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# Reforming the Private Insurance Market:
## Lessons from California for National Health Reform

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## EXECUTIVE SUMMARY

As national health care reform efforts go forward, it is instructive to review states' experience with regulation of health insurance markets. This policy brief presents lessons from California, the largest state in the union. The shortcomings of California's loosely regulated individual insurance market and demise of its health insurance purchasing alliance (exchange) for small employers underscore the importance of developing sustainable national and/or state exchanges. This review of California's experience regulating health insurance points to five major lessons for the design of national and state health insurance exchanges. Incorporating these elements into the exchanges is critical to ensure that they will provide Americans with access to comprehensive, affordable coverage.

- **First**, premiums for health insurance products offered through national and state health insurance exchanges should be calculated on the basis of community rating. Carriers should be required to provide guaranteed issue and renewability and be prohibited from excluding coverage for preexisting conditions.

- **Second**, mechanisms should be established to ensure that health insurance coverage sold through health insurance exchanges is affordable, such as subsidies, tax credits, and public program expansions.

- **Third**, health insurance products offered to consumers through health insurance exchanges should be standardized with respect to covered benefits and cost sharing requirements.

- **Fourth**, rules regarding premium rate setting should be consistent for health insurance products sold within and outside the health insurance exchanges.

- **Fifth**, strong consumer protection standards should be established for coverage sold through national and state exchanges.

## INTRODUCTION

The prospects for national health care reform are more promising than at any time since 1994. President Obama and Members of Congress have made health care reform a top priority and legislation is moving forward in the Senate and the House of Representatives.

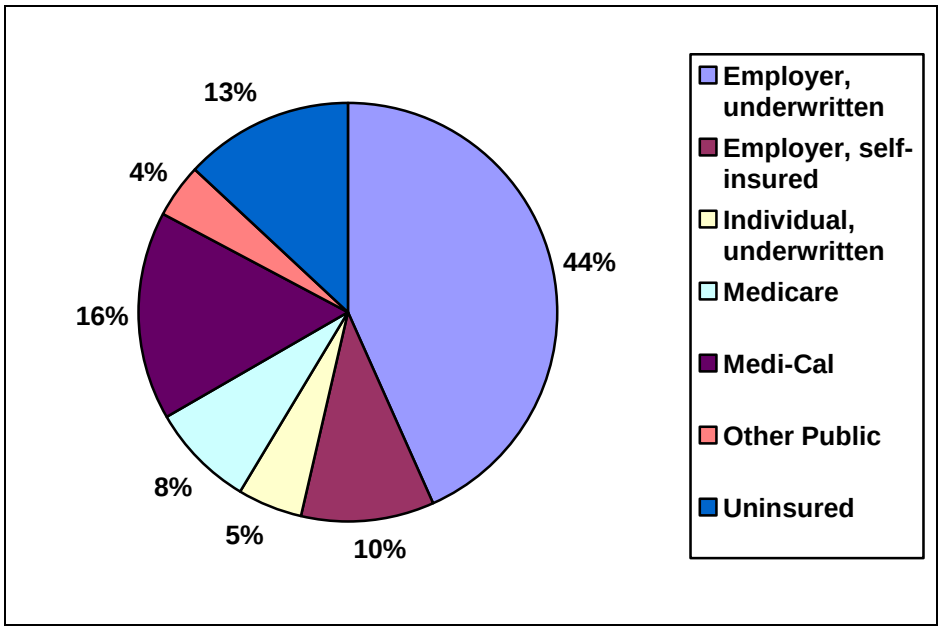
As these efforts go forward, it is instructive to review states' experience with regulation of health insurance markets. Historically, states have had primary responsibility for the regulation of health insurance in the United States. Although the scope of states' regulatory authority has diminished somewhat since the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), which encouraged employers to create self-insured health plans, states continue to regulate all commercial health insurance products sold in the individual market and many products sold in the group market.

This policy brief presents lessons from California, the largest state in the union. Consumers' experience in California's loosely regulated individual health insurance market illuminate the shortcomings of individual insurance and the need for reforms that improve access to comprehensive, affordable coverage. The limited success of California's efforts to reform the small group market underscores the need for policymakers to ensure that the same rules for setting premiums apply to health insurance products sold inside and outside the health insurance "exchange" structures contemplated in Congress, to reduce the risk of adverse selection. Health care reform bills currently pending before both houses of Congress contain a number of provisions similar to those proposed in California's failed attempt at comprehensive reform in 2007 and Massachusetts' successful effort. This policy brief focuses on lessons for the design of national or state health insurance exchanges.

## CALIFORNIA'S HEALTH INSURANCE MARKET

Lack of access to affordable, comprehensive health insurance is a major problem in California. Figure 1 displays the health insurance coverage of Californians in 2008 by source of coverage (if any). Compared to the rest of the United States, California has a greater percentage of persons who are uninsured and a smaller percentage with employer-sponsored health insurance. California also has a relatively large individual health insurance market.[1] Thirteen percent of Californians were uninsured in 2008.[2] Fifty-four percent obtained health insurance through employers (10% through self-insured health plans and 44% through products purchased from commercial insurers). In addition, Californians with employer-sponsored health insurance also were less likely to be enrolled in self-insured health plans than persons in other parts of the United States.[3] California's experience contrasts with that of Massachusetts, which had a relatively small individual health insurance market prior to enacting health insurance reform in 2006.

