period was either a twelve month (14 states) or six month (13 states) period. The most common exclusionary period was 12 months (22 states) followed by 24 months (10 states).

Impact of State Regulation

States, in their actions, can and do make very different decisions about how to regulate the individual health insurance market. These actions reflect different values, political climates, and expectations. They also are designed to achieve specific policy goals, such as expanding access, with most states having considered laws and/or regulations of guaranteed issue, guaranteed renewability, and rate reforms. However, achieving these goals often requires trade-offs. For example, establishing rating rules that allow high-risk, older individuals to get low-cost health insurance without exclusions can make health insurance affordable for this population, but increases the price that younger, healthier persons would otherwise pay in this market (New, 2005). When the pool of insured persons does not include the participation of younger individuals, their absence heightens the need for increasing premiums as health care use and costs rise among the existing pool of older persons.

A paper by the Heritage Foundation (New, 2005) examined several studies on insurance regulation and presented an analysis of state

health plan premiums, comparing premiums to the number of mandates and the existence of several types of reforms in the states. The author concluded that while some of the variation in health insurance premiums could be due to regional differences in underlying health care costs, overall "state level regulations of heath insurance are correlated with higher premiums." In terms of the impact state regulation has had on the market for individual health insurance, the research examined indicates that while access to coverage generally increases, affordability is still a major problem.

A study by the Commonwealth Fund (Turnbull and Kane, 2005) examined insurance markets in seven states with varying degrees of market reforms. Among its key findings was the determination that stricter regulation made an important difference by creating "individual health insurance markets where comprehensive coverage is available to all," but with premiums more affordable for higher-risk people at the expense of less-affordable coverage for younger and healthier people. It also found that older and less healthy people faced a range of problems in less regulated states including higher rejection rates for applicants. Of five states in the study with relatively strict regulations, only three still maintain all of those in place at the time of the study; the other two states subsequently rolled back many of their reforms.

A similar study of eight states by Milliman (Wachenheim and Leida, 2007), that included several of the same states as the Turnbull and Kane analysis, found consistent results of decreasing individual insurance enrollment and increased premiums. An additional finding in the Milliman study, which concentrated on guaranteed issue and community rating reforms, was that a deteriorated market resulted after reforms were enacted, with insurance companies choosing to stop selling individual insurance.

The table in Appendix A - state mandates compiled by CAHI – includes a column of information that attempts to quantify the cost impact on premiums for each of the mandates listed. CAHI estimates that mandated benefits increase the cost of basic health coverage from less than 20 percent to more than 50 percent depending on the state and its mandates.

Several other studies conclude that the effect of regulation is small. While persons with higher expected expenses due to chronic health conditions living in unregulated states paid higher health policy premiums and were somewhat less likely to obtain coverage, the variation between premiums and risk is far from proportional (Pauly

and Herring, 2007; Herring and Pauly, 2006). This is because in looking at regulated versus unregulated states, using guaranteed issue and community rating as measures of regulation, that there was considerable pooling of risk in unregulated states. They concluded that the effect of regulation was to produce a "slight increase in the proportion uninsured, as increases in low risk uninsured more than offset decreases in high risk uninsured."

These studies are not inconsistent. Pauly and Herring do agree that requirements such as community rating and guaranteed issue do cause higher premiums for some insured and lower premiums for others, and lead to an increase in the total number of uninsured. However, they observe a higher degree of risk pooling in unregulated states that would otherwise be believed. Additionally, other studies looked at requirements beyond community rating and guaranteed issue to include coverage mandates that affected the amount of premiums paid by policyholders.

Summary

The nongroup (individual) health insurance market provides access to coverage for persons who cannot obtain health insurance coverage through their employer or do not qualify for public programs. For some persons it provides a temporary source of coverage while between jobs or for early retirees who are not yet eligible for Medicare. The population covered through the individual market is relatively small, and this market provides relative ease of access to affordable coverage for persons who are comparatively young and/or in reasonably good health. For older, less healthy persons there can be some barriers to health coverage in the nongroup market. Applicants for coverage usually must go through an underwriting process, which may result in higher premiums than they might pay for coverage in the group insurance market, lack of coverage for specific conditions, or rejection for coverage entirely.

States, as the primary regulators of insurance companies and insurance products, try to improve access to health insurance through the passage of various types of laws and regulations. In the absence of federal reform activities, some states have implemented their own reforms with greater or lesser degrees of success. Some states such as Maine, Massachusetts, and Vermont, have implemented comprehensive reforms to emphasize shared responsibilities for obtaining health coverage, while at the same time easing access to

affordable plans. Other states have taken more incremental approaches such as Washington and Illinois, to cover all children, while states such as Connecticut, Idaho, Indiana, and others have expanded coverage to young adults by changing the definition of “dependent” and extending coverage for those older than 18.

Actions such as implementing guaranteed issue, community rating laws, various mandated requirements, and reforms as mentioned above, have differing effects on the cost and availability of health coverage for insurance applicants of differing characteristics. Policymakers must be cognizant of how these laws and regulations surrounding the individual health insurance market affect their ability to meet various population needs as they attempt to reform the health insurance market.

