Quality File

AMERICAN ACADEMY *of* ACTUARIES

January 29, 1998

The Honorable Christopher C. Jennings
Special Assistant to the President for Health Policy Development
Rm 216 Old Executive Office Building
The White House

Dear Chris,

I want to thank you for the opportunity for John Trout and myself to discuss matters of mutual interest with you and Jeanne Lambrew recently. As we indicated in that meeting, the Academy will develop its official analysis of the Medicare buy-in proposals as soon as we get the details of the proposals. We will let you know as the Academy's analysis progresses.

We appreciate the offer to provide briefings on Medicare buy-in for Academy members; that will be most helpful at the appropriate time. In the meantime, we have released the enclosed letter concerning the status of the Academy's analysis of the proposals.

We stand ready to provide nonpartisan technical assistance to all interested parties on issues where actuarial expertise would be helpful.

Yours truly,

Wilson

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The Honorable Christopher C. Jennings
Special Assistant to the President for Health Policy Development
Rm 216 Old Executive Office Building
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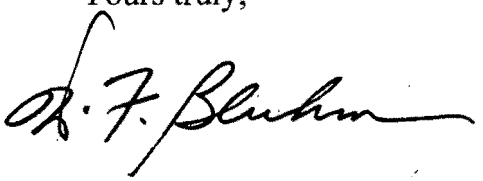
Dear Mr. Jennings:

The American Academy of Actuaries has taken no position in support of or in opposition to Medicare buy-in proposals announced by the President. Nor has the Academy concluded that those proposals are workable or unworkable, or that the cost estimates, premium amounts, and projected participation figures are accurate or inaccurate. The Academy provides nonpartisan analysis to elected officials and does not take positions on policy issues.

There are issues about which we need more information before the Academy can adequately analyze the Medicare buy-in proposals from an actuarial perspective. When the details of the proposals are made available, we will analyze them as thoroughly as possible. We will be happy to discuss the results of our analysis with all interested parties and stand ready to assist in the development of technically sound policies.

Similar letters are being sent to the Senate Minority Leader, the Speaker of the House, the House Minority Leader, and the Administration.

Yours truly,



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David Rudolph

228-3904

Table 12 Total and Population-Adjusted Number of Insurers in the Individual Health Insurance Market: 10 Study States, 1995		
State	**Total number of insurers**	**Number of insurers per million population**
CA	50	1.8
FL	40	3.4
IA	17	6.7
LA	31	8.2
MT	7	9.5
ND	8	15.1
NY	37	2.3
PA	32	3.1
UT	11	6.1
WA	16	3.3

Source: Alpha Center Health Insurer Database, 1997; and Alpha Center tabulations of the March 1996 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

Table 13 Individual Health Insurance Market Share Held by the Largest Five Insurers and the Smallest Half of Insurers: 10 Study States, 1995		
State	**Market share of largest five insurers (percent)**	**Market share of smallest half of insurers (percent)**
CA	69.1	3.7
FL	76.6	3.9
IA	79.3	11.2
LA	67.6	9.3
MT	92.3	21.8
ND	85.7	22.5
NY	77.4	5.4
PA	72.0	6.7
UT	88.0	12.0
WA	88.9	6.0

Source: Alpha Center Health Insurer Database, 1997.

The presence of many small insurers holding very small market shares suggests several implications for these markets. Some insurers may be in the process of entering or exiting the market in a given year

and hold small market share because they are ramping up or down their presence in a state. (We have eliminated consideration of some but probably not all of these insurers by disregarding those that reported less than $500,000 of earned premiums.) Alternatively, a small insurer may be operating in a niche market, defined by its underwriting practices, marketing, or product design. Traditional indemnity insurers not bound by the geographic constraints of a provider network may strategically seek small amounts of business in many states.

How Markets Are Changing: Agent Impressions

Agents reported their general impressions of how volatile or stable their markets had been in the past few years, whether significant insurers were entering or leaving the state, and their perceptions of what factors were driving the market now. Agents in four states—California, Florida, Utah, and Washington—described their states' individual markets as highly competitive and/or volatile, with many insurers leaving the market and few entering:

- In both the southern and northern parts of California, the market was described as highly competitive but stable: relatively few insurers have left the California market in recent years. The abrupt departure of one prominent commercial insurer in 1997 from both the group and individual markets was attributed by one agent to liberal underwriting (accepting applicants with health conditions that other insurers might have denied), coupled with that insurer's having offered a true indemnity product in a market dominated by managed care. (However, in a letter to California agents, that insurer cited the "tremendous increase in competition" in the California market as a primary reason for its withdrawal.) The competitive disadvantage of insurers that offer traditional indemnity products in a managed care market was given also as the reason for the withdrawal of another commercial insurer from the individual health insurance market nationwide.

- In Florida, the market also was described as very competitive, with insurers experiencing "abysmal" loss ratios attributable in part to what the agent described as the state Department of Insurance's restrictive policy on approving rate increases.[10] The agent also believed that Florida's reforms in the small group market were affecting the individual market. He theorized that insurers were underwriting in the individual market more aggressively because they anticipated losses in the small group market, where guaranteed issue is required and rates are banded. In early 1998, an insurer

[10]A loss ratio is defined as the ratio of the insurer's medical losses (claims paid) to premiums earned. Many states regulate premium increases by setting a minimum loss ratio. Such states typically require a minimum loss ratio for group business at 75 percent and a minimum aggregate loss ratio for individual business at 65 percent as a precondition for granting an insurer's application for a rate increase.

known for primarily selling individual insurance announced its intent to withdraw from both the group and individual markets in Florida.

- In Utah, Blue Cross/Blue Shield and a Utah-based HMO are the only major insurers now writing in the individual health insurance market. Since 1995, one national HMO and several large commercial insurers have left Utah's individual health insurance market The HMO had tried to withdraw both of its subsidiaries, but the state had allowed it to withdraw only one. The HMO's remaining subsidiary was reported to be raising premiums by an average of 70 percent and rolling its PPO product into an HMO product. A large Utah-based HMO reports that it is losing a million dollars a month on their individual plans. Although a few smaller commercial insurers remain, some agents are reluctant to place business with them, fearing they will leave. Expressing an apparently common sentiment, our agent attributed the exit of insurers to the recent implementation of individual market reforms.

- In Washington, a number of insurers left the state in the years following the 1993 and 1995 reforms. All of the commercial insurers have left, and the insurers that remain (particularly the Blue Cross and Blue Shield plans) are reported to be incurring significant losses in the individual market. Our agent reported a strong sentiment within the industry that the small-group and individual health insurance reforms were excessive. In particular, she pointed to the very short pre-existing condition waiting and look-back periods (3 months each) which allow consumers to postpone buying insurance until they anticipate immediate health care expenditures. In 1997, the governor vetoed a bill which had been passed by the legislature creating a once-a-year open enrollment period in lieu of the continuous open enrollment now in effect.

- In five other study states (Iowa, Montana, North Dakota, New York, and Pennsylvania), the individual health insurance markets were described as stable and relatively quiet. In Montana and Pennsylvania, the dominance of Blue Cross and Blue Shield plans seems to anchor and stabilize the individual health insurance market. (In Pennsylvania, our agent attributed the state's stable market both to a "favorable" regulatory climate and to the large market share held by Blue Cross and Blue Shield plans.) In the wake of Montana's 1993 small-group reforms, our agent there believed that the individual health insurance market now is more stable than its group market. In North Dakota, relatively modest reforms have not disrupted the individual health insurance market: insurers have modified their product lines, but they have stayed in the individual market. North Dakota's reforms are perceived within the insurance agent community generally as fixing rather than fundamentally changing the market. In New York, several commercial insurers left the individual health insurance market immediately (without incurring significant experience) following the implementation of

community rating and other reforms in 1993. However, the market stabilized quickly.[11] At present, only one commercial insurer is writing non-HMO individual coverage in New York, but this has raised no particular concern among insurers, regulators, or consumers.