**Figure 1.**
**Health Insurance Coverage by Source, California, 2008**




Source: California Health Benefits Review Program, "Table 1: Health Insurance Coverage of Californians, 2008" (2009).

## LESSONS FROM HEALTH INSURANCE REGULATION IN CALIFORNIA

California's experience with health insurance regulation offers federal policymakers five important lessons for the design of national or state health insurance exchanges.

***Lesson 1. Design health insurance exchanges to ensure that all individuals who do not have access to employer-sponsored health insurance can purchase comprehensive coverage regardless of their health status, gender, or age. Essential elements include guaranteed issue and renewability, community rating, and restrictions on use of preexisting condition exclusions and use of health status and demographic characteristics to set premiums.***

California's loosely regulated individual health insurance market functions poorly for consumers with the greatest need for health insurance.[i] Health insurance carriers may deny applications for individual insurance based on health status. Carriers can also exclude or impose waiting periods on coverage for preexisting conditions. There are no restrictions on rates or rate increases.[4] In addition, California allows carriers to take age and sex into account when setting premiums for individual health insurance provided differentials are based on sound statistical and actuarial data.[5] A recent report on premiums charged to men

[i] Persons and families transitioning from group to individual coverage have some legal protections against denial of coverage and preexisting condition exclusions, although, as discussed below, many cannot afford to purchase the policies for which they are eligible. *See* Families USA at note 32.

and women in the capital cities of the 50 states and Washington, DC, found that some of the best selling individual insurance policies sold in California rate premiums by gender and that premiums charged to 40-year old women for these policies were 10% to 39% higher than premiums charged to 40-year old men with similar health status.[6] The report found even greater differences in premiums charged to men and women in a number of other states.

A report issued by the Kaiser Family Foundation illustrates the difficulties that aggressive medical underwriting in the individual health insurance market creates for Californians in less than perfect health.[7] The authors submitted applications for six hypothetical single adults aged 24 to 62 years and one hypothetical family to seven health insurance companies and health maintenance organizations that sold products in a large metropolitan area in California (Fresno). All hypothetical single adults and one of the members of the hypothetical family had either a current chronic condition (hay fever, asthma, depression, high blood pressure, HIV) or had an acute condition in the past (breast cancer, major knee injury). All of the single adults were denied coverage by two or more carriers and three of the seven policies offered to the family excluded coverage for the member with a chronic condition. Carriers that accepted applicants often charged higher premiums than those charged to persons in perfect health and/or limited the level of coverage available (e.g., offered a policy with a $2,500 deductible instead of a $500 deductible).[8]

Many Californians who are denied coverage in the individual health insurance market have few alternatives for obtaining coverage, especially if they have not previously had employer-based coverage. Many are self-employed or work for employers who do not provide health insurance benefits. They often are not eligible for Medicare, Medi-Cal (California's Medicaid program), or other public programs. One of the few options available is a high-risk pool that California established in 1991 to assist consumers who are denied coverage in the individual market, are not eligible for public programs, and have exhausted any continuation coverage to which they may have been entitled under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or California's Cal-COBRA law.

While the high-risk pool has been helpful to some "medically uninsurable" consumers, it lacks sufficient resources to provide them with affordable policies. Premiums are higher than the already high rates charged for individual policies purchased outside the pool.[9] In addition, the maximum annual benefit is $75,000 and the maximum lifetime benefit is $750,000.[10] These maximums are lower than those set by most other states that have established high risk pools. They may be adequate for persons with well-controlled chronic conditions, but persons with acute episodes of illness can easily incur expenses in excess of these amounts. In addition, enrollment of new applicants has been halted periodically due to funding shortfalls.[11]

Over the past several years, California policymakers have increasingly focused on "rescissions" of individual health insurance policies once a subscriber submits a claim for an expensive procedure. Carriers have maintained that policies are cancelled only where they obtain evidence that a subscriber intentionally presented false information about his or her health on his or her application. However, investigations have found that some carriers have inappropriately cancelled policies. A private arbitration judge in Los Angeles ordered one carrier to pay $9 million to a subscriber with breast cancer whose policy was cancelled while

she was receiving chemotherapy.[12] State regulators have also levied fines against major carriers that rescinded policies.[13]

The experience of consumers in the individual health insurance market in California differs sharply from that of consumers in states with highly-regulated markets. Eight states have enacted guaranteed issue laws that require health plans and health insurers to issue policies to all persons regardless of their health status.[14] Five of the states that require guaranteed issue also require community rating of health insurance premiums, a method under which premiums are based on the average costs of all persons in a community rather than the characteristics of individuals. One state mandates pure community rating, whereas the other four states require modified community rating under which premiums can vary on the basis of limited demographic characteristics, such as age, gender or geographic location. Three additional states require modified community rating but not guaranteed issue.[15] In six of the states that mandate community rating, the community rating statute prohibits the use of gender to set premium rates. Four additional states have enacted laws that prohibit gender rating in the individual insurance market. Table 1 lists the states that have enacted each of these types of laws.