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Appendix A follows:

BENEFITS	Total	Est. Cost	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Alcoholism	45	1% to 3%	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Alzheimer's	2	<1%																					Y																						Y											
Ambulatory Surgery	12	1% to 3%			Y	Y						Y	Y	Y						Y	Y					Y											Y		Y											Y				
Ambulance Services	8	<1%							Y			Y									Y				Y		Y									Y	Y		Y														
Anti-Psychotic Drugs	3	<1%																								Y								Y																Y			
Autism	11	<1%						Y			Y		Y		Y			Y		Y			Y											Y			Y					Y		Y									
Birthing Centers/Midwives	8	<1%						Y				Y																		Y		Y	Y		Y															Y			
Blood Lead Poisoning	7	<1%					Y				Y											Y						Y							Y																Y			
Blood Products	2	<1%																					Y														Y																	
Bone Marrow Transplants	11	<1%										Y	Y							Y	Y	Y				Y	Y							Y	Y															Y				
Bone Mass Measurement	15	<1%					Y						Y				Y		Y	Y			Y			Y			Y		Y			Y			Y		Y					Y			Y	Y					
Breast Reconstruction	49	<1%	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Cancer Medications	3	<1%																			Y											Y																				Y				
Cervical Cancer/HPV Screening	29	<1%	Y				Y	Y	Y	Y	Y		Y					Y				Y	Y	Y	Y	Y		Y	Y			Y			Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y		Y			Y	Y
Chemotherapy	4	<1%																								Y											Y				Y					Y								
Chlamydia	3	<1%											Y										Y																							Y									
Cleft Palate	14	<1%						Y				Y				Y		Y				Y				Y					Y		Y															Y	Y		Y	Y		
Clinical Trials	23	<1%				Y	Y		Y		Y		Y								Y	Y	Y	Y		Y		Y	Y			Y			Y		Y	Y	Y				Y		Y	Y			Y	Y		Y	Y	
Colorectal Cancer Screening	28	<1%	Y	Y	Y				Y	Y	Y		Y				Y	Y			Y	Y		Y	Y	Y		Y	Y			Y	Y	Y		Y	Y	Y			Y	Y		Y			Y	Y		Y	Y	Y
Congenital Bleeding Disorders	2	<1%																																		Y															Y			
Contraceptives	31	1% to 3%	Y		Y	Y	Y		Y		Y		Y	Y	Y	Y	Y			Y			Y	Y	Y	Y		Y	Y			Y			Y	Y	Y	Y	Y		Y	Y		Y			Y	Y	Y		Y	
Dental Anesthesia	31	<1%	Y		Y		Y	Y	Y			Y	Y		Y		Y	Y	Y	Y	Y		Y	Y		Y	Y	Y	Y		Y	Y	Y		Y	Y	Y	Y	Y		Y				Y		Y		Y	Y		
Diabetes Self-Management	27	<1%	Y		Y	Y	Y	Y		Y		Y	Y	Y	Y		Y	Y	Y	Y			Y	Y		Y		Y			Y				Y		Y	Y		Y	Y				Y		Y			Y	Y		Y
Diabetic Supplies	47	<1%	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Drug Abuse Treatment	34	<1%	Y	Y	Y		Y		Y	Y	Y	Y		Y					Y		Y		Y	Y	Y	Y		Y	Y			Y	Y	Y		Y	Y	Y			Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	
Early Intervention Services	3	< 1%						Y																												Y																		
Emergency Services	44	<1%			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Habilitative Services	2	<1%								Y							Y																																						
Hair Prostheses	10	<1%							Y			Y										Y	Y			Y	Y							Y		Y				Y			Y											
Hearing Aid	10	<1%							Y											Y	Y		Y	Y		Y		Y			Y				Y					Y			Y			Y								
HPV Vaccine	16	<1%						Y							Y		Y	Y					Y	Y		Y		Y			Y	Y					Y							Y			Y	Y			Y			
Home Health Care	18	<1%				Y	Y	Y	Y									Y			Y		Y	Y		Y		Y			Y				Y		Y	Y				Y				Y			Y	Y			
Hospice Care	11	<1%			Y			Y						Y							Y		Y	Y		Y	Y										Y	Y												Y		Y			
In Vitro Fertilization	13	3% to 5%			Y		Y		Y					Y			Y						Y	Y					Y							Y							Y										Y		
Kidney Disease	2	<1%																																																		Y	Y	
Long Term Care	4	1% to 3%								Y																														Y												Y		
Lyme Disease	4	<1%							Y															Y		Y																		Y											
Mammogram	50	<1%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mastectomy	24	<1%			Y		Y		Y			Y	Y				Y		Y	Y	Y	Y	Y		Y		Y	Y		Y	Y					Y		Y	Y	Y	Y	Y	Y	Y					Y				
Mastectomy Stay	25	<1%			Y		Y		Y			Y	Y				Y		Y		Y		Y		Y			Y		Y	Y					Y	Y		Y	Y	Y		Y	Y	Y			Y		Y				Y
Maternity	21	1% to 3%			Y		Y	Y	Y					Y	Y					Y			Y	Y		Y		Y			Y				Y		Y			Y		Y	Y					Y	Y	Y			
Maternity Stay	50	<1%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mental Health General	39	1% to 3%		Y	Y		Y	Y	Y	Y		Y	Y	Y			Y		Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y					Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	
Mental Health Parity	47	5% to 10%		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minimum Hysterectomy Stay	1	<1%																																																	Y			
Minimum Testicular Cancer Stays	1	<1%																					Y																															
Morbid Obesity Treatment	4	1% to 3%											Y					Y					Y																												Y			
Neurodevelopment Therapy	1	<1%																																																	Y		
Newborn Hearing Screening	17	<1%	Y								Y	Y						Y					Y						Y		Y	Y	Y	Y		Y	Y													Y		Y		
Newborn Sickle-Cell Testing	3	<1%																															Y								Y											
Off-Label Drug Use	36	<1%		Y	Y	Y	Y		Y		Y		Y				Y	Y	Y				Y	Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	
Orthotics/Prosthetics	12	<1%					Y	Y	Y			Y											Y	Y		Y	Y									Y						Y			Y									
Ostomy Related Supplies	1	<1%							Y																																												
Other Infertility Services	8	<1%					Y										Y									Y			Y					Y	Y		Y													Y		
Ovarian Cancer Screening	3	<1%											Y				Y									Y												Y																
Psychotic Drugs	2	<1%																																				Y														Y		
PKU/Formula	32	<1%	Y		Y	Y	Y	Y	Y			Y		Y				Y		Y	Y					Y		Y	Y		Y			Y	Y	Y	Y	Y		Y	Y	Y			Y	Y	Y	Y		Y	Y		
Port-wine Stain Elimination	2	<1%																									Y																										Y		
Presciption Drugs	2	5% to 10%																						Y																												Y		
Prostate Cancer Screening	33	<1%		Y			Y	Y	Y	Y	Y		Y				Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y		Y		Y	Y
Rehabilitation Services	8	1% to 3%							Y								Y					Y	Y			Y												Y	Y														Y		
Second Surgical Opinion	10	<1%					Y				Y							Y						Y														Y														Y		
Smoking Cessation	2	1 % to 3%																					Y																															
TMJ Disorders	20	<1%			Y							Y	Y				Y			Y						Y		Y		Y	Y	Y			Y	Y	Y													Y		Y		
Well-Child Care	31	1% to 3%			Y		Y	Y	Y	Y		Y	Y	Y	Y				Y		Y	Y	Y				Y	Y	Y	Y	Y		Y		Y	Y		Y	Y	Y		Y		Y	Y	Y			Y	Y		

