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IssueBrief

When a Health Insurer Leaves the Individual Market:

What States Can Do before Certain Affordable Care Act Changes Take Effect in 2014

More than 14 million Americans have health insurance through policies sold in the individual market,[1] which is the only place many of these consumers can buy coverage. Most people covered through the individual market are self-employed, work for small businesses, cannot afford or do not qualify for their employer's plan, are between jobs, or have retired but do not yet qualify for Medicare.[2]

Consumers seeking coverage in the individual market aren't yet protected by the same federal and state rules that protect people in job-based plans. For example, the federal Health Insurance Portability and Accountability Act (HIPAA, enacted in 1996) requires that all plans sold in a *group* market (that is, job-based plans) be "guaranteed issue." This means that health insurers cannot refuse to cover a particular employer or employee based on health status. Furthermore, HIPAA limits the amount of time that a group plan can refuse to cover treatment of a policyholder's pre-existing condition. This is called an exclusion period, and HIPAA does not allow group plans to exclude coverage for an employee's pre-existing condition for more than 12 months. In addition to this and other federal regulations, several states regulate how much plans can vary the premiums they charge policyholders in a group.[3] However, in many states, adults who buy coverage in the individual market don't have any of these protections.[4]

Because there are currently so few consumer protections in the individual market, many people who are covered by individual market policies would have an especially hard time finding coverage if their insurer left the state. Half of consumers who are covered by plans in the individual market say it would be difficult to find a new plan because of a pre-existing condition, because the search process would be too complicated, or because an affordable alternative simply does not exist.[5] Fortunately, in 2014, this will change: The Affordable Care Act will prohibit insurers from denying anyone coverage because of health status, excluding coverage of pre-existing conditions, or charging people higher premiums because of health status or gender. These protections will make it easier for consumers in the individual market to find new, affordable coverage. Until such reforms go into full effect, it is important to understand what consumer protections currently exist and what role states can play in supplementing them.

States are sometimes hesitant to pass consumer-friendly insurance laws or regulations because insurers threaten that, if such protections end up making a state's insurance market "less profitable," insurers will then leave the state. If a state loses an insurer before the Affordable Care Act's exchanges and consumer protections are fully in place in 2014, many adults will be left without access to comprehensive insurance. However, states do have some power to protect consumers when insurers leave or threaten to leave.

If an insurer withdraws from a state, the state can establish its own consumer protections that go beyond current HIPAA protections to ensure that affected policyholders transition smoothly into new, affordable coverage. A state can take the following actions:

- Entice insurers to stay in all markets by requiring insurers who want to sell group policies in the state to also sell individual policies.
- Negotiate with the remaining insurers in the market to take on affected policyholders.
- Use state high-risk pools as a buffer against possible market disruptions.
- Use guaranteed issue plans as a buffer against possible market disruptions.

In the sections that follow, we examine existing consumer protections, then we take a more in-depth look at each of the actions listed above.

What Protections Exist Now or Are Coming in 2014?

Throughout the years, many insurers have withdrawn from state markets. Though insurers sometimes threaten to leave when they dislike a proposed regulation, in point of fact, there are likely other reasons for their departure. Often, insurers leave a state's market because they are not competitive enough or because their business interests have changed, rather than because of any changes in state or federal policy.

HIPAA sets some federal requirements for insurers who leave a market or drop specific policies.[6] Currently, HIPAA bars insurers that leave the individual market from re-entering for five years.[7] This helps maintain stability in the market and keeps insurers from gaming the system by re-entering only when it is most profitable. HIPAA also requires insurers to provide policyholders with 180 days' notice before exiting the market, which gives consumers time to find new coverage.[8] The Affordable Care Act includes several new protections that will supplement existing HIPAA regulations.[9]

States that currently have "guaranteed issue" requirements and restrictions on "health rating" offer consumers some protection if an insurer leaves the market: These measures can help consumers obtain coverage from the insurers that remain. We discuss these protections below.