The Role of Blue Cross and Blue Shield Plans

Historically, Blue Cross and Blue Shield (BCBS) plans have played a special role in health insurance markets: commonly, they have guaranteed issue and community rated their policies. In return, all states have exempted them from taxation. In recent years, BCBS plans have changed significantly. Some have become for-profit companies (relinquishing their tax-exempt status) or have formed for-profit subsidiaries which now hold a significant portion of their business. Others have converted to not-for-profit mutual companies, allowing them to sell products across state lines. Still others, while retaining their nonprofit status, no longer are required by the state to guarantee issue or to community rate their products, or have merged with other regional plans to gain market share. The BCBS plans in our study states have participated in these national trends:

- In California, Blue Cross of California has converted to for-profit status, while Blue Shield of California remains not-for-profit (and recently purchased a for-profit health plan with the intention of converting it to not-for-profit status). In Montana, New York, and Pennsylvania, BCBS plans have created for-profit HMO subsidiaries.

- In Washington, King County Blue Shield is aligning with BCBS of Oregon and Blue Shield of Idaho. Our Washington agent attributed this strategic move in part to Washington's difficult market following implementation of the state's insurance reforms.[12] In Utah, BCBS has joined a consortium

[11] Two studies (Institute for Health Policy Solutions, 1995; and Barents Group, 1996) reported significant drops in enrollment and premium increases in the years following implementation of New York's individual health insurance reforms. Barents Group (1996) estimated that the number of individuals enrolling in this market dropped continuously between 1992 and 1995 (with 1995 enrollment just 73 percent of the 1992 level), and that the premium for single coverage increased by 15.5 percent, on average (ranging from 3.9 percent to 31.1 percent in different areas of the state). The average price of family coverage rose 18.2 percent (ranging from -2 percent to 45.6 percent). While there is some evidence that New York's small group market did experience initial jumps in premiums (Paul and Chollet, 1996), it remains unclear how much of the decline in individual coverage in New York is attributable to the state's individual health insurance market reforms.

[12] Blue Cross and the regional Blue Shield plans are among the few insurers remaining in Washington's individual market. According to our agent in Washington, Blue Cross continues to report losses on its individual products. Blue Shield's "stripped" plans appear to be profitable, but its older, richer-benefit plans are not. One factor complicating matters in Washington is the history of insurers' rating practices there. Because the individual insurance market had been heavily underwritten prior to reform, premiums historically had been low. Insurers had not increased individual health insurance premiums since 1992, and they were unable to argue on a prospective actuarial basis for a rate increase, anticipating higher risk enrollees after reform. By 1995, the six largest insurers reported combined losses of $58 million, but the insurance commissioner nevertheless denied insurers' requests for

of Blue Cross Plans, and in Pennsylvania, Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield have merged to form a consolidated BCBS corporation called Highmark.

In only two of our study states, did BCBS plans *de facto* play a special role:

- In California, Blue Cross offers a limited type of guaranteed issue, "rating-up" policies for certain health conditions rather than declining coverage altogether, particularly for previously uninsured individuals. Both Blue Cross and Blue Shield offer individuals who are wait-listed for California's high-risk pool (called MRMIP or "Mr. MIP") an identical plan at premiums considerably higher than the MRMIP premium. However, these products are available only until the policy holder is accepted into MRMIP.

- In Pennsylvania, BCBS plans guarantee issue and community rate some of their policies. Pennsylvania has proposed to comply with HIPAA's provisions requiring guaranteed issue to federally qualified individuals in the individual health insurance market by designating BCBS plans as the insurer of last resort.

While most BCBS plans now resemble their for-profit competitors, they continue to dominate the individual health insurance market in most states — and in all of our study states, except California. In three of the study states (Pennsylvania, Utah, and Washington) BCBS plans held at least 60 percent of the market in 1995 (see Table 14). Collectively, Washington's four BCBS plans held 77 percent of the market; as many commercial insurers are reported to have left Washington's individual health insurance market, the collective market share of its BCBS plans probably has increased since 1995.

In seven of the ten study states, BCBS plans hold a larger share of the individual market than the group market. However, in three of the states with the largest individual health insurance markets (Iowa, Montana, and North Dakota), BCBS plans hold a larger share of the group market than the individual market. Perhaps coincidentally, it is in these states — where BCBS plans are dominant in the individual markets(described below), BCBS HMOs typically write very little coverage in the individual market (see Figure 5).

Name recognition and reputation for service were cited by several agents as the principal reasons for

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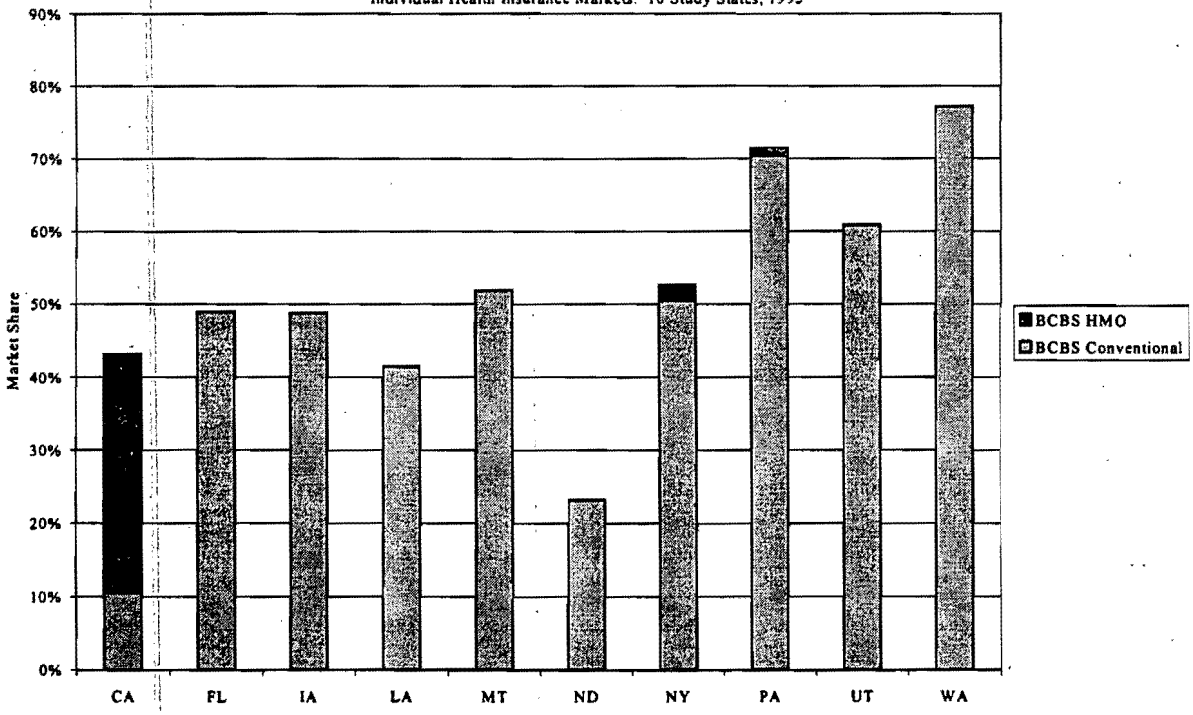
significant rate increases. In response, one insurer proceeded to raise its rates by 34 percent anyway; another brought suit, challenging the commissioner's decision (Crystal, 1996).