	Total	Est. Cost	AK	AL	AR	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
PROVIDERS																																																						
Acupuncturists	11	1% to 3%					Y					Y												Y					Y					Y	Y					Y		Y				Y		Y		Y			
Chiropodist	4	<1%						Y																										Y														Y		Y			
Chiropractors	48	1% to 3%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Dentists	35	3% to 5%	Y	Y	Y	Y	Y	Y	Y						Y			Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y		Y			Y		Y
Denturists	2	<1%																											Y																						Y			
Dieticians	3	<1%																								Y																							Y					Y
First Nurse Assistant	5	<1%											Y							Y	Y			Y																							Y							
Lay Midwives	3	<1%																						Y											Y															Y				
Licensed Health Professional	12	<1%			Y			Y									Y	Y					Y			Y										Y									Y			Y			Y	Y		Y
Marriage Therapists	14	<1%						Y	Y			Y		Y									Y	Y		Y		Y		Y		Y				Y								Y				Y		Y				
Massage Therapists	4	<1%																					Y												Y														Y					
Naturopaths	4	<1%	Y																										Y																						Y	Y		
Nurse Anesthetists	21	<1%		Y	Y	Y		Y										Y	Y			Y	Y	Y		Y		Y	Y	Y	Y				Y	Y					Y	Y		Y					Y			Y
Nurse Midwives	30	<1%	Y			Y	Y	Y	Y		Y	Y										Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y		Y		Y		
Nurse Practitioners	29	<1%	Y			Y	Y	Y	Y		Y				Y				Y			Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					Y	Y	Y		Y	Y	Y		Y	Y	Y	Y
Nurses	11	<1%						Y						Y	Y								Y	Y	Y				Y	Y			Y		Y	Y						Y								Y				
Occupational Therapists	11	1% to 3%	Y			Y	Y		Y			Y									Y			Y	Y											Y	Y								Y									Y
Opticians	3	1% to 3%																						Y												Y														Y				
Optometrists	43	1% to 3%	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y
Oral Surgeons	8	<1%						Y				Y					Y	Y	Y						Y								Y																						
Osteopaths	22	1% to 3%	Y		Y			Y				Y					Y	Y	Y	Y					Y						Y	Y		Y	Y		Y	Y		Y	Y		Y			Y		Y		Y	Y	Y
Pain Management Specialist	3	1% to 3%						Y	Y										Y																																			
Pastoral Counselors	3	<1%																						Y						Y			Y																					
Pharmacists	5	<1%		Y															Y							Y				Y																					Y				
Physical Therapists	18	1% to 3%	Y						Y										Y		Y		Y			Y			Y					Y	Y	Y	Y				Y				Y				Y		Y			Y
Physician Assistants	18	<1%	Y	Y							Y	Y			Y				Y	Y			Y		Y				Y	Y						Y					Y									Y		Y			Y
Podiatrists	35	<1%		Y	Y	Y	Y	Y			Y	Y					Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Professional Counselors	18	<1%			Y		Y	Y				Y					Y						Y							Y	Y	Y	Y		Y									Y			Y	Y		Y				Y
Psychiatric Nurse	18	<1%					Y	Y	Y			Y											Y	Y		Y		Y		Y		Y	Y											Y	Y							Y		Y
Psychologists	44	1% to 3%	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Y
Public or Other Facilities	25	<1%			Y	Y	Y		Y			Y				Y		Y				Y		Y	Y	Y		Y	Y	Y		Y							Y		Y		Y			Y	Y		Y		Y		Y	Y
Social Workers	27	1% to 3%	Y				Y	Y	Y			Y					Y		Y		Y	Y	Y	Y	Y	Y		Y	Y	Y		Y			Y	Y				Y			Y	Y	Y	Y		Y				Y
Speech or Hearing Therapists	20	<1%	Y		Y	Y	Y									Y	Y				Y	Y		Y	Y										Y	Y		Y		Y		Y			Y	Y		Y		Y			Y
COVERED PERSONS																																																					
Adopted Children	43	<1%	Y		Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Continuation/Dependents	44	<1%			Y	Y	Y	Y	Y		Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Continuation/Employees	45	<1%			Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Conversion to Non-Group	41	1% to 3%			Y	Y	Y	Y		Y		Y	Y		Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Dependent Students	30	<1%						Y	Y		Y	Y	Y			Y		Y			Y	Y		Y	Y	Y		Y		Y		Y	Y	Y	Y	Y					Y	Y	Y		Y	Y	Y	Y	Y	Y		Y	
Grandchildren	4	<1%																					Y			Y																							Y					
Handicapped Dependents	41	1% to 3%			Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y			Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Newborns	51	1% to 3%	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Custodial Children	11	<1%						Y	Y															Y		Y			Y		Y					Y																		Y
Domestic Partners	13	<1%					Y	Y	Y	Y					Y							Y		Y	Y										Y								Y								Y		Y		
Additional Mandates*	20				1		1					1	2										1	3						1		2	3			2																2			
Total	1981		28	19	41	29	50	49	51	19	25	48	41	23	25	15	40	37	37	33	43	43	63	53	28	64	39	29	40	47	34	32	39	42	51	52	55	26	38	36	38	47	29	31	40	54	23	55	27	53	34	38	32