■ Guaranteed Issue

Guaranteed issue helps ensure that consumers can easily find and purchase coverage without being denied because of age, gender, health status, medical history, disability, or other health and claims experience.

HIPAA requires all policies sold in the *group* market to be guaranteed issue. This means that health insurers cannot refuse to enroll a certain employer and its employees because of the group's overall health status.[10] Furthermore, job-based plans cannot refuse to enroll an individual employee based on health status, and if that person had previous coverage for at least 12 months, his or her new job-based plan cannot refuse to cover any pre-existing conditions.[11]

People also have some protections when they move from group coverage to the individual market: If the person had been covered continuously for 18 months when he left his job-based plan, designated insurers in each state must accept him.[12] Unfortunately, premiums for this new coverage can be prohibitively expensive.

HIPAA does *not* provide guaranteed issue for people who wish to change from one plan in the individual market to another individual market plan, or who want to buy an individual plan after being uninsured, and just a few states require their own individual market to be guaranteed issue.

The Affordable Care Act is changing this. Starting in 2010, plans that cover children aged 19 and under can no longer exclude, limit, or deny coverage based on health status or disability. This applies to all non-grandfathered job-based plans and to individual market plans that are issued after March 23, 2010. (Grandfathered plans are health plans that existed on the day the health law was enacted. These plans are exempt from requirements to comply with some of the consumer protections in the health care law. Non-grandfathered plans, on the other hand, must comply with these requirements.) This protection will be extended to all adults in 2014. Until then, when an individual market insurer exits a state, residents with pre-existing conditions may have an especially difficult time finding other coverage in their state's individual market.

Health Rating Restrictions

Affordability plays a major role in whether consumers are able to purchase coverage. Federal law does not currently regulate how much plans can vary their premiums in the individual market, and only a few states regulate premiums in the individual market using "rate bands" or "community rating."

- *Rate bands* limit how much an insurer can vary premiums for a person based on factors like health, gender, and age.
- *Community rating* prohibits any insurer from charging its enrollees different prices based on the enrollees' health. All enrollees in a particular plan in a particular service area are charged the same premium for a product. Some states with community rating do allow insurers to make adjustments to individual premiums based on factors such as age, but they are not permitted to make adjustments based on health.

Starting in 2014, new health plans sold in the individual market will not be allowed to charge consumers higher premiums based on health status or gender. Plans will be allowed to vary premiums on a limited basis based only on age, premium rating area, family composition, and tobacco use. But until 2014, the lack of adequate health rating protections in the individual market in most states may cause problems for consumers whose insurer has left the market.

Tools for Protecting Consumers When Insurers Leave the Market

When an insurer decides to leave the individual market, it has a legal obligation under HIPAA to provide at least 180 days' notice to affected policyholders before the insurer closes out all blocks of its business. States should consider requiring this 180 days' notice to contain information that helps affected policyholders find new coverage. The state could work with the insurer to include information about all the possible alternative coverage options an affected policyholder may have. For example, if the affected policyholder is a young adult (under 26 years), she may qualify as a dependent under her parents' coverage. Or, if the affected policyholder has a spouse with job-based group coverage, he may be able to enroll in his spouse's plan.[13]

Other HIPAA, Affordable Care Act, and state market protections, like limitations on pre-existing condition exclusions, can make it easier for affected policyholders to find new health coverage when their insurer withdraws from the market. However, when a state learns that an insurer is planning to withdraw—or if it just wants to do more to protect health care consumers—the state can go beyond current federal and state protections by actively ensuring that consumers can transition smoothly into new and affordable coverage alternatives.

- ### Entice insurers to stay in all markets by requiring insurers that want to sell group policies in the state to also sell individual policies.