**Table 1**
**States with Laws Regarding Guaranteed Issue, Community Rating, or Gender Rating**

| State | Mandates Guaranteed Issue | Mandates Community Rating | Prohibits Gender Rating |
|---|---|---|---|
| Idaho | X | | |
| Maine | X | X | X* |
| Massachusetts | X | X | X* |
| Minnesota | | | X |
| Montana | | | X |
| New Hampshire | | | X |
| New Jersey | X | X | X* |
| New Mexico | | | § |
| New York | X | X† | X* |
| North Dakota | | X | X |
| Ohio | X | | |
| Oregon | | X | X* |
| Rhode Island | X | | |
| Vermont | X | X | § |
| Washington | | X | X* |

**Sources:** Susan Laudicina, Joan Gardner and Angela Crawford, "State Legislative Health Care and Insurance Issues: 2008 Survey of Plans" (Washington, D.C.: Blue Cross and Blue Shield Association, 2008); National Women's Law Center, "Nowhere to Turn: How the Individual Health Insurance Market Fails Women" (2008).

**Notes:**

* Prohibition on gender rating is included in the state's community rating statute.

† New York is the only state that mandates pure community rating. All others mandate modified community rating that allows premiums to vary on the basis of limited demographic characteristics.

§ New Mexico and Vermont have established rate bands that limit the amount by which insurers can vary premiums based on gender.

Guaranteed issue and community rating laws have been critical components of state health insurance reform efforts because they help ensure that persons with current or previous health problems can obtain coverage in the individual health insurance market. However, premiums for younger, healthier people are generally higher in states with highly-regulated individual health insurance markets than in California and other states with loosely-regulated markets.[16] Higher premiums create a disincentive for younger, healthier people to purchase coverage in the individual market, which can lead to adverse selection (i.e., health insurance is disproportionately purchased by sicker people) and concomitant increases in premiums.

In 2007, California attempted to enact comprehensive health insurance reform legislation modeled after legislation enacted in Massachusetts in 2006. ABx1 1, the final, compromise version of California's 2007 health reform bill, offers one strategy for balancing the interests of older, sicker persons and younger, healthier persons in the individual insurance market. The bill would have helped older, less healthy persons by requiring guaranteed issue for health insurance products sold in the individual market and prohibiting the use of health status to determine health insurance premiums.[17] To prevent "rate shock" among younger, healthier persons in the individual market, the ban on the use of health status to set premiums would have been phased in over four years.[18] In addition, as discussed below, the legislation included several mechanisms for ensuring that premiums would be affordable for all Californians.

Another option for mitigating "rate shock" among young adults is to create "age bands" under which premiums are allowed to vary by age group within a limited range specified by statute. The use of age bands reduces premiums for young adults while limiting the amount of variation in premiums charged to younger and older adults. Seven states have established age bands. For example, Maine permits carriers to vary the community rate by plus or minus 20% due to age.[19] California's comprehensive health insurance reform legislation also would have established age bands for individual health insurance sold to persons not eligible for state-subsidized coverage.[20] Age bands are useful for limiting the increase in premiums that healthy young adults would face. However, age bands should be coupled with other mechanisms, such as subsidies and tax credits, to ensure that premiums are affordable for older adults with low and moderate incomes.

Bills that would prohibit gender rating were introduced in the California Senate and Assembly earlier this year. AB 119 (Jones) would repeal provisions in current law that permit health plans to use statistical and actuarial data as a basis for charging women higher premiums than men.[ii]

California legislators have also sought to restrict carriers' ability to rescind individual health insurance policies. AB 2 (De La Torre) would strengthen existing law that prohibits post-claims underwriting and would limit the conditions under which a health plan or health insurer may cancel a policy. In addition, the legislation would require state health insurance officials to establish an independent review process for rescissions under which all rescissions would be reviewed, except where consumers choose to opt out of the process.

[ii] A companion bill, SB 54 (Leno), was introduced in the California Senate, but later gutted and amended to address a different topic.

Legislation currently pending before Congress incorporates a number of provisions to ensure that all persons have access to comprehensive health insurance which are similar to those proposed in California and enacted in Massachusetts. The Senate Health, Education, Labor and Pensions Committee (HELP) bill and the House Tri-Committee bill would establish federal and state health insurance exchanges through which certain small employers and persons who do not have access to employer-sponsored health insurance could purchase coverage. Both bills would require carriers to provide guaranteed issue and renewability for policies sold in through an exchange or directly to consumers or employers. They would also prohibit preexisting condition exclusions. Both bills would also prohibit gender rating and limit variation in premiums based on age to a ratio of 2 to 1. The House Tri-Committee bill would completely prohibit the use of health status to set premiums and the Senate HELP bill would only permit consideration of tobacco use. In addition, both bills would prohibit rescission of coverage except where there is clear evidence of fraud.[21] "Rate shock" for younger, healthier consumers with individual insurance would be addressed by "grandfathering" individual insurance coverage in force prior to the legislation's effective date. The Senate Finance Committee is considering similar legislation, although less information is available about specific provisions because the committee had not marked up its bill at the time of this writing.

To mitigate the risk of adverse selection across health plans that participate in a national or state health insurance exchange, both the House Tri-Committee bill and the Senate HELP bill would require the exchange to risk adjust payments to participating health plans.[22] The Senate Finance Committee is considering a similar proposal. Under all three proposals, health plans participating in the exchange that attract enrollees who are sicker would receive larger payments than those that enroll healthier persons. Risk adjustment ensures that all health plans will be compensated commensurate with their expenses and, thus, prevent large financial losses that could lead health plans to cease offering coverage through the exchange.