Appendix B follows

National Association of Health Underwriters

State Level Individual and Small Group Market Health Insurance Reforms

March 2007

State	Individual Market Reforms						Small-Group Market Reforms[1]		
	Guarantee Issue	**Rating Structure**	**Elimination Riders**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Credit for Prior Coverage**	**Medically Uninsurable Individuals**	**Size[2]**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Rating Structure**
Alabama	No	NRS	Yes	60/12	No	HRP[3]	2-50	6/12	+/- 20%
Alaska	No	NRS	Yes	None	No	HRP	2-50	6/12	+/- 35%
Arizona	HIPAA[4]	NRS	Yes[5]	None[6]	No[7]	None	2-50	6/12	+/- 60%
Arkansas	No	NRS	Yes	60-month Look-Back	No	HRP	2-50	6/12	+/- 25%
California	HIPAA[8]	NRS	No	6/6 or 12/12[9]	Yes	HRP/GI[10]	2-50	6/6	+/- 10%
Colorado	No	NRS	Yes	12/12	Yes	HRP	1-50[11]	6/12	+/10% -25%
Connecticut	No	NRS	Yes	12/12	No	HRP	1-50[12]	6/12	MCR[13]
Delaware	HIPAA[14]	NRS	Yes[15]	None[16]	No[17]	None	1-50[18]	6/12	+/- 35%
Florida	HIPAA[19]	NRS	Yes[20]	24/24[21]	Yes	HRP[22]	1-50[23]	6/12	MCR +/- 15%[24]
Georgia	HIPAA[25]	NRS	Yes[26]	24-month Exclusionary Period[27]	No[28]	None	2-50	6/12	+/- 25%
Hawaii	HIPAA[29]	NRS	Yes[30]	36-month Exclusionary Period[31]	No[32]	None	1-50[33]	None	NRS[34]
Idaho	GI[35]	+/- 50%	No	6/12[36]	Yes	HRRP	2-50	6/12	+/- 50%
Illinois	No	NRS	Yes	12/24[37]	No	HRP	2-50	6/12	+/- 25%
Indiana	No	NRS	No	12/24	No	HRP	2-50	6/9	+/- 35%
Iowa	No	RB[38]	Yes	12/12 and	No[40]	HRP	2-50	6/12	+/- 25%