  As discussed in more detail on page 11, in 2010, insurers in some states wanted to stop offering child-only policies because the companies could no longer exclude children with pre-existing conditions. Some states took action and passed legislation that required all insurers in their individual markets to offer child-only policies.[14] Doing so meant that insurers could no longer sell only more lucrative family policies, which was another way they had discriminated against children with pre-existing conditions.

  Just as some states passed legislation requiring insurers to sell child-only policies, a state could require insurers to stay in the individual market in order to have access to the state's group market. Job-based insurance, which includes coverage purchased through the group market, as well as self-insured employers, covers 10 times more people nationally than the individual market.[15] Because the group market may represent a large share of an insurer's business, requiring the company to sell in the individual market in order to compete in the group market may convince it to stay.

However, this tactic might not work in every state. Depending on how many insurers there are, the levels of competition, and the market share of different carriers, insurers might not be induced to sell in both markets. Each state should consider whether this approach would work for its particular market. States can also consider other types of incentives. For instance, if insurers in a state must compete to sell to state employees or to sell in the exchange, the state could announce that it will give special consideration to insurers that pledge to continue to sell in the individual market.

Summary of Recommendations

States can pass legislation that requires insurance companies to offer plans in the individual market in order to have access to the group market.

■ Negotiate with the remaining insurers in the market to take on affected policyholders.

States can actively work with an insurer that is leaving the market to transition affected policyholders to remaining insurers. These negotiations help both consumers and insurance companies: Consumers will be able to find new coverage, and insurers will gain new customers, meaning they will make more money and will be able to spread risk across more covered people.

State Examples

Ohio: When insurers withdraw from the market, the Department of Insurance works with the remaining insurers in the state to take on their "fair share" of policyholders who have lost coverage. The state did this in 2009, for example, when Nationwide withdrew from the individual market.[16] Different insurers each volunteered to take a portion of policyholders on a guaranteed issue basis. (In accordance with state law, these insurers were still allowed to rate the new policyholders based on their health status.)[17] Separately, Ohio also generally requires all insurers that sell in the individual market to offer certain standardized plans on a guaranteed issue basis until the plans have enrolled a certain state-determined number of enrollees.[18,19]

Illinois and Texas: Insurers can also negotiate directly with other carriers when they withdraw from the market. In 2009, for example, WellPoint, the parent company of UniCare, announced that UniCare would be withdrawing from all markets in Illinois and Texas. This departure affected about 180,000 policyholders in each state.[20] WellPoint negotiated with Health Care Service Corporation, which operates as Blue Cross and Blue Shield (BCBS) of Illinois and of Texas, to accept UniCare's policyholders on a guaranteed issue basis. Policyholders were given the

choice of either switching to BCBS or staying with UniCare until their coverage was terminated. Once their coverage with UniCare ended, policyholders who had not elected to move into BCBS were responsible for finding new coverage on their own.[21]

These kinds of negotiations among insurers may benefit all companies involved and improve their business relationships. Since the negotiated transfer of policyholders, WellPoint has collaborated with BCBS of Texas and Health Care Services Corporation on several different business ventures.[22, 23]

Summary of Recommendations

Whether the state insurance department or the withdrawing insurer decides to negotiate with remaining insurers in the market, a state must consider requiring that these negotiations include certain consumer protections. The protections listed below will help ensure that all affected policyholders have access to alternative coverage options.

- States must establish either a guaranteed issue requirement that provides consumers with access to all remaining plans in the market or a way to equitably distribute policyholders among plans that prevents plans from "cherry-picking" healthier policyholders and denying coverage to others.
- Insurers must give consumers timely notice and information about alternative coverage options. This information can be included in the 180-day notice that withdrawing insurers are already required to send to their policyholders.
- Regulators should consider whether the benefits offered by remaining carriers are as comprehensive as the benefits offered by the insurer that's leaving, and they should warn consumers of any gaps.
- If possible, the state should prohibit insurers from "re-underwriting" the enrollees that they take on from the withdrawing insurer. That is, they should not allow the new insurer to re-examine the health status of each policyholder or place new customers in higher rate bands. States that have reinsurance pools or risk-adjustment systems may be able to compensate insurers that take on higher-risk enrollees after another insurer exits the market. Reinsurance pools use contributions from all insurers to help pay for very high medical claims. Similarly, risk-adjustment systems provide insurers with additional money if they have a disproportionate number of enrollees with serious health conditions.