Figure 5
Conventional and HMO Blue Cross and Blue Shield Market Share in
Individual Health Insurance Markets: 10 Study States, 1995



Source: Alpha Center Health Insurer Database, 1997

the continued dominance of BCBS plans. Our agent in New York believed that BCBS plans have continued to gain market share as an individual health insurer despite the demise of hospital rate regulation that had given BCBS plans a significant discount on hospital charges. In California, Florida, and New York, agents attributed BCBS plans' continued dominance to highly competitive prices and products. In Florida, BCBS had not raised individual base rates since 1991; in California, Blue Shield offered a $2,000 deductible plan at only a slightly higher premium than another insurer's $10,000 deductible plan.

The individual insurance market in Montana suggests how difficult it may be for new insurers to enter a market dominated by a single large insurer such as BCBS. In Montana, BCBS's rates were reported to be often higher than those of commercial insurers. One commercial insurer that entered Montana's market several years ago with low initial rates did succeed in taking market share from BCBS. However, that insurer is now raising renewal rates by as much as 30 percent. Prior to that, three insurers were reported to have tried and failed to take BCBS's market share; each of these companies became insolvent and the state ultimately paid their incurred but unpaid claims.

Table 14 Individual Health Insurance Market Share by Plan Type: 10 Study States, 1995 (in percents)				
State	BCBS (conventional)	BCBS HMO	HMO (non-BCBS)	Commercial
CA	10.6	32.6	34.1	22.9
FL	48.9	—	17.3	33.8
IA	48.9	—	—	51.1
LA	41.5	—	3.4	55.1
MT	52.0	—	—	48.1
NY	50.5	2.1	28.0	19.4
ND	23.3	—	—	76.7
PA	70.4	1.1	7.8	20.8
UT	60.9	—	17.2	21.9
WA	77.2	—	15.7	7.2

Source: Alpha Center Health Insurer Database, 1997.

The Role of HMOs and Managed Care

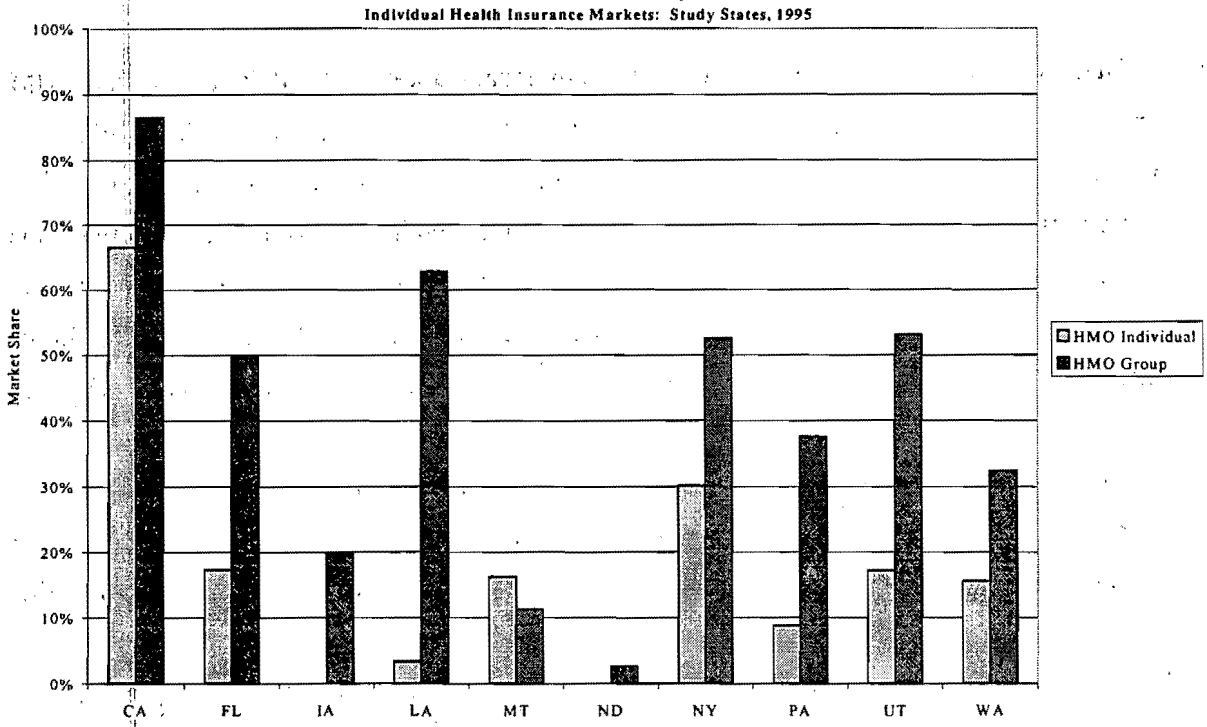
The prevalence of HMOs (as well as the use of managed care techniques more generally) has soared in many group markets as employers have embraced managed care as a means to control employee benefit costs. As of 1995, however, HMO penetration (measured as HMO premiums earned as a percent of market wide premiums earned) was much lower in the individual health insurance market than in the group market (see Figure 6).[13] Only in California did HMOs' share of the individual market exceed 50 percent.[14] In four of the study states (Iowa, Louisiana, North Dakota, and Pennsylvania), HMO market share was less than 10 percent.

To update our information on HMO penetration, we asked our agents to discuss their perceptions of the role of HMOs in their state's individual market since 1995, the degree to which HMOs were actively

[13] HMO business is defined here as premium volume reported by companies reporting to the state as HMOs. HMO market share should not be confused with managed care penetration more generally, as nearly all conventional insurance plans now incorporate some features of managed care. Conversely, some companies filing as HMOs may be offering other products, such as PPO products.

[14] One insurance official noted that a significant portion of business reported by Blue Cross or Blue Shield HMO plans may in fact be PPO business.

Figure 6
HMO Market Share in Group and
Individual Health Insurance Markets: Study States, 1995



Source: Alpha Center Health Insurer Database, 1998

soliciting individual business. As there are no available data that measure the use of managed care techniques by commercial insurers and BCBS plans at the state level, we asked them also to describe the prevalence of other forms of managed care (such as preferred provider organizations, or PPOs) in the individual health insurance market.

- California has been at the vanguard of managed care development. In 1995, four of the top five individual insurers in California were HMOs. One California agent surmised that HMOs had been motivated to gain individual business in order to comply with Medicare's 50/50 rule, which was repealed in the 1997 Balanced Budget Act. Most individual health insurance products in California that are not HMOs are reported to be PPOs. The recent difficulties of two insurers (one left the California market, the other left the individual market nationwide) were reportedly a result of adverse selection (and a resulting high price) in their non-PPO indemnity products. One commercial insurer recently introduced a point-of-service product for individuals, reportedly the first in the state.

- In New York, the role for HMOs in the individual health insurance market is reported to be active and growing. Some managed care plans are competing aggressively for market share, offering rates at least 25 percent below prevailing rates for indemnity products. Most indemnity insurers have

responded to competition from HMOs by converting pure indemnity products to some form of managed care.

- In Utah, most HMOs now offer products in the individual market. Both BCBS and the large HMOs are reported to have kept rates especially low to gain or preserve market share. HMO individual products are available at lower initial and renewal rates than the individual products sold by competing indemnity insurers. One large, vertically integrated hospital system and health plan is competing aggressively for market share in some areas of the state. Other insurers (including one out-of-state HMO that recently withdrew from Utah) have claimed that the hospital system limits their access to providers in the system's network and offers unfavorable rates to its competitors.[15]

- In the other study states also, managed care products are emerging in the individual health insurance market. However, managed care in these states is largely confined to the states' urban centers. In North Dakota, HMOs "won't venture out of the Fargo area." In Louisiana, two of the major HMOs confine their provider networks to the New Orleans and Baton Rouge metropolitan areas, but a third HMO has begun to offer individual products in a broader geographic region. In Pennsylvania, HMOs have "mixed interest" in offering coverage to individuals. However, large commercial insurers that write individual products have been forming PPO networks, competing aggressively to control the individual managed care market. In Pennsylvania, our agent reports that PPO networks are contracting widely; and in turn, commercial insurers are contracting with as many PPO networks as possible.