State	Individual Market Reforms						Small-Group Market Reforms[1]		
	Guarantee Issue	Rating Structure	Elimination Riders	Preexisting Conditions (Look-Back/ Exclusionary Period in Months)	Credit for Prior Coverage	Medically Uninsurable Individuals	Size[2]	Preexisting Conditions (Look-Back/ Exclusionary Period in Months)	Rating Structure
				60/12[39]					
Kansas	No	NRS	Yes	12/24	No	HRP	2-50	6/3	+/- 25%
Kentucky	No	+/- 35%	No	6/12	Yes	HRP	2-50	6/12	+/- 35%
Louisiana	No	NRS[41]	Yes	12/12	Yes	HRP	3-35	6/12	+/- 35%
Maine	GI[42]	MCR[43]	No	12/6	Yes	GI	2-50	6/12	MCR[44]
Maryland	No	NRS	Yes	4/24	No	HRP	1-50[45]	0/0	MCR[46]
Massachusetts	GI[47]	MCR[48]	No	6/6	Yes	GI	1-50[49]	6/6	MCR[50]
Michigan	GI[51]	CR/NRS[52]	No	6/6 and 6/12[53]	No	CLR[54]	2-50[55]	6/12	+/- 45%[56]
Minnesota	No	RB[57]	No	0[58]	Yes	HRP	2-50	6/12	+/- 25%
Mississippi	No	NRS	Yes	12/12	No	HRP	1-50[59]	6/12	+/- 25%
Missouri	No	NRS	Yes[60]	Unlimited/24[61]	No[62]	HRP	3-25	6/12	+/- 25%
Montana	No	NRS	Yes	36/12	Yes	HRP	2-50	6/12	+/- 25%
Nebraska	No	NRS	Yes	None	No	HRP	2-50	6/12	+/- 25%
Nevada	HIPAA[63]	+/- 50%	Yes[64]	None[65]	Yes	None	2-50	6/12	+/- 25%
New Hampshire	No	RB	Yes	3/9	Yes	HRP	2-50	6/12	MCR[66]
New Jersey	GI[67]	CR[68]	No	6/12	Yes	GI	2-50	0/0 or 6/6[69]	MCR[70]
New Mexico	No	NRS	Yes	6/6	Yes	HRP	2-50	6/6	+/- 25%
New York	GI[71]	MCR[72]	No	6/12	Yes	GI	2-50	6/12	CR[73]
North Carolina	HIPAA[74]	NRS	Yes[75]	12/12[76]	Yes	CLR[77]	1-50[78]	6/12	+/- 20%
North Dakota	No	RB	No	6/12	Yes	HRP	2-25	6/12	+/- 35%
Ohio	HIPAA[79]	NRS[80]	Yes	6/12	Yes	OE[81]	2-50	6/12	+/- 35%
Oklahoma	No	NRS[82]	Yes	None[83]	No	HRP	2-50	6/12[84]	+/- 25%
Oregon	GI[85]	MCR[86]	Yes	None[87]	Yes	HRP	2-25	6/12	MCR[88]
Pennsylvania	HIPAA[89]	NRS	Yes[90]	60/36[91]	No[92]	CLR[93]	2-50[94]	6/12	NRS[95]
Rhode Island	GI[96]	NRS	Yes[97]	36/12[98]	No[99]	CLR[100]	1-50[101]	6/12	+/- 10%
South Carolina	No	NRS	Yes	12/12 and unlimited/24[102]	No	HRP	2-50	6/12	+/- 25%
South Dakota	No	+/- 30%	Yes	12/12	Yes	HRP	2-50	6/12	+/- 25%
Tennessee	HIPAA[103]	NRS	Yes[104]	None[105]	No[106]	None[107]	2-50	6/12	+/- 35%
Texas	No	NRS	Yes	60/24[108]	Yes[109]	HRP	2-50	6/12	+/- 25%

State	Individual Market Reforms						Small-Group Market Reforms[1]		
	Guarantee Issue	**Rating Structure**	**Elimination Riders**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Credit for Prior Coverage**	**Medically Uninsurable Individuals**	**Size[2]**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Rating Structure**
Utah	GI[110]	+/- 30%	Yes	6/12	No	HRP	2-50	6/12	+/- 30%
Vermont	GI[111]	MCR[112]	No	9/12	Yes	GI	2-50	6/12	MCR[113]
Virginia	HIPAA[114]	NRS	Yes[115]	12/12[116]	No[117]	CLR[118]	2-50	6/12	NRS[119]
Washington	GI[120]	MCR[121]	No	6/12	Yes	HRP	2-50	6/12	MCR[122]
West Virginia	No	+/- 30%	Yes	12/24	No	HRP	2-50	6/12	+/- 30%
Wisconsin	No	NRS	Yes	24-month Exclusionary Period	No	HRP	2-50	6/12	+/- 30%
Wyoming	No	NRS	Yes	6/12	Yes	HRP	2-50	6/12	+/- 35%

Explanation of Abbreviations

Individual Market Reforms

Guarantee Issue—GI=Guarantee issue required; and HIPAA=People exercising their group-to-individual portability rights under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) must be guarantee-issued products in the traditional individual market.
Rating Structure—NRS=No rating structure. Medical underwriting allowed without restriction; RB=Rate bands; CR=Community rated; MCR=Modified community rated; and +/- X%=Rate bands of plus or minus the specified percentage of the indexed rate.
Medically Uninsurable Individuals—HRP=High-risk health insurance pool; HRRP=High-risk reinsurance pool; None=No mechanism for providing individual market access to medically uninsurable people; CLR=Carrier of last resort; OE=Open enrollment; and GI=Guarantee-issue.