■ Use state high-risk pools as a buffer against possible market disruptions.

High-risk pools are nonprofit associations that can provide coverage to three specific groups of individuals in states: medically eligible people (those with pre-existing conditions who are unable to obtain coverage elsewhere), HIPAA-eligible people (those moving from the group to the individual market who are guaranteed the right to purchase individual coverage), and/or Health Coverage Tax Credit (HCTC)-eligible people (certain workers and retirees whose job-based coverage is lost because of increased imports or trade-related relocation).[24] Currently, 34 states operate a high-risk pool, and 32 of those are open to medically eligible people.[25]

High-risk pools are where many affected policyholders end up if they cannot find new coverage on their own. However, many states use their high-risk pool as a last resort for those with pre-existing conditions, and the eligibility criteria for the pools often reflect that. State high-risk pools that accept medically eligible individuals generally require applicants to document that 1) they first applied for coverage in the individual market and were denied, 2) the coverage they found in the individual market had higher premiums than those in the high-risk pool, or 3) the coverage they found had restrictive riders that excluded their pre-existing condition.[26]

Premiums in high-risk pools are higher than average premiums in the individual market, but they are lower than they would be based on the enrollees' pre-existing conditions. Premiums in high-risk pools are capped at anywhere from 100 to 250 percent of standard rates, which is quite expensive but still below what health care would cost without insurance or coverage in the individual market. In most states, assessments on state-licensed insurers help fund the additional costs of care for this population.[27, 28] These premiums may still be so high, however, that coverage is not affordable for consumers affected by an insurer leaving the market. States should consider creating lower caps for consumers who have involuntarily lost their coverage in the individual market.

States should also consider making involuntary termination of coverage an automatic eligibility category for their high-risk pools. This would allow affected policyholders who know they will have a hard time finding new coverage in the private market to quickly sign up through the high-risk pool and avoid gaps in coverage. Also, because the scope and quality of coverage sold in the pool may vary from the coverage sold in the individual and group markets, states may want to inform consumers if such differences exist.

Summary of Recommendations

If a state decides to use its high-risk pool to help affected policyholders, it should consider doing the following:

- Making policyholders who have involuntarily lost their coverage automatically eligible for the high-risk pool.
- Establishing lower caps on premiums for these enrollees and/or requiring the withdrawing insurer to pay any increased costs that its former policyholders will have to pay if they enroll in high-risk pools.
- Providing timely notice and information about the high-risk pool. This information could be included in the 180-day notice that withdrawing insurers are required to send their policyholders.

Use guaranteed issue plans as a buffer against possible market disruptions.

States that don't have a high-risk pool that is open to new enrollees may have an "insurer of last resort" or may require that some or all carriers offer guaranteed issue plans. Just like high-risk pools, these plans may be where those who lose coverage end up if they cannot find coverage elsewhere. In five states, Blue Cross Blue Shield plans operate as the insurer of last resort.[29, 30] In six other states, insurers offer certain guaranteed issue plans to all consumers or to specific people who meet eligibility requirements.[31] In five additional states, the entire individual market is guaranteed issue.[32]

Open enrollment periods and/or enrollment caps, which are used by guaranteed issue plans, can restrict access to coverage. Once the cap is reached or the enrollment period ends, access to the plan is closed until some future point when the plan can take on new enrollees or the enrollment period opens again.