Individual Health Insurance Products

The health insurance products described in this section were selected to represent all health insurance products available to individuals in the 10 study states. While we were able to identify the insurers writing individual coverage in each state, each insurer offers a number of products that vary in several dimensions — the amount of cost-sharing required, the amount of managed care imposed, the degree to which the product is underwritten, and the price of the product. Among all of the products offered by a particular insurer, which particular products have the largest enrollment is proprietary information. While we selected insurers in each state as a stratified sample of all insurers writing individual coverage, we were forced to rely on our network of insurance agents to select those insurers' most popular products. In total, we reviewed 60 insurance products, distributed among the ten states; in all states but

[15]In a recent report describing Pacificare's planned exit from Utah, the HMO's spokesperson attributed its decision to its inability to provide a full range of hospital services "without contracting on unfavorable terms with a rival HMO operator" (*Medicine and Health*, 1997)

Utah,[16] these plans represented 40 to 80 percent of premiums earned in the individual markets (see Table 15).

In general, a health insurance product is defined by the health care services that it covers and the extent to which health care is managed. Within each product, consumers are offered an array of deductibles, coinsurance, and copayment provisions. While we are relatively confident that we obtained information about the sample insurers' most popular products, it is impossible to identify which levels of cost sharing are most popular for each product. Thus, the discussion that follows relies heavily on agent impressions about which levels of cost sharing were most popular in the individual health insurance market. Throughout, we offer the agents' rationales for their perceptions.

Table 15
Number, Type, and 1995 Market Share of Sample Insurers: 10 Study States

	Number of sample insurers				Market share of sample insurers (in percents)			
State	**BCBS**	**HMOs**	**Commercial**	**Total**	**BCBS**	**HMOs**	**Commercial**	**Total**
CA	5*	6	5	16	43.1	30.1	1.0	74.2
FL	1	0	3	4	48.9	—	5.9	54.8
IA	1	0	7	8	48.9	—	9.0	57.8
LA	1	2	2	5	41.5	2.6	7.2	51.3
MT	1	0	4	5	51.9	—	21.8	73.7
NY	4	5	3	12	48.3	16.0	10.5	74.9
ND	1	0	3	4	23.3	—	22.0	45.3
PA	2	1	1	4	41.7	—	1.3	43.0
UT	0	1	0	1	—	12.6	—	12.6
WA	3	2	0	5	70.3	14.2	—	84.5

Source: Alpha Center Health Insurer Database, 1997.

* We obtained several different products each from Blue Cross of California and Blue Shield of California, which are separate companies.

[16]We were able to review only one Utah insurer, writing three products. While this insurer wrote a relatively small share of Utah's total estimated individual insurance business in 1995, we understand that it is a much more prominent insurer in that market now.

Cost Sharing

In each of the study states, consumers are able to choose among a number of products with different levels of deductibles, coinsurance and copayments. However, the lowest deductible and co-insurance products are frequently HMO products, which may be available in only some areas of the state.

While the insurance products that we identified are not strictly representative of all products available in the state, the range of cost-sharing in these plans appears to vary among the states (see Table 16). In five states, deductibles were as high as $10,000. In Louisiana, New York, and Pennsylvania, the range of deductibles was narrower. In New York and Pennsylvania, the coinsurance levels in popular products also varied within a lower range: consumers of these products pay as much as 20 percent of covered charges, compared to as much as 50 percent in popular products in other states.

Table 16 Summary of Deductibles and Coinsurance Provisions in Individual Health Insurance Products: 10 Study States		
State	**Range of Deductibles**	**Range of Coinsurance[a]**
CA	$0-10,000	0-50 percent
FL	$250-2,250	0-50 percent
IA	$0-10,000	0-50 percent
LA	$0-5,000	0-50 percent
MT	$0-10,000	0-50 percent
ND	$0-10,000	0-50 percent
NY	$500-5,000	0-20 percent
PA	$0-2,500	0-20 percent
UT	$500-3,000	20 percent
WA	$0-10,000	0-30 percent

Source: Alpha Center analysis of sample insurers' product descriptions, 1997.

[a]Coinsurance rates are the percent of covered charges that the *insured* pays, after the policy's annual deductible has been met.

While high-deductible plans are available in each of the study states, consumer interest in these plans seemed to vary widely. In California, Montana, and North Dakota, our agents reported substantial consumer interest in high-deductible products:

- According to one California agent, about 60 percent of Blue Shield's individual contracts are products with deductibles of $1,000 or $2,000. The California Farm Bureau markets plans with even higher deductibles; the rates for these plans are not much less than those for a $2,000-deductible plan, and they are purchased only by consumers who are determined to pay the absolute minimum premium.

- In Montana, our agent reported that high-deductible products ($1,000 or more) were popular among ranchers and other rural consumers. He reported much lower consumer interest in individual products with a deductible of about $250.

- In North Dakota, products with lower deductibles were reported to be more popular in urban areas such as Fargo. However, rural customers preferred high-deductible products, and the rural market

for high-deductible plans appeared to be growing. Our North Dakota agent reasoned that, because people in rural areas will travel to see doctors only for serious illnesses, the prepayment for smaller health care expenditures embodied in a low-deductible plan is not worthwhile to them.

In other states (Utah, Washington, Florida, and New York), high-deductible plans were reported to be less popular. In these states, there appears to be a growing tension between insurers' inclination to keep prices in check by raising deductibles and ongoing consumer demand for relatively low cost-sharing:

- In Utah, insurers are marketing very high deductible products ($5,000 or higher), but the demand for these products appears to be limited. Our Utah agent estimated that as much as 80 percent of policies sold have deductibles between $250 and $500. Also, in Washington, our agent reported that some insurers had pulled or attempted to pull some lower deductible plans from the market. However, in general consumers continued to prefer products with deductibles in the range of $250 to $500.

- Also in Florida and New York, our agents reported that typical deductibles are $250 or $500. However, our Florida agent believed that the prevailing deductibles were becoming unaffordable. Our New York agent observed that insurers there had responded to the price differential between indemnity and managed care plans by rolling their products into managed care, not by raising deductibles.

Products Linked to Medical Savings Accounts

Given the apparent popularity of high-deductible plans in some of the study states and the recent availability of federally tax-deductible MSAs for self-employed individuals,[17] we asked our agents whether MSAs were becoming popular in their states. Our Pennsylvania agent reported that interest in MSA products had grown slowly, with increasing interest in recent months. In all states, our agents typically mentioned several reasons that they believed MSA-linked individual insurance products were not selling quickly:

- MSAs are unpopular because high-deductible products generally are unpopular.

[17]HIPAA makes MSA contributions by small-group employees and self-insured individuals federal tax deductible on a demonstration basis. As of June 1997, only 22,051 tax-deductible MSAs had been opened (GAO, 1997).

- Only "healthy and wealthy" consumers find MSAs attractive; "doctors and lawyers" are inclined to use them primarily as tax vehicles.