Small-Group Market Reforms

Rating Structure—+/- X%=Rate bands of plus or minus the specified percentage of the indexed rate; NRS=No rating structure; CR=Community rated; and MCR=Modified community rated.

[1] In addition to the reforms noted, as per the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), all health insurance contracts for employer-groups of 2-50 employees must be issued on a guarantee-issue basis. All group insurance contracts must also be guarantee-renewable, unless there is non-payment of premium, the employer has committed fraud or intentional misrepresentation or the employer has not complied with the terms of the health insurance contract. In addition, according to HIPAA, credit for prior coverage is required as long as there is no more than a 63-day break in coverage.
[2] Despite the group-size definition imposed by the state, as per federal law, all HIPAA protections apply to groups of 2-50.

[3] Alabama's high-risk health insurance pool only serves the state's HIPAA-eligible population.
[4] In Arizona, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[5] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[6] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[7] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[8] In California, all individual market carriers must guarantee issue their two most popular individual products to people who are exercising their group-to-individual portability rights provided by HIPAA. Carriers must also guarantee issue coverage to people who have spent two years in the state's high-risk health insurance pool.
[9] In the California traditional individual health insurance market, there is a 12-month look-back and exclusionary period limit for pre-existing conditions for policies that cover one or two people. There is a 6-month look-back and exclusionary period limit for individual policies that cover three or more people.
[10] Carriers must guarantee issue coverage to people who have spent two years in the state's high-risk health insurance pool.
[11] For employer groups-of-one employee, Colorado carriers must guarantee issue basic and standard small-group coverage during an annual open enrollment window to groups-of-one with involuntary loss of coverage only.
[12] Connecticut regulations allow groups of one to apply for any plan however, following medical history review they may be offered the small group regulation guarantee issue product.
[13] Connecticut requires that small-group rates be based on a community rate with adjustments allowed for age, gender, geography, group size, family, and industry.
[14] In Delaware, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market carrier offering coverage in the state.
[15] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[16] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[17] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[18] In Delaware, carriers must guarantee-issue coverage to employer groups-of-one.
[19] Currently in Florida, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through either a conversion product, or through individual market carriers.
[20] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[21] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[22] Florida's current high-risk pool, the Florida Comprehensive Health Association has been closed to new enrollees since 1991. As such, there is no mechanism currently in place to serve new medically uninsurable individuals who do not either have access to group coverage or guarantee issue rights provided under HIPAA. However, legislation was enacted in Florida in 2004 to create the Florida Health Insurance Plan, a new high-risk pool, which would combine the existing pool with new enrollees. The development of the pool is contingent upon the creation of a funding mechanism. A legislative effort is currently underway to create a funding mechanism for the pool, so that it can become operational and accept new enrollees.
[23] In Florida, carriers must guarantee issue certain small-group products to groups-of-one during annual open enrollment periods.
[24] In the small group market in Florida there are rate bands of +/-15% of the indexed rate depending on the health of the group. Groups over 10 employees may use a group medical questionnaire. Groups of fewer than 10 employees must answer individual medical questionnaires. Small employer health insurance carriers may only use the following rating factors: geographic area and number of employees, as well as health of the group. Renewals are capped at 15% plus trend.
[25] In Georgia, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through either a conversion product, or through individual market carriers on an assignment basis.
[26] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[27] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[28] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[29] In Hawaii, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[30] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[31] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.