Legislation introduced by Senator Tom Coburn and Representative Paul Ryan as an alternative to the House and Senate committees' proposals would neither prohibit nor limit carriers from rating premiums on the basis of health status, age, and gender.[23] As a consequence, this legislation would be unlikely to improve access to individual health insurance for persons in less than perfect health. The bill would permit states to establish health insurance exchanges and would require health insurance carriers that sell health insurance products through the exchanges to provide coverage on a guaranteed issue basis and prohibit the use of preexisting condition exclusions. However, these provisions would not apply to individual health insurance products sold outside the state exchanges, which could make the exchanges vulnerable to adverse selection and undermine their viability.

***Lesson 2. Establish mechanisms to ensure that health insurance coverage sold through a national or state exchange is affordable, such as subsidies, tax credits, and public program expansions.***

Even for persons in good health, the coverage available in California's individual health insurance market is often unaffordable. Health insurance products available in California's individual health insurance market have a lower actuarial value (i.e., the percentage of total health care expenses the insurer can be expected to cover) than

employer-sponsored health plans. The actuarial value of health insurance products sold in the individual market declined from 75% to 55% between 2003 and 2006, leaving consumers to shoulder the balance of expenses.[24] The size of deductibles charged to consumers in the individual market has also increased markedly. In 2006 the average deductible charged to consumers in the individual market ($2,136) was six times as large as the average deductible charged in the small employer market.[25] Fifty-five percent of consumers in the individual market in 2008 were enrolled in high deductible health plans (i.e., plans with a deductible of $1,150 or more).[26]

While increases in deductibles charged for individual health insurance products have enabled insurers to limit premium increases, they have simultaneously exposed consumers to higher out-of-pocket costs. In 2006 a single consumer earning the median income in California who purchased coverage in the individual market would have paid an average of 16% of his or her income for premiums and out-of-pocket expenses combined. A single consumer working full-time at a minimum wage job would have paid an average of 35% of his or her income.[27] These high costs make individual health insurance unaffordable for low- and moderate-income individuals and families. High cost sharing also contributes to medical debt and personal bankruptcies.[28]

The cost of individual health insurance is high for both persons transitioning from employer-sponsored to individual health insurance and persons without prior group coverage.[29] The federal COBRA and Cal-COBRA statutes permit persons transitioning from employer-sponsored health insurance due to involuntary termination (i.e., a layoff) to continue receiving coverage through their former employers' plans for specific periods of time following termination.[30] As implemented in California, the federal Health Insurance Portability and Accountability Act (HIPAA) requires carriers to offer their two most popular products to persons who previously had group insurance coverage for at least 18 months and who have exhausted any COBRA or Cal-COBRA coverage to which they were entitled. Persons losing group coverage because an employer terminates health insurance benefits or goes out of business are also eligible for HIPAA coverage.

Many persons who are eligible for COBRA, Cal-COBRA, or HIPAA coverage cannot afford the premiums. This is especially true of persons who have been laid off from their jobs. In 2008, the average cost of employer-sponsored health insurance in California was $4,906 for individual coverage and $13,427 for family coverage (The national average costs were $4,704 and $12,680, respectively).[31] A recent report estimated that the average monthly premium for individual COBRA coverage in California in 2008 was equivalent to 28.8% of average monthly unemployment benefits. The average monthly premium for COBRA coverage for California families was a staggering 81.6% of average unemployment benefits.[32] The American Recovery and Reinvestment Act of 2009 has provided temporary relief to persons laid off between September 1, 2008, through December 31, 2009, in the form of subsidies equivalent to 65% of the cost of COBRA coverage,[33] but at the time of this writing it is not known whether these subsidies will be extended.

Mechanisms to improve the affordability of health insurance policies for consumers that lack access to employer-sponsored health insurance are critical to the success of an "individual mandate" (i.e., a requirement that all Americans obtain health insurance). ABx1 1, the final version of California's health insurance reform bill, contained several

interlocking mechanisms to ensure affordability, some of which are similar to those enacted by Massachusetts. First, the legislation would have expanded eligibility for Medi-Cal and Healthy Families (California's CHIP program) to adults with incomes up to 250% of poverty and children from families with incomes up to 300% of poverty. Expanding eligibility for existing public programs can be an effective strategy for quickly increasing the number of persons with health insurance, because existing programs can be scaled up more rapidly than new entities can be established.