If a state considers using guaranteed issue plans to help consumers who are affected by an insurer's withdrawal from the market, these plans need to be available immediately when consumers lose their coverage. To prepare for such a situation, states should consider creating special enrollment periods for guaranteed issue plans that are triggered whenever consumers involuntarily lose their coverage. States could also require remaining carriers in the individual market to open up their plans to affected policyholders on a guaranteed issue basis. This would sidestep enrollment caps for existing guaranteed issue plans that may hit their limit if a large number of consumers lose coverage.

While some states have guaranteed issue plans, insurers in most states can still charge consumers more based on health status under state law. As discussed earlier, few states have strong rules limiting the extent to which insurers can vary the premiums they charge consumers in the individual market. States should consider enacting rating limits for guaranteed issue plans that enroll individuals who have involuntarily lost their coverage.

Guaranteed issue plans or high-risk pools can act as a buffer against market disruptions and instability, but states need to ensure that affected policyholders can afford these plans. If each insurer takes on a fair proportion of enrollees, these insurers are not likely to face greater financial risk if they accept the former policyholders of an insurer that exits the market. That's because if an insurer withdraws from the individual market in a state, hundreds or even thousands of policyholders would be added to the pool of consumers, and remaining insurers would benefit from having more customers and thus better spreading their own business risk. Moreover, some states already have risk-adjustment or reinsurance mechanisms that could help compensate insurers that take on a significantly less healthy population.

Summary of Recommendations

If states decide to use guaranteed issue plans to help affected policyholders, they should consider doing the following:

- Creating special enrollment periods for guaranteed issue plans that are triggered when consumers involuntarily lose their coverage due to events like an insurer withdrawing from the market.
- Requiring remaining carriers in the market to open up their plans to affected policyholders on a guaranteed issue basis. This would be especially important if existing guaranteed issue plans had enrollment caps.
- Enacting rating limits for guaranteed issue plans that enroll individuals who have involuntarily lost their coverage.
- Providing affected policyholders with information about guaranteed issue plans in their state and how to enroll in these plans. This information could be included in the 180-day notice that withdrawing insurers are already required to send their policyholders.

The Power of State Negotiations: A Lesson from Child-Only Policies

States have the power to negotiate when insurers want to leave the market or to stop offering specific policies. In 2010, for example, when insurers in many states announced that they would no longer sell child-only health insurance policies, many states worked to stop them.[33] These policies are important to families when a parent's job-based insurance does not cover dependents, when the parent(s) cannot afford coverage for the entire family but wants the child covered, or when the child lives away from his or her parent(s) and needs separate coverage.

Starting in 2010, under the health care law, new plans sold in the individual market that covered children aged 19 and under could no longer exclude, limit, or deny coverage based on health status or disability. When this requirement went into effect, insurers threatened to stop selling child-only policies because they feared parents would sign up for the policies only after their children got sick.

States took a variety of actions to keep child-only policies on the market and to allay insurers' fears. Under guidance issued by the Department of Health and Human Services, many states established annual uniform open enrollment periods.[34] Parents can enroll their children only during these periods, and after they close, children can be enrolled only under certain circumstances, such as when a parent loses coverage due to divorce or adds new dependents. Some states, like Arkansas, California, Colorado, and Washington, also passed legislation requiring all insurers operating in the individual market to offer child-only policies.[35, 36, 37] In May 2012, Georgia became the latest state to require individual market insurers to offer at least one child-only policy.[38] As of July 2011, 33 states had insurers that sold child-only policies or guaranteed issue policies for children.[39]

In the future, these policies may be sold in more states if states continue to pass legislation or establish open enrollment periods. For example, Arkansas did three important things to protect children covered through child-only policies. First, the state passed legislation in March 2011 that requires all insurers in the individual market to offer child-only plans on a guaranteed issue basis. Second, to prevent adverse selection, the state established an annual open enrollment period (each October).[40] Third, at the end of March 2011, Mercy Health Plan, the sole issuer of child-only policies in Arkansas, was planning on exiting the entire market. This would have left children covered through Mercy's child-only policies with no alternative coverage option until the first open enrollment period in October 2011. The Insurance Department negotiated an agreement with Mercy under which Mercy paid up to $3,500 for each of its former policyholders (including children and adults) to move into the state's high-risk pool until they could enroll in other plans. This helped consumers pay the higher premiums charged by the high-risk pool.[41]