[32] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[33] Hawaii does not have a statute that defines the size of their small group market. Most carriers define it as 1-50; however, some use the definition of 1-100. Individuals who attempt to obtain guarantee-issue coverage as a business group-of-one must satisfy criteria set by the carrier.
[34] Coverage in the Hawaii small group market may be medically underwritten. The state does not have specified rate requirements, except that all rates must be reasonable for the coverage provided, and effective 1/1/2003, all rates must have prior approval by the state Department of Insurance.
[35] Idaho individual health insurance carriers must guarantee issue at least three products (basic, standard and catastrophic) to all individual market consumers with 12 months of creditable coverage, including all HIPAA-eligible individuals.
[36] Preexisting conditions may not be considered for standardized policies.
[37] For traditional individual health insurance policies in Illinois, there is a 12-month look back period during first two years of coverage. If the condition is determined to be preexisting a 24-month exclusionary period is allowed.
[38] Carriers are subject to rating restrictions based on the pricing for their different blocks of business. The rate differential between the two policy forms must be no more than 2.028 to 1 at each age, (i.e., the composite effect of 30%, and 20%). Subsequent rate changes must be within 15% of each other.
[39] Carriers are subject to rating restrictions based on the pricing for their different blocks of business. The rate differential between the two policy forms must be no more than 2.028 to 1 at each age, i.e., the composite effect of 30%, and 20%. Subsequent rate changes must be within 15% of each other.
[40] Credit for prior coverage is required for HIPAA-eligibles and standardized policies.
[41] There are no rate caps in the individual health insurance market in Louisiana, as statutory rate bands are not enforced.
[42] In Maine, all major medical individual health insurance products must be sold on a guarantee issue basis to all consumers, including all HIPAA-eligible individuals.
[43] In Maine, the individual market is rated on a modified community basis. Adjustments of plus or minus 20 percent of the community rate are only allowed for age, occupation, and geography. A separate adjustment can be made for smoker status.
[44] In Maine, small group health plan rates are determined on a modified community basis. Rates can only be adjusted by plus or minus 20% from the standard community rate for the following factors: age, geography, occupation, and smoking status. The use of medical underwriting is prohibited.
[45] In Maryland, carriers must guarantee issue a standardized coverage plan to self-employed individuals during an annual open enrollment period.
[46] In Maryland, small group health insurance coverage premiums must be community rated with up to 40 percent plus or minus variations allowed for age and geography.
[47] All Massachusetts individual market health insurance carriers must sell at least three products to all consumers on a guarantee issue basis, including all HIPAA-eligible individuals.
[48] Carries may adjust rates on a modified community rated basis. Adjustments are limited to age, geography and benefit level on a 2:1 basis.
[49] In Massachusetts, carriers must guarantee-issue coverage to business groups-of-one.
[50] In Massachusetts, small group health insurance premiums must be based on a community rate, with adjustments allowed for age, industry, group size, geography, family composition, participation rate, wellness program participation, and participation in the small employer reinsurance plan.
[51] Blue Cross Blue Shield of Michigan must offer all products to all residents on a guarantee issue basis, and HMOs in the state must offer guarantee issue coverage to residents during annual open enrollment periods.
[52] Blue Cross Blue Shield of Michigan must community rate products in the individual market, but other carriers have no rate restrictions.
[53] There is a 6-month look-back and exclusionary period limit on preexisting health conditions for Blue Cross Blue Shield of Michigan and HMOs. All other individual market carriers are subject to a 6-month look-back and a 12-month exclusionary period limit on preexisting health conditions.
[54] Blue Cross Blue Shield of Michigan is required by statute to serve as the carrier of last resort for people seeking coverage in the individual market through a year-round open enrollment for specified products. Also, HMOs in Michigan are required to offer individual coverage with a 30-day open enrollment period for all individuals annually.
[55] In Michigan, commercial carriers and Blue Cross Blue Shield of Michigan may impose an open enrollment period for sole proprietors and impose a 6 month look-back and exclusionary period for preexisting conditions.
[56] Blue Cross Blue Shield of Michigan is allowed to impose a 35 percent variation from the geographic rate for small groups.
[57] Minnesota individual health insurance market rates are subject to bands of plus or minus 25 percent of the base individual market rate for health status, plus or minus 50 percent for age and plus or minus 20 percent for geography.
[58] There is no exclusionary period allowed for preexisting health conditions for people with creditable coverage in Minnesota.
[59] In Mississippi, carriers must guarantee-issue coverage to business groups-of-one.
[60] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.

[61] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[62] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[63] In Nevada, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage in the form of a basic or standardized plan through any individual market carrier.
[64] Elimination riders permitted except for HIPAA-eligibles and in the Nevada basic and standard plans.
[65] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[66] In New Hampshire, small group health insurance premiums must be based on a community rate, with adjustments allowed for age, family composition, group size and industry classification when determining rates, and the use of health status, claims experience, duration of coverage, geographic location and other characteristics is prohibited.
[67] All New Jersey individual market health insurance carriers must guarantee issue five standardized products to all consumers, including HIPAA-eligible individuals.
[68] Traditional individual coverage must be purely community-rated. Carriers may also offer a basic and essential plan, which may have 3.5:1 variations for age, gender and geography.
[69] In New Jersey, new groups sized 2-5 are subject to a 6-month look-back/6-month preexisting condition exclusion period, but other small groups are not subject to an exclusion period. Late enrollees in groups of 2-50 may also be subject to a 6-month preexisting condition waiting period.
[70] In New Jersey, small-group premiums are based on a modified community rate, and carriers may consider only the age, gender and family status of eligible employees, and the location of the employer in determining the premium for the group. Carriers may not consider any other factor, including health status or prior claims history of eligible employees or the type of business. Carriers are required to limit the range of premiums from the highest risk group and the lowest risk group to a 2:1 basis.
[71] In New York, all carriers must guarantee issue all individual health insurance products to all consumers, including HIPAA-eligible individuals.
[72] Coverage must be community-rated with adjustments limited to family composition and geographic regions.
[73] In New York, small group health insurance premiums are subject to pure community rating.
[74] In North Carolina, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market carrier. In addition, Blue Cross/Blue Shield of North Carolina voluntarily sells certain products on a guarantee-issue basis to all consumers.
[75] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[76] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[77] Blue Cross Blue Shield of North Carolina voluntarily serves as the carrier of last resort for people seeking coverage in the individual market through a year-round open enrollment for specified products.
[78] In North Carolina, carriers must guarantee issue basic and standard plans to business groups-of-one.
[79] Traditional Ohio individual market carriers must guarantee issue two standardized products to individuals exercising their group-to-individual portability rights provided by HIPAA until they meet enrollment caps, and HMOs must guarantee issue coverage one month each year to HIPAA eligible individuals.
[80] Standardized plans are subject to rate caps.
[81] In Ohio, HMOs and insurers must hold annual open enrollment periods during which they must offer two specified products to all individuals until they meet specified statutory enrollment caps.
[82] Individual market HMOs are subject to rate caps; however, no HMOs offer individual market coverage in the state at this time.
[83] Preexisting conditions may not be considered for HMO products in the Oklahoma individual health insurance market, however, no HMOs offer individual market coverage in the state at this time.
[84] In Oklahoma, HMOs cannot consider, look-back at or issue exclusions for preexisting conditions. All other group health insurance carriers can impose a 6-month look-back/12-month exclusionary period for preexisting conditions on enrollees who do not have prior creditable coverage.
[85] In Oregon, all individual market carriers must guarantee issue portability products to residents with six months of prior coverage.
[86] Oregon individual carriers must use community rating with variances allowed based on geography and benefit design.
[87] Preexisting conditions may not be considered for portability products in Oregon's individual health insurance market.
[88] Small group health insurance premiums in Oregon must be based on a modified community rate. For groups of 2-25 employees, rating is based on family mix, member age, and geographic location of the employer. All carrier rates must have no more than a .43 difference in rates between the highest age and lowest age band. For groups of 26-50 employees, rates also must be based on family mix, member age, gender and geographic location of the employer, but there are no age band requirements.