ABx1 1 would also have established a purchasing pool for persons with incomes above 250% of poverty. Persons with incomes between 250% and 400% of poverty who enrolled in the purchasing pool would have received refundable tax credits for purchase of coverage through the pool that phased out as income rose. The amount of the tax credit would have been linked to the cost of a mid-level plan purchased through the pool to help ensure that both premiums and out-of-pocket costs would be affordable. Persons with incomes above 400% of poverty would have been eligible to participate in the pool and to receive a 20% discount on premiums, if their employers contributed to the pool. Employers would have been required to provide IRS Section 125 plan ("cafeteria plan") tax sheltering to all employees regardless of whether they were eligible for employer-sponsored health benefits. California's proposed approach contrasted with that of Massachusetts, which waives its individual mandate for residents whose incomes fall below a specific ceiling and whose premium cost would exceed a particular amount.[34] California's approach is preferable for national reform, because it would maximize the number of persons with health insurance. Studies have consistently found that persons with health insurance are diagnosed and treated more promptly than persons who are uninsured, because they are less likely to delay or forego seeking necessary care.[35]

The purchasing pool proposed in ABx1 1 would have had the authority to negotiate premiums on behalf of all enrollees. The broad authority proposed in California is in contrast to Massachusetts, where the pool only negotiates premiums for a low-cost product for young adults. Authority to negotiate premiums is critical to ensuring an exchange's ability to control health insurance costs and offer affordable premiums.[36]

Legislation currently pending before Congress addresses affordability through a combination of subsidies and limits on out-of-pocket costs. Both the House Tri-Committee bill and Senate HELP bill would provide premium credits on a sliding scale to individuals and families with incomes up to 400% of poverty who are not eligible for other coverage. Premium credits would be available only for the purchase of health insurance through national or state health insurance exchanges. The size of the premium credits would be based on the average premiums of the three lowest-cost comprehensive plans offered in a specified geographic area. Premiums for persons with incomes up to 400% of poverty would also be limited to a specific percentage of income that would rise as income rises. The House Tri-Committee bill would limit annual premium increases for coverage sold through an exchange to 150% of the annual increase in medical inflation. In addition, both the House Tri-Committee bill and the Senate HELP bill would provide tax credits to certain small employers to purchase coverage for their employees.[37] The Senate Finance committee is considering similar proposals; however it has suggested limiting subsidies to persons at or below 300% of poverty. Eliminating subsidies for persons with incomes between 300% and

400% of poverty could make it difficult for persons in this income bracket, especially the near elderly, to obtain affordable coverage in the individual market.

To ensure that out-of-pocket costs are affordable, both the Senate HELP Committee bill and the House Tri-Committee bill would bar carriers from establishing annual or lifetime limits on the dollar value of coverage sold in either the group or individual market. The House Tri-Committee bill also would establish a sliding scale of cost sharing credits that would reduce cost sharing amounts and annual cost sharing limits for families with incomes below 400% of poverty. This bill would also mandate that health plans cover at least 70% of the actuarial value of the covered benefits and would limit annual cost-sharing for persons with incomes above 400% of poverty to $5,000 per individual and $10,000 per family. The Senate HELP bill would limit cost sharing for preventive services recommended by the United States Preventive Services Task Force and the House Tri-Committee bill would prohibit cost sharing for these services.[38]

Legislation introduced by Senator Tom Coburn and Representative Paul Ryan would also provide refundable tax credits to individuals for the purchase of health insurance but is far less likely to ensure access to affordable coverage than the Senate HELP, Senate Finance, and House Tri-Committee bills. As noted previously, the Coburn-Ryan bill would not place restrictions on the use of health status, age, or gender to set premiums. The tax credits proposed in this bill ($2,290 for individuals and $5,710 for families) probably would not be sufficient to enable older persons and persons in less than perfect health to purchase coverage in the individual market at all. The bill would provide supplemental debit cards to persons below 200% of poverty but no additional assistance to persons between 200% and 400% of poverty.

***Lesson 3. Establish consistent rules regarding minimum benefits, maximum cost sharing, and other aspects of benefit design to ensure that all consumers have comprehensive coverage and to help consumers make meaningful comparisons across health insurance products offered through an exchange.***

Choosing among the large number of individual health insurance products sold in California and other states is challenging for consumers. A recent review of the literature on health plan choice suggests that consumers often have difficulty choosing a health insurance policy that best meets their needs.[39] A new study of Medicare beneficiaries finds that the difficulty consumers experience in distinguishing among health plans goes up as the number of options increases.[40] Comparing individual health insurance products sold in California and other states that have loosely regulated individual markets is especially difficult because prices, benefit design, and covered services vary widely.[41]

Moreover, some health insurance policies sold in the individual health insurance market in California have major gaps in coverage that can lead consumers with acute or chronic illnesses to incur large out-of-pocket expenses. A recent report assessed the out-of-pocket costs that consumers with one of three common, costly to treat conditions (breast cancer, diabetes, and heart attack) would incur if they had purchased any of 10 policies sold in California's individual or small group markets.[42] Annual deductibles for these policies ranged from zero to $3,500 and annual maximum limits on out-of-pocket spending ranged from $1,500 to $7,500. Some policies either did not cover prescription drugs or covered

only generic drugs. In addition, most policies placed no limits on cost sharing for prescription drugs. Restrictions on coverage for prescription drugs could lead consumers who have cancer or other conditions that are treated with expensive specialty drugs to incur large out-of-pocket costs. One policy did not cover non-hospital outpatient care until enrollees reached an annual out-of-pocket spending limit for hospital-based and certain other services. Such restrictions limit coverage for enrollees who only need non-hospital outpatient services, some of which can be quite expensive, such as chemotherapy, radiation, and surgery. Most policies also limited coverage for mental health conditions other than the biologically-based conditions for which California law mandates parity with coverage for physical conditions.[43]