Conclusion

Throughout the years, insurers have left the individual market for a number of reasons. HIPAA provides some consumer protections by banning insurers from leaving and returning to the market whenever they want, and by requiring that insurers give policyholders timely notice. HIPAA and state laws also provide some regulation of how much plans can charge consumers. However, because many states' individual markets have few consumer and cost protections, policyholders may find themselves in a vulnerable position if their insurer withdraws from the market.

Until the Affordable Care Act's market reforms are in effect in 2014, states can establish transitional tools for affected policyholders. These consumer protections would be a bridge to 2014, when all insurance markets will be guaranteed issue, and when consumers will no longer be denied coverage based on pre-existing conditions.[42] Insurers will also not be allowed to charge higher premiums because of gender or health status.[43] In the meantime, states have a number of options for protecting consumers.

If an insurer leaves the individual market, many policyholders will be scrambling to find new coverage. Implementing transitional tools can help ensure that all consumers in a state continue to have access to quality, affordable health insurance.

Endnotes

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[2] Kaiser Family Foundation, *Survey of People Who Purchase Their Own Insurance* (Washington: Kaiser Family Foundation, June 2010), available online at http://www.kff.org/kaiserpolls/upload/8077-R.pdf.

[3] Kaiser Family Foundation, *Small Group Health Insurance Market Rate Restrictions, 2011* (Washington: Kaiser Family Foundation, 2011), available online at http://statehealthfacts.org/comparetable.jsp?ind=351&cat=7.

[4] Kaiser Family Foundation, *Individual Market Health Insurance Market Rate Restrictions, 2011* (Washington: Kaiser Family Foundation, 2011), available online at http://statehealthfacts.org/comparetable.jsp?ind=354&cat=7.

[5] Kaiser Family Foundation, *Survey of People Who Purchase Their Own Insurance*, op. cit.

[6] If an insurer drops a particular type of coverage but does not exit the entire individual market, it must offer the affected policyholders the option to purchase new coverage. The insurer must provide the affected policyholders with at least 90 days' notice and the option to purchase other health insurance products sold by the insurer. The insurer cannot take into account or exclude pre-existing conditions under the new coverage options.

[7] 42 U.S.C. § 6A, XXV, Part B, subpart 1, 300gg-42(c)(2)(B).

[8] 42 U.S.C. § 6A, XXV, Part B, subpart 1, 300gg-42(c)(2)(i).

[9] The Affordable Care Act requires guaranteed issue and renewability. Rating variation is allowed based only on age (limited to a 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to a 1.5 to 1 ratio) in the individual and small group markets and the exchanges.

[10] 42 U.S.C. § 6A, XXV, Part A, subpart 1, 300gg-1(a)(1).

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[23] *BlueCross BlueShield of Texas, Health Care Service Corporation, Wellpoint, and Blue Cross Blue Shield of Michigan Collaborate in National Private Exchange and Defined Contribution Solution for Employers*, September 20, 2011, available online at http://www.bcbstx.com/company_info/newsroom/press_releases/2011/2011_09_20.html.

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[26] National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis*, 23rd ed., 2009/2010 (Denver, CO: NASCHIP, August 2009).

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[29] These five states are the District of Columbia, Michigan, Pennsylvania, Rhode Island, and Virginia.

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[42] The Affordable Care Act requires plans in the individual and group markets be sold on a guaranteed issue basis. That means plans must accept all employers, employees, and individuals who apply for coverage. This does not apply, however, to grandfathered plans in the individual market and grandfathered and self-funded plans in the group market.

[43] This does not include grandfathered plans in the individual market and grandfathered and self-funded plans in the group market.

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