- Most consumers of high-deductible individual products view MSA policies as more expensive. In Montana, our agent estimated that he sells ten regular high-deductible individual policies for every one MSA policy. He believed that most consumers who buy high-deductible policies view the MSA contribution as part of the premium cost, not as savings toward the deductible. From this perspective, MSA policies are more expensive than other high-deductible plans when insurers require a minimum monthly MSA contribution. Similarly, our North Dakota agent commented that making an MSA contribution which was then unavailable for other cash-flow needs was unappealing to traditional purchasers of high-deductible individual products. Purchasers are principally attracted to these products because they are willing to assume risk in order to minimize their initial cash outlay.

In Florida, our agent reported that the state's small-group reforms — requiring guaranteed issue and modified community rating to groups as small as one — were a deterrent to at least one prominent marketer of MSAs. However, the U.S. General Accounting Office reported that 6 to 10 insurers in Florida offered approved qualifying MSA plans as of December 1997 (GAO, 1997).

Covered Services

Based on an informal survey of health plans in seven states, the GAO (1996) recently concluded that the benefits offered by individual plans were comparable to those offered by employer-sponsored group plans. That is, most major medical expense plans covered a wide range of benefits, including inpatient and outpatient hospital expenses, physician services, diagnostic and laboratory services, specialty services, and prescription drugs. Many plans (particularly HMOs, but also PPOs and traditional indemnity plans) covered some preventive services, sometimes with little or no cost sharing.

However, our examination of benefit descriptions for products commonly sold in the study states revealed significant variations in coverage both within and between states for certain services, including coverage of mental health and substance abuse services, maternity services, and prescription drugs. Some policies also specified separate benefit limitations for AIDS/HIV and organ transplants. Policies within states and between states differed in whether they limited certain benefits and in the way they limited benefits (that is, with separate deductibles, higher coinsurance, or specific dollar limits). In many cases, a consumer facing limitations under one policy apparently could avoid them under another if he

were able to buy both policies. However, for most products, we were unable to compare the insurers' underwriting guidelines, as we did not have underwriting guidelines for every plan.

Prescription drug benefits. Most individual plans that we examined provided some coverage for prescription drugs. Most Blue Cross/Blue Shield insurers and HMOs, and many commercial insurers offer prescription drug coverage within the insurance product, while some commercial insurers offer prescription drug coverage only as a separate rider. Sample monthly rates for prescription drug riders ranged from $4 to $8 for a child or young adult; for an adult 50 years old or more, sample monthly rates for prescription drug riders ranged from $8 to $27.[18]

Many of the policies we examined limited prescription drug benefits. Some commercial plans nationwide and some of the HMOs in California imposed an annual dollar cap on prescription drug benefits, ranging from $1,000 to $3,000. One commercial plan alluded to a limit on drug coverage in its basic description of benefits, but did not specify the type or amount of the limit. One California HMO imposes a $2,500 annual limit and also specifies that prior authorization is required for certain medications, including AZT. This HMO also excluded coverage for new drugs (those on the market for less than six months) without prior approval from the plan.

Some insurers explicitly or *de facto* underwrite within the prescription drug benefit. One commercial insurer listed a PCS drug card entitling the holder to prescription drug discounts as a standard benefit, but stipulated that the PCS card would not be issued to "persons undergoing medical treatment at the time of application or with a history of ongoing use of prescription medications." Several insurers listed psychotropic drugs among items excluded from coverage — a definition subject to some degree of interpretation, but which might include antihistamines, antidepressants, sedatives, and antipsychotics. Another commercial insurer imposed a $250 annual limit on drugs for mental health conditions as well as less favorable co-insurance (50 percent).

Maternity benefits. Except in Montana, where state law requires that maternity be covered like any other condition, the plans we examined almost universally single out maternity coverage for special treatment as a benefit. Commercial insurers generally exclude normal maternity benefits from their standard policy and offer maternity coverage as a separate rider, but some exclude maternity benefits entirely. The monthly cost of a maternity benefit rider ranged from $27 (for a $1,000 benefit limit) to

[18]In each range, the lowest rates are for products that include a drug deductible of $50 to $200 depending on the size of the primary policy deductible. The higher rates are for products with no deductible for drug coverage.

$175 (for a policy with a $1,000 maternity deductible). Typical monthly costs for a maternity benefit rider were $75 to $100.

Because maternity riders predictably attract substantial adverse selection (that is, people buy them when they are pregnant or anticipate a pregnancy), plans frequently phase coverage in over a period of years: full coverage is generally unavailable until the rider has been in effect two years or more. Typically, coverage is 50 percent of the full benefit during the first year, 75 percent during the second year, and 100 percent in the third and subsequent years of coverage; but one insurer imposed a 15 month waiting period before any benefits were paid. Insurers may also stipulate that the maternity rider may be purchased only at the time that the base policy is issued and cannot be added later. Finally, most insurers specify that only the primary insured or their spouse is eligible for the maternity rider; dependents are excluded from coverage.

In Washington, the state's Basic Health Plan (BHP) – a public health insurance program that subsidizes enrollment for low-income people without insurance (and which permits higher income participants to enroll at unsubsidized rates) – writes nearly all individual insurance for maternity care. While private insurers are required to offer BHP "look-alike" plans, premiums for these plans are generally higher than the unsubsidized BHP premium.[19] Insurers' non-look-alike plans invariably exclude maternity services. The fact that Washington's individual insurance market for maternity coverage has collapsed where it is not required by regulation is one result of the state's individual insurance market reforms – guaranteed-issue with continuous open enrollment and a three month waiting period for preexisting conditions. As a result of adverse selection into BHP, the program's unsubsidized premiums are rising sharply: BHP's 1998 rates are 30 to 70 percent higher than the 1997 rates (depending on the BHP plan, and the enrollee's age and geographic location); by comparison, subsidized BHP premiums (which exclude maternity coverage) rose 15 percent.

Most Blue Cross Blue Shield plans and HMOs, as well as commercial insurers that included maternity benefits within the major medical plan, imposed separate (and higher) deductibles for maternity services and higher coinsurance (raising the share of covered charges paid by the insured). While most HMO plans covered maternity services as part of their standard benefit package, they imposed separate deductibles or copayments of $500 to $2,000; $1,000 was typical. Typically, BCBS plans and commercial insurers also imposed separate deductibles or copayments of $500 to $1,000 for

[19]Low-income women who qualify for a subsidy in the BHP must apply for Medicaid coverage in order to obtain maternity coverage.

maternity services, but may be as high as $5,000. Maternity copayments generally were not applicable to the plans' annual limit on out-of-pocket expenditures.

Many insurers place lower dollar limits on coverage for maternity services, either alone or in combination with higher cost sharing. Among commercial products, benefit maximums averaged about $3,000. Maternity coverage limits were lower in products with a shorter benefit exclusion (less than three years) and in products that corresponded to a maternity rider.

While many plans impose more restrictive cost-sharing and limits on maternity benefits, some Blue Cross and Blue Shield plans (in North Dakota and Pennsylvania) cover maternity as they do any other condition. In these markets, commercial plans typically imposed the sorts of risk-limiting techniques described above. Blue Cross and Blue Shield of Iowa offered different benefits in different plans; some plans offered maternity and mental health benefits, and others did not.[20]

Mental health and substance abuse benefits. Nearly all of the products that we examined included separate, more limited terms for coverage of mental health conditions and substance abuse. A significant number offered no mental health benefits at all. These individual insurance products typically imposed higher copayments and coinsurance for mental health services compared to other medical services, as well as any of a series of other limitations: annual visit and day limits on outpatient and inpatient care respectively, per-visit and per-day dollar limits, and separate annual and lifetime dollar limits. In addition, out-of-pocket expenditures for mental health and substance abuse services generally were not applicable to the insured's out-of-pocket maximum. Table 17 offers examples of how such limitations are combined within one plan.