The wide variation in health insurance products sold in the individual health insurance market in California is due in part to the division of regulatory authority between two state agencies.[44] The California Department of Managed Health Care (DMHC) regulates health maintenance organizations (HMOs) and some preferred provider organizations (PPOs). The California Department of Insurance (CDI) regulates the remaining PPOs, indemnity plans, and other health insurance products. Some of the largest health insurance carriers in California are licensed to sell products regulated by both agencies.[45] The market shares of health insurance products regulated by DMHC and CDI differs between the group and individual health insurance markets. In 2008 products regulated by DMHC accounted for 91% of enrollment in the group market but only 48% of enrollment in the individual market.[46]

The division of regulatory authority between CDI and DMHC has led to inequities in minimum benefits packages. All HMOs and PPOs regulated by DMHC are required to provide "basic services," which DMHC defines as a comprehensive package of services that encompasses hospital inpatient care, hospital outpatient care, physician services, diagnostic laboratory services, imaging services, preventive services, emergency services, home health services, and hospice care.[47] No such minimum benefits requirement applies to health insurance products regulated by CDI, although these products are required to provide some specific benefits mandated by statute, such as coverage for biologically based mental illnesses and certain cancer screening tests. One major difference between DMHC- and CDI-regulated products in the individual market is that DMHC-regulated products are required to provide coverage for maternity care but CDI-regulated products are not. In 2008, only 22% of persons enrolled in CDI-regulated individual insurance products had coverage for maternity care versus 100% of persons enrolled in DMHC-regulated products.[48] (Federal law requires all group insurance products to cover maternity care.)

DMHC- and CDI-regulated policies also differ with respect to cost sharing. DMHC has authority to review cost sharing arrangements and other limitations on coverage to ensure that such requirements are reasonable and that exclusions from coverage do not render health insurance benefits "illusory".[49] In contrast, cost sharing for CDI-regulated products is not subject to regulatory oversight. The lack of regulations regarding cost sharing and minimum benefits enable CDI-regulated carriers to charge lower premiums for their products. However, consumers with chronic or acute conditions who purchase these products may incur much greater out-of-pocket expenses than consumers who purchase more comprehensive coverage from DMHC-regulated carriers.

California's experience suggests that health insurance products sold through national or state exchanges should be standardized to ensure that all products provide comprehensive coverage and to assist consumers in comparing products. Several pieces of legislation introduced in California over the past several years provide models for standardization. ABx1 1 would have established a minimum benefits package for all products sold in the individual market by carriers regulated by both DMHC and CDI and would have required all carriers to offer the same range of standardized products.[50] These provisions of ABx1 1 were later revised and reintroduced as a stand alone bill, SB 1522 (Steinberg), which died in the state legislature in 2008 and was reintroduced in 2009 as AB 786 (Jones). AB 786 would require carriers to provide consumers with standardized information about policies sold in the individual market. To ensure that consumers are protected against catastrophic expenses, AB 786 would also mandate that all coverage sold in the individual market limit per person out-of-pocket costs to $15,000 for services obtained from providers in a carrier's network.

Legislation currently pending in Congress mirrors these models. The House Tri-Committee Bill and the Senate HELP bill would require all carriers to provide an essential benefits package that would encompass a comprehensive array of services for physical and mental health conditions. States would have the option to add to the essential benefits package if they also provide funds to cover additional costs associated with providing subsidies for expanded benefits packages. Both bills would establish standardized categories of health insurance plans sold through a national or state exchange and would permit participating carriers to sell only health plans that conform to these categories. The categories would differ with regard to the percentage of benefit costs covered and the amount of cost sharing required. The House Tri-Committee bill would also include a category for health plans that provide benefits for additional services such as dental and vision care. The Senate Finance Committee is considering legislation that would extend the requirement for standardized benefits packages to health plans sold outside the exchange as well as within the exchange. All three bills would require the exchange to develop tools to help consumers select health plans that best meet their needs.

As noted previously, the House Tri-Committee bill also establishes limits on the maximum cost sharing that consumers would face on an annual basis. The bill would establish a sliding scale of cost sharing credits that would reduce cost sharing amounts and annual cost sharing limits for families with incomes below 400% of poverty. It would also limit annual cost sharing for persons with incomes above 400% of poverty to $5,000 per individual and $10,000 per family.

***Lesson 4. Ensure that the rules by which premiums are set are consistent for health insurance products sold through and outside a national or state exchange to reduce the risk that the exchange will experience adverse selection.***

Premiums for employer sponsored health insurance have risen dramatically in California over the past decade as they have in other states. Small employers (defined in California as firms with 2 to 50 employees) experienced the largest increase with premiums rising 53% between 2003 and 2006.[51] Employers have responded to these cost increases by raising deductibles, coinsurance, copayments, and other forms of cost sharing that erode the actuarial value of coverage offered to employees and dependents.

The evolution of the small group health insurance market in California over the past 20 years suggests that federal policymakers need to think carefully about how to reduce the risk that a national or state exchange will experience adverse selection. During the 1990s, California and many other states enacted legislation to reform the small group market. These reforms included requirements for guaranteed issue and renewal of coverage, limits on preexisting condition exclusions, and restrictions on the use of enrollee health status as a basis for setting or increasing rates.[52] Under California law, premiums charged to small firms can be no more than 10% above or below carriers' "standard" rates, which can be calculated only on the basis of age, family size, and geographic location. Preexisting condition restrictions are limited to a single, six-month period and previous coverage must be counted toward the six-month period. California also established the first and largest purchasing alliance, or exchange, for small employers.[53] The challenges encountered by California's purchasing alliance offer important lessons for federal policymakers as they consider whether or not employers would be permitted to purchase coverage through an exchange.