[89] In Pennsylvania, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee issue private individual health insurance coverage through the various Blue Cross/Blue Shield plans serving as the state's carriers-of-last resort. The various Blue Cross/Blue Shield plans also offer a medical-only product to all consumers on a guarantee-issue basis.
[90] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[91] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[92] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[93] The various Blue Cross/Blue Shield plans operating in the state voluntarily serve as the carriers-of-last-resort for people seeking coverage in the individual market through a year-round open enrollment for specified products.
[94] Pennsylvania does not have a specific statute or regulation that defines the size of a small employer for the purposes of providing health insurance coverage. Most Pennsylvania insurance carriers define a small group as 2-50 employees.
[95] In the small group health insurance market in Pennsylvania, medical underwriting is allowed without restriction with rate variations allowed up to 300 percent of the base rate. Some Blue Cross/Blue Shield carriers community rate or use a modified community rate voluntarily.
[96]All carriers must guarantee issue coverage to all individuals with at least 12 months of prior coverage. Blue Cross Blue Shield of Rhode Island voluntarily offers an individual health insurance product to all consumers on a guarantee issue basis. HIPAA-eligible individuals can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[97] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA or for the guarantee issue products.
[98] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA or those with 12 months of prior coverage.
[99] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA and in the guarantee issue plans.
[100] Blue Cross Blue Shield of Rhode Island voluntarily serves as the carrier of last resort for people seeking coverage in the individual market through a limited annual open enrollment period.
[101] In Rhode Island, carriers must guarantee issue coverage to business groups-of-one.
[102] There is a 12-month look-back and exclusionary period limit for preexisting conditions for HMOs in South Carolina's individual health insurance market. There is an unlimited look-back and 24-month exclusionary period limit for preexisting conditions for other individual policies.
[103] In Tennessee, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[104] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[105] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[106] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[107] Some medically uninsurable individuals in Tennessee are still eligible for the state’s scaled-back TennCare program.
[108] Preexisting conditions may not be considered for HMO products in the Texas individual market.
[109] Credit for one month or more prior coverage is required.
[110] In Utah, individual market carriers must guarantee issue products to people that meet certain health criteria. Individuals who do not meet these criteria can obtain guarantee-issue private individual health insurance coverage through the state's high risk pool.
[111] All individual health insurance products in Vermont must be sold on a guarantee issue basis, including to HIPAA-eligible individuals.
[112] Vermont individual health insurance carriers may only offer coverage on a community rated basis with adjustments limited to those approved by the state Insurance Commissioner. Currently variances of plus or minus 20 percent of the average group rate based on age and gender are allowed.
[113] In Vermont, small group health insurance premiums must be based on a community rate with variations allowed only for age and gender.
[114] In Virginia, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[115] Elimination riders are not allowed for people exercising their group-to-individual portability rights under HIPAA.
[116] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[117] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[118] The various Blue Cross Blue Shield plans operating in the state are required by statute to serve as the carrier of last resort for people seeking coverage in the individual market through an open enrollment period for specified products.

[119] In the small group market in Virginia, private health insurance carriers can medically underwrite rates without restriction, except for standardized plans. For the standardized plans, rates may vary by plus or minus 25 percent of the indexed rate based on age, gender, geography, health status, claims experience and duration of coverage for similar groups.

[120] In Washington, individual market carriers must guarantee issue products to people that meet certain health criteria. Individuals who do not meet these criteria can obtain guarantee-issue private individual health insurance coverage through the state's high-risk pool. Individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.

[121] Washington individual health insurance carriers may only offer coverage on a modified community rated basis with adjustments limited to age, geography, wellness, family size and tenure in the plan.

[122] In Washington, small group premium rates must be based on a community rate with adjustments allowed for age, geography and family composition. The rating between the highest rate and lowest rate for the community cannot exceed 375 percent.