Other specific exclusions and limits on coverage. The products that we examined usually excluded treatment of obesity, infertility treatment, cosmetic surgery, and temperomandibular joint disorders. However, these limitations are not unique to individual coverage — they also may be found in small- and large-group policies.

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[20]The difference in monthly premium rates between a policy that includes maternity and mental health coverage and an otherwise similar policy that does not was approximately $8 for a male aged 25-29, and $46 for a female of the same age group. The rate for a female insured in the plan that covers both maternity and mental health coverage was $68 more than for a male of the same age. (Rates are typically higher for females than males in that age group even in plans that do not cover maternity.)

Table 17 Selected Plan Limits on Mental Health and Substance Abuse Benefits: Selected States and Products, 1997				
State	**Type of plan**	**Outpatient benefit**	**Inpatient benefit**	**Other restrictions**
CA	BCBS	50 percent coinsurance; 20 visits combined SA/MH	MH not covered; SA detox only (3 days per admission)	
	HMO POS	MH: 20 visits; $35 co-pay per visit SA: Detox only; 50 percent coinsurance	MH: Not covered SA: Detox only; 50 percent coinsurance	
	Commercial	50 percent coinsurance to maximum of $25/visit; 26 visits $3000 annual limit per person; $10,000 lifetime limit	30 days per year	Rx: $250 annual limit for mental health-related drugs
	BCBS	Plan pays $175/day, up to 30 days	Plan pays $25/visit, up to 20 visits	
IA	Commercial	No coverage	Plan pays 25 percent up to $2500 lifetime limit	
ND	Commercial	50 percent co-insurance (copayments are not applicable to the out-of-pocket maximum) $500 annual limit	Plan pays $50/visit	Combined annual limit of $2500

Source: Alpha Center analysis of sample insurers' product descriptions, 1997.

Note: Where benefits are offered within a PPO or POS plan, these terms apply to in-network benefits. Higher copayments and coinsurance and lower benefit limits typically apply for out-of-network care, or the plan may offer no coverage for out-of-network benefits.

Seven of the study states forbid or limit special insurance plan provisions related to treatment for HIV infection. California, Iowa, New York, North Dakota,, and Washington require that HIV be treated the same as any other illness. In Utah, insurers may impose a minimum $25,000 lifetime cap on payments for services related to HIV; otherwise insurance products must cover HIV-related services just as any other illness. Florida prohibits the imposition of separate benefit caps for HIV-related services and requires insurers to cover these services as they do all other services for policyholders who were tested for HIV prior to the effective date of coverage.

However, where allowed by law, some of the products we examined (including most commercial products and one Louisiana HMO) limited coverage for expenses related to HIV. Insurers typically excluded HIV-related expenses for the first one or two years of coverage, imposed lifetime dollar limits

on coverage for HIV/AIDS (typically $10,000 to $25,000), or both. Several insurers excluded coverage for HIV if the policyholder manifests symptoms within the first year of coverage. In addition to explicit limits on coverage (and in states that prohibit differential treatment of HIV-related services), these plans' dollar limits on prescription drug benefits can pose a considerable financial barrier to access to the expensive combination drug therapies currently used to treat asymptomatic HIV infection and AIDS. Such combinations cost at least $10,000 a year; many California insurers limited coverage of prescription drugs to $2,500 a year or less.

Pre-existing condition exclusions. Depending on state law, individual policyholders may not be covered for the full range of benefits listed in plan descriptions for some or all of the insurance contract period. Insurance products may impose waiting periods before coverage of a preexisting condition begins, or they may permanently exclude coverage for stated conditions (permanent exclusion riders are discussed below in the discussion of underwriting). Table 11 summarized the limits that some of the study states have placed on allowable look-back and waiting periods for preexisting conditions, the shortest being Washington's (3 months/ 3 months). Most limit the look-back to 6 months (New York, North Dakota, and Utah) or 12 months (California, Iowa, and Louisiana), but Florida and Montana permit look-back periods of two and three years, respectively. Seven of the study states limit waiting periods to 12 months; only Florida has a less restrictive limit — 24 months. All of the study states that limit look-back and waiting periods also require that insurers credit prior coverage for preexisting conditions against the current policy's waiting period.

Pennsylvania is among the 22 states nationwide that do not limit preexisting condition exclusions in individual health insurance plans. In the absence of state regulations, the plans we examined had a look-back period ranging from 12 to 60 months, and several insurers did not restrict the length of the look-back period at all. Waiting periods were typically either 12 or 24 months. Most insurance products immediately covered conditions that were disclosed on the health questionnaire (and not explicitly excluded from coverage) with no waiting period. However, several products imposed the preexisting condition limitations on disclosed health conditions. One Blue Cross Blue Shield product in Pennsylvania used a five-year look-back period to exclude coverage for both disclosed and undisclosed preexisting conditions.

Rating and Denials

Where not restricted by law, insurers may use any factor or combination of factors to determine rates for individuals. The most common rating factors include age, gender, health status or claims experience, geographic location, family size, and various lifestyle indicators such as tobacco use. States that restrict

insurer rating practices may: (1) prohibit the use of selected rating factors, such as health status or claims experience or age; (2) limit the amount that rates may vary for selected factors or for any factor; or both.

Among our study states, two states (New York and Washington) limit insurers' ability to use age and health status in setting rates; three states (Iowa, Louisiana, and Utah) limit insurers' use of health status, but allow insurers to rate on age. North Dakota limits insurers' use of age, but allows insurers to rate on health status. The remaining four states (California, Florida, Montana, and Pennsylvania) regulate neither individual insurance rate factors nor rate variation.

In all of the study states except New York, age and gender (where gender rating is not prohibited) were important determinants of insurers' standard premiums. Typically, a 60-year-old male pays a premium more than three times that of a 25-year-old male for the same plan (see Table 18). This is true in part because the study states that restricted the use of age rating nevertheless set wide bands (4:1 in Washington and 5:1 in North Dakota) on age-rates. (A North Dakota commercial insurer charged one of the highest rate differences for a 60-year old male compared to a 25-year-old male that we found in any state— a ratio of 4.28 to 1). In states that limit insurers' use of health status in setting rates, rate bands are relatively narrow on health status (2:1 in Iowa and 1.2:1 in Louisiana), leading insurers to load average claims experience fully into age-rates, rather than varying rates within age groups to reflect differences in health status. Thus, in Iowa and Louisiana, sample premium ratios on age were generally as high or higher than in states that did not restrict insurer rates at all.

In New York, Washington, California, and Montana, insurers are prohibited from using gender as a factor in setting insurance rates. However, in other states, rates generally are higher for women at younger ages (even in plans that exclude maternity coverage) but lower for women aged 55 or more.

Finally, insurers in all states (including New York) may vary their standard rates by geographic area. While the premium rates cited in Table 18 are the intermediate standard rates that each insurer charges, Table 19 offers a sample of how these rates vary geographically. In general, the geographic variation in rates charged by HMOs is lower than that for BCBS plans or commercial insurers, probably in part reflecting the smaller geographic reach of these plans' provider networks. Only rarely (for example, in California and Florida) did the insurers' standard rates vary by more than 2 to 1 within a state.

In addition to state regulation, a number of insurer practices can affect the level of the standard rates that they charge. For example, insurers' propensity to deny coverage altogether or to exclude conditions

specific to the individual purchaser (as a rider on the base plan) may yield lower average claims experience and, therefore, lower standard rates. If the application includes several members of a family, the insurer may make different underwriting decisions for each family member (for example, one member might be issued the policy at a standard rate, another with a rate-up, and another denied coverage.[21] Six of the study states (Florida, Iowa, Louisiana, Montana, North Dakota, and Pennsylvania) permit insurers to use exclusion riders to permanently or temporarily exclude specified conditions from coverage. Such riders are not subject to the pre-existing condition regulations in force in those states—they may be in effect for the duration of the contract. California, New York, Utah, and Washington prohibit the use of exclusion riders.