California's purchasing alliance had difficulty attracting small employers. Although enrollment grew steadily during the program's first five years, even at its height the purchasing alliance's market share was never more than 5%. One reason for the purchasing alliance's small market share was that it was unable to sustain its initial success in negotiating lower premiums than those charged for products available to small groups outside the exchange. This early success put pressure on carriers that did not offer coverage through the purchasing alliance to lower premiums in order to remain competitive. As the purchasing alliance matured, aggressive price competition among carriers selling products outside the alliance (within the limits discussed above) led employers with younger, healthier enrollees to drop out of the alliance, leaving the alliance with a pool of older, less healthy persons who were more expensive to cover.[54] Carriers began dropping out of the purchasing alliance due to financial losses. The purchasing alliance ceased operation in 2006 after one of the three remaining carriers exited the alliance.[55] Small group purchasing alliances in other states have experienced similar difficulties.[56]

The experience of California and other states suggests that purchasing alliances and exchanges may not be sustainable if participants can purchase similar coverage at a lower cost outside the alliance or exchange. The availability of lower cost options outside an alliance or exchange creates a disincentive for healthier individuals and groups to purchase coverage through the alliance or exchange. The risk of adverse selection can be greatly reduced by requiring carriers to provide coverage sold outside the exchange under the same terms and conditions that apply to coverage sold through the exchange, because small employers with healthier employees could not obtain better prices outside the exchange.[57] California's comprehensive health reform bill, ABx1 1, sought to reduce the risk of adverse selection into the pool by limiting the availability of tax credits and discounts solely to coverage purchased through the pool. Offering coverage through the pool at a lower cost to consumers than coverage available outside the pool would have increased the likelihood that the pool would have attracted persons of all ages and levels of health status.[58]

The Senate HELP Committee bill would require carriers that sell coverage in the individual and small group markets to comply with the same regulations as coverage sold through a national or state exchange with regard to guaranteed issue and renewability, prohibition on excluding coverage for preexisting conditions, and limits on the use of health

status and demographic characteristics to set premium rates. The Senate Finance Committee is considering a similar proposal. The House Tri-Committee bill would extend these requirements to all coverage sold in the group market regardless of group (employer) size. Requiring all health insurance carriers to follow the same rules in all market segments would ensure that all carriers compete on a level playing field and would reduce the risk that any of them would experience adverse selection.

Another option is to create financial incentives for individuals or employers to obtain coverage through the exchange.[59] As noted previously, the Senate HELP, Senate Finance, and House Tri-Committee bills would create financial incentives for individuals to purchase coverage through a national or state exchange by providing tax credits only for coverage obtained through an exchange. This approach ensures that individuals have a financial incentive to purchase coverage through the exchange regardless of their health status. This approach could be extended to small employers. All three bills would provide certain small employers with tax credits to offset the cost of providing health insurance to their employees.[60] If tax credits were available only for coverage purchased through the exchange, small employers would have an incentive to purchase coverage through it regardless of the health status of their employees.

A third option would be to mandate that individuals and/or small employers obtain coverage through a national or state exchange. The House Tri-Committee bill would require individuals who do not have access to employer-sponsored coverage and who do not have existing coverage eligible for grandfathering to obtain coverage through an exchange. Extending this requirement to small employers would prevent adverse selection into the exchange for this segment of the population and would help the exchange to enroll sufficient numbers of persons to spread risk and administrative costs.[61] Requiring both individuals and small employers to purchase coverage through the exchange would provide the best guarantee against adverse selection into the exchange. Restricting tax credits for small employers (as well as individuals) to coverage obtained through the exchange could also be effective, provided that the same rules regarding guaranteed issue and renewability, preexisting conditions, and use of health status to set premiums apply to products sold within and outside the exchange. Such rules are necessary to ensure that coverage purchased through the exchange is always less expensive than coverage purchased outside the exchange regardless of the health status of a small employer's workforce.

***Lesson 5. Build upon existing state laws to develop strong consumer protection standards for health insurance purchased through national or state exchanges.***

To date, debates regarding health care reform have focused primarily on improving access to affordable, comprehensive coverage. Once a general blueprint for reform is established, a second set of important questions concerning consumer protections should be addressed. Consumers need clear and accurate information about their health insurance coverage. Mechanisms for resolving grievances about coverage and care delivery and ensuring that consumers receive high quality care are also critical.

A number of states strengthened consumer protection laws during the late 1990s and early 2000s. A review of California's consumer protection laws illustrates the protections available to persons across the United States who have commercial insurance coverage in the

group or individual markets. (Because of ERISA, these state laws do not apply to self-insured health plans.[iii]) Both DMHC and CDI require carriers to disclose information regarding benefits, services, and contract terms in readily understood language.[62] DMHC also monitors availability and accessibility of providers and reviews health plans' quality assurance procedures. In addition, the legislation that created DMHC established an Office of the Patient Advocate, which assesses the quality of care provided by DMHC-regulated health plans and provides enrollees with information about their rights and responsibilities.[63]

California has also enacted legislation to assist consumers in resolving disputes with insurers regarding coverage and care delivery. Both DMHC and CDI operate toll-free "hotlines" to assist consumers in resolving complaints. Carriers regulated by DMHC are required to establish an internal grievance system to respond to all types of consumer complaints.[64] CDI-regulated carriers must develop a mechanism for reviewing grievances regarding the provision of experimental and investigational treatments to consumers with life-threatening or debilitating conditions.[65] Consumers with both DMHC- and CDI-regulated coverage can request an Independent Medical Review (IMR) of "medical necessity" disputes (i.e., disputes as to whether a particular treatment is medically necessary for an individual consumer) that are not resolved through their health plans' internal grievance processes.[66] In this, California is not atypical. Table 2 lists the 44 states that have established external grievance review processes.[67]

**Table 2**
**States with Laws that Mandate External Grievance Review**

| | | | |
|---|---|---|---|
| Alaska | Illinois | Missouri | Pennsylvania |
| Arizona | Indiana | Montana | Rhode Island |
| Arkansas | Iowa | New Hampshire | South Carolina |
| California | Kansas | New Jersey | Tennessee |
| Colorado | Kentucky | New Mexico | Texas |
| Connecticut | Louisiana | New York | Utah |
| Delaware | Maine | North Carolina | Vermont |
| District of Columbia | Maryland | North Dakota | Virginia |
| Florida | Massachusetts | Ohio | Washington |
| Georgia | Michigan | Oklahoma | West Virginia |
| Hawaii | Minnesota | Oregon | Wisconsin |

**Source:** Susan Laudicina, Joan Gardner and Angela Crawford, "State Legislative Health Care and Insurance Issues: 2008 Survey of Plans" (Washington, D.C.: Blue Cross and Blue Shield Association, 2008).

Proposals for either a single national exchange or a series of state exchanges should incorporate provisions that ensure that persons who obtain coverage through an exchange have access to the same sorts of consumer protections that persons in California and many other states currently enjoy. The House Tri-Committee bill would establish an office within

[iii] ERISA reform would guarantee greater access to consumer protections for all Americans, but that issue is beyond the scope of this brief. Many of the types of state consumer protections laws described in this brief have faced ERISA challenges.

the national health insurance exchange that would answer consumers' questions and assist them if they encounter problems with their health plans. The bill would require carriers that offer coverage through national or state exchanges to establish mechanisms for disclosure of information and for timely resolution of grievances and appeals, including an external, independent review process. It is unclear how these requirements would interact with existing state consumer protection laws. Federal policymakers should consider adopting minimum national consumer protection standards but allowing states with stricter standards to apply those standards to commercial health insurance sold both within and outside a state-based exchange.

## RECOMMENDATIONS FOR FEDERAL HEALTH INSURANCE REFORM LEGISLATION

This review of California's experience with regulation of health insurance points to five major lessons for federal policymakers regarding the design of national and/or state health insurance exchanges. These design elements are essential to ensure that exchanges will meet the needs of Americans who lack access to comprehensive, affordable coverage.

- **Health insurance exchanges should be designed to ensure that all individuals who do not have access to employer-sponsored health insurance can purchase comprehensive coverage regardless of their health status, gender, or age**. Achieving this goal will require guaranteed issue and guaranteed renewability of policies, limits on preexisting condition exclusions, and restrictions on the use of health status, gender, and age in setting premiums. Transition provisions and/or age bands will be needed to prevent "rate shock" for younger, healthier persons in states in which extensive medical underwriting exists in the individual health insurance market.

- **Establish mechanisms to ensure that health insurance coverage sold through health insurance exchanges is affordable, such as subsidies, tax credits, and public program expansions**. If an individual mandate to purchase health insurance is enacted, all Americans must have access to affordable coverage. Efforts to ensure affordability must encompass both premiums and out-of-pocket costs because premium subsidies alone will not be sufficient to provide low- and moderate-income persons with affordable coverage.

- **Establish consistent rules regarding minimum benefits, maximum cost sharing, and other aspects of benefit design to ensure that all consumers have comprehensive coverage and to help consumers make meaningful comparisons across health insurance products offered through health insurance exchanges**. Standards for minimum benefits and maximum cost sharing are necessary to ensure that all Americans have comprehensive health insurance that covers a substantial portion of their health care expenses. Standardizing benefit designs would also help consumers select the coverage that best meets their needs and preferences.

- **Ensure that the rules by which premiums are set are consistent for health insurance products sold inside and outside health insurance exchanges to reduce the risk that the exchange will experience adverse selection**. Unless carriers are

required to abide by the same rules when setting premiums for health insurance products sold through and outside the exchange, the exchange will be vulnerable to adverse selection, which would render it unsustainable. Members of Congress should also consider creating additional financial incentives for small employers to purchase coverage through the exchange or require small businesses to purchase coverage through the exchange.

- **Build upon existing state laws to develop strong consumer protection standards for health insurance purchased through national or state exchanges**. Many states have established mechanisms for disclosure, quality assurance, and dispute resolution that could serve as models for national consumer protection standards for policies sold through a national exchange. Federal policymakers should require that all health insurance products sold through a national exchange meet national consumer protection standards. They should also permit states to enforce stricter standards for products sold through state-based exchanges or outside the exchanges.

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