Also, insurers' propensity to rate-up the base premium for purchasers' specific health conditions may yield lower standard rates – although very few purchasers may actually pay the standard rate. Finally, some insurers simply do not offer "competitive" rates. According to some of the agents with whom we spoke, these rates may be based on especially adverse experience. Such insurers are uninterested in additional growth in these products, and may not wish even to maintain their current share of the market. These insurers may hold their standard rates at relatively high levels, so that they do not attract new business.

[21] Some applications ask if the underwriting process should proceed for remaining family members if one member is denied coverage.

Table 18
Sample Individual Major Medical Insurance Rates:
Base Rates by Age and Gender, 1998

State *(and rate bands on selected factors)*	Insurer type	Deductible/ coinsurance	Age 25 M/F		Age 45 M/F		Age 60 M/F		Ratio Age 60/25 M/F		Notes
State restricts use of age and health status (NY and WA also require guaranteed issue of all products):											
NY *(1:1 on all demographic and health status factors)*	Comm	HMO	$210		$210		$210		1.00		
	Comm	POS	$216		$216		$216		1.00		
	BCBS	$500; 80/20	$265		$265		$264		1.00		
	BCBS HMO	none	$232		$232		$232		1.00		
WA *(4:1 on age and other factors)*	HMO	none	$133		$208		$310		2.33		
	BCBS POS	$500; 80/20	$42		$89		$149		3.55		No MH/SA or maternity; $500 Rx limit
	BCBS HMO	none	$142		$188		$319		2.25		Includes MH/SA and maternity
	HMO	$0; copayments	$130		$180		$331		2.55		
	HMO (PPO)	$500; 80/20	$57		$103		$205		3.60		No maternity
ND *(5:1 on age)*	BCBS	$500; 80/20	$74		$130		$225		3.04		
	Comm PPO	$500; 80/20	$45	$60	$94	$115	$193	$177	4.28	2.95	
	Comm	$500; 80/20	$71	$78	$120	$137	$237	$192	3.34	2.46	

Table 18, continued											
State	**Insurer type**	**Deductible/ Coinsurance**	**Age 25 M/F**		**Age 45 M/F**		**Age 60 M/F**		**Ratio Age 60/25 M/F**		**Notes**
State limits use of health status; no limits on age rating:											
IA *(2:1 on health status)*	Comm	$1000; 80/20	$88	$104	$153	$181	$324	$280	3.68	2.69	Iowa Standard plan; guaranteed issue to qualified individuals
	Comm	$500; 80/20	$64	$94	$115	$140	$233	$206	3.64	2.19	
	BCBS PPO	$600; 90/10	$63	$131	$112	$148	$207	$195	3.29	1.49	Includes maternity and MH/SA
	BCBS PPO	$500; 80/20	$55	$85	$93	$122	$170	$154	3.09	1.81	No maternity or MH/SA
LA *(1.2:1 on health status)*	Comm PPO	$500; 80/20	$130	$144	$211	$243	$426	$340	3.28	2.36	
	HMO	$500; 80/20	$68	$84	$120	$151	$233		3.43	2.97	No maternity or MH/SA
UT	HMO/PPO	$500; 80/20	$77		$129		$213		2.77		1/98 rates; $5,000 maternity deductible.
State does not restrict rates:											
CA	Comm PPO	$500; 85/15	$89		$142		$250		2.81		No MH/SA
	HMO	$0; copayments	$90		$141		$240		2.67		
	HMO (PPO)	$500; 80/20	$98		$154		$262		2.67		
	BCBS HMO	$0; copayments	$90		$150		$260		2.89		
FL[a]	Comm PPO	$500; 80/20	$138	$155	$227	$268	$468	$376	3.39	2.43	
	BCBS PPO	$500; 80/20	$49	$72	$103	$154	$225	$194	4.59	2.69	No maternity
	Comm PPO	$500; 80/20	$95		$174		$329		3.46		

Table 18, continued												
State	Insurer type	Deductible/ coinsurance	Age 25 M/F		Age 45 M/F		Age 60 M/F		Ratio Age 60/25 M/F		Notes
MT	Comm	$500; 80/20	$132		$190		$324		2.45		
	Comm	$500; 80/20	$74		$128		$222		3.00		4/96 rates
	BCBS[b]	$0; 80/20	$152		$250		$359		2.36		
	BCBS	$0; 80/20	$455		$745		$1073		2.36		
PA	Comm	$500; 80/20	$72	$89	$146	$162	$278	$230	3.86	2.58	10/95 rates
	BCBS PPO	$200; 100	$167		$167		$167		1.00		
	BCBS	$500; 80/20	$82		$100		$149		1.82		
	BCBS HMO		$98	$213	$120	$262	$179	$392	1.83	1.84	Underwritten; GI

Source: Alpha Center analysis of sample insurers' product descriptions and rates, 1997.

[a]Florida prohibits durational rating, but allows insurers to rate on all other factors.
[b]"Healthy Montanan" plan rates are based on the applicant's responses to a lifestyles questionnaire in addition to a standard health questionnaire.

Notes:
Insurer type: BCBS = Blue Cross/Blue Shield; Comm = Commercial; HMO = HMO
Deductible/coinsurance: Where possible, rates were quoted for a $500 dollar deductible and 20 percent coinsurance; PPO plans are noted and the rates are for in-network cost-sharing.
Age and gender: Where one rate is listed, the same rate applies for males and females in that age group. Otherwise, rates for males are listed first in each column; rates for females second. Rates for females exclude maternity coverage, if maternity services are covered only under a supplemental rider.. Rates quoted are for non-smokers and do not reflect "rate-ups" for certain health conditions, such as hypertension, obesity or other medical conditions. Standard rates should be considered as "best-case" rates, not as average rates. Where possible, a "middle-cost" geographic region was used rather than the insurers' geographic high or low rate within the state.
Exclusions: Significant features or exclusions of coverage are noted where information was available. MH/SA = mental health/substance abuse coverage.
Guaranteed issue (GI): Only in Washington and New York are all products guaranteed-issue. Otherwise, unless noted, applicants may be denied coverage based on health status or products may entail permanent exclusion riders.

Table 19 Geographic Rate Variations: Low and High Standard Rates										
State	Insurer type	Age 25		Age 45		Age 60		Ratio of high-area to low-area standard premium		
		Low	High	Low	High	Low	High	Age 25	Age 45	Age 60
CA	BCBS	$64	$131	$97	$211	$172	$339	2.05	2.18	1.97
	HMO	$83	$92	$114	$119	$238	$292	1.20	1.08	1.23
	HMO	$93	$144	$151	$223	$262	$393	1.55	1.48	1.50
	BCBS	$72	$149	$110	$235	$192	$405	2.07	2.14	2.11
	Comm	$140	$247	$229	$403	$456	$807	1.77	1.76	1.77
FL	BCBS	$60	$132	$120	$262	$209	$456	2.18	2.18	2.18
	Comm	$79	$133	$145	$245	$273	$462	1.69	1.69	1.70
	Comm	$145	$231	$243	$384	$490	$781	1.59	1.58	1.59
IA	BCBS	$63	$63	$112	$112	$207	$207	1.00	1.00	1.00
PA	Comm	$63	$82	$128	$165	$243	$315	1.30	1.29	1.30
NY	HMO	$193	$218	$193	$22	$193	$218	1.13	1.13	1.13
	BCBS	$250	$311	$250	$311	$250	$311	1.24	1.24	1.24
	HMO	$215	$256	$215	$256	$215	$256	1.19	1.19	1.19

Source: Alpha Center analysis of sample insurers' product descriptions and rates, 1997

Examples of common health status conditions for which insurers deny, issue exclusion riders, or rate-up coverage are presented in Table 20, selected from the underwriting guidelines of 10 insurers across the study states. For some conditions, these insurers deny coverage altogether. In some cases, where a single insurer (such as a Blue Cross and Blue Shield or commercial insurer) operated an HMO and also one or more competing indemnity plan, the insurer might deny coverage from the HMO, but accept applicants into one of the indemnity plans with a rate-up or exclusion rider.[22] Note that for some conditions (for example, myocardial infarction and clinical anxiety or depression) some insurers will both rate-up *and* issue an exclusion rider, excluding coverage for care related to those conditions for the

[22]Several agents' observations and insurers' underwriting guidelines suggest stricter underwriting criteria for plans with lower cost sharing, particularly HMOs. For example, a BCBS insurer in California sometimes denies an applicant entry to their HMO, and offer them a PPO plan instead. BCBS of Florida requires a physical examination of all individual adults who apply for HMO coverage, but requires them of PPO applicants only if they have not seen a physician in the last 3 years. Similarly, underwriting guidelines for commercial insurers sometimes specify less strict underwriting decisions for applicants to very high-deductible plans.

duration of the contract.[23] Except in Washington and New York (which require guaranteed issue and prohibit the use of health status as a rate factor), insurers require applicants to complete a set of health and lifestyle questions; examples of such questions are offered in Appendix 2.[24]

We were able to obtain detailed information about rate-ups from the underwriting guidelines of 5 insurers in 3 states. Table 21 offers information about the rate-ups that these insurers use for three selected conditions: overweight or obesity, smoking, and hypertension. Each of these insurers limits the amount of its cumulative rate-up to between 50 and 200 percent of its base rate. That is, considering all of the applicant's health conditions, if the cumulative rate up would exceed its maximum rate-up, the applicant is denied coverage. Insurers' practice of limiting their rate-ups also has the effect of constraining total variation in premiums, even for the sickest person admitted for coverage. Among the products that we observed, the highest rated-up premium paid by a 60-year-old male (in an intermediate-cost geographic area) would be $597.[25] Applicants with poor health status related to these or other health conditions and applicants who have several health problems that individually would trigger a rate-up are denied altogether.[26, 27]

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[23]Several of our agents noted variations among insurers in their underwriting practices. Our Montana agent estimated that one insurer denies about half of the applicants he sends them, while another underwrites "as they need the business." Our North Dakota agent reported an overall tightening of underwriting in the individual market, but noted that underwriting tends to move in cycles. Similarly, our Florida agent estimated that 40 percent of his clients receive either a declination, an exclusion rider, or a rate-up. One of our California agents reported that about half of the cases that she considers borderline are denied.

[24]Typically, the insurer also requires signed authorization, releasing the applicant's medical records, information from the applicant's previous insurance company and data from MIB (formerly Medical Information Bureau). MIB is an organization maintained by life and health insurers that acts as a repository of information on applicants' responses to health questions in past applications for life and health insurance.

[25]Note that this $597 rated-up premium for a 60-year-old male compares to a standard rate of $1,073 offered by another Montana insurer. Both rates are higher than the rate charged for Montana's high-risk pool. However, neither of the private insurer products place lifetime limits on coverage that are as low as that in the high-risk pool ($500,000).

[26]In addition to specific conditions that trigger an automatic declination of coverage, applicants may be denied coverage for other reasons. Several underwriting guidelines assigned points to conditions, with a point threshold above which the applicant would be denied. Others specified that applicants with three or more rider conditions would be denied. Under some such schemes, obesity or smoking reduce the point threshold.

[27] Our agent in Pennsylvania noted that agents "field underwrite" by steering risky clients to Blue Cross and Blue Shield rather than risk a declination with another insurer.

Table 20 Example Underwriting Guidelines for Common Conditions: Selected Insurers and States	
Health condition	**Underwriting guideline**
Osteoarthritis	Exclusion rider
Rheumatoid arthritis	Deny
Allergies or hay fever (medical treatment within 3 years)	Exclusion rider
Headaches (use of prescribed medications or regular treatment)	Exclusion rider or deny
Kidney stone (within 2 years)	Exclusion rider or deny
Endometriosis (no surgery)	Exclusion rider
Emphysema/chronic cough (mild)	25 percent rate-up (individual consideration, if moderate)
Gallbladder disease	Exclusion rider
Angina (within last 5 years)	Deny
Myocardial infarction/angioplasty/bypass/coronary artery disease	Deny
Myocardial infarction (within 2 years)	Deny
Myocardial infarction (no congestive heart failure or enlargement; within 3-10 years)	40 percent rate-up and exclusion rider
Stroke	Deny
Genital herpes (more than 1 year after recovery or remission)	40 percent rate-up
Anxiety or depression (mild to moderate, within 2-5 years)	40 percent rate-up and exclusion rider
Otitis media (multiple attacks within last 5 years, under age 15)	Exclusion rider
Ulcer	Exclusion rider
Hypertension (mild)	25 percent rate-up

Source: Alpha Center analysis of sample insurers' underwriting guidelines, 1997.

Table 21
Sample Rate-Ups for Selected Risk Factors and Rated-Up Premiums

State	Plan type	Rate-ups for selected risk factors			Maximum rate-up for health status	Standard premium plus maximum rate-up for health status					
		Overweight	Smoker	Hypertension		Age 25 M/F		Age 45 M/F		Age 60 M/F	
CA	Comm	Deny[a]			75%	$112		$211		$373	
CA	BCBS	20-50% or deny		20% or deny	50%[b]	$81		$164		$304	
IA	Comm	20-100%		25%-100%	100%	$142	$173	$243	$290	$482	$402
IA	Comm	20-80%	20-40%[c]	20% or deny	100%	$122	$145	$214	$253	$452	$391
MT	Comm	5-50% or deny	10%	20-60% or deny	200%	$231		$384		$597	

Source: Alpha Center analysis of sample insurers' underwriting guidelines, 1997.

[a]Insurer denies if applicant's weight is 15 percent in excess of insurer standard.

[b]Applicant may be ineligible for most plans but offered a plan with a higher out-of-pocket annual maximum ($5000 vs $2000) and lower lifetime benefit maximum ($2 million vs $5 million) than the standard plans at a rate approximately 75% higher than a standard plan with comparable benefits.

[c]Smokers over age 40 are rated up 40 percent.

Eight of the ten study states have a high-risk pool that accepts individuals who are otherwise uninsurable in the private market, although two of these pools (in California and in Florida) are not accepting new enrollment.[28] Table 22 offers a summary of the enrollment, selected provisions and premiums in each of these high-risk pools. All of these high-risk pools subsidize premiums, limiting the high-risk pool rates to 125 percent to 250 percent of the average premium for comparable individual coverage in the state. Thus, the high-risk pool rates typically range below the rated-up premiums that we found in the private market — and in many cases, below the standard rates charged by private insurers. However, all charge 20-25 percent coinsurance (with out-of-pocket limits that vary from $1,500 in Utah and Washington, to $10,000 in Florida). Some have very low annual and/or lifetime limits on coverage — in Louisiana, $100,000 per year and $500,000 over the enrollee's lifetime. In general, private insurers would rate above the state's high-risk pool to deter applicants who would qualify for the high-risk pool.

[28]Our agents estimated that the waiting list for California's high risk pool is 1 to 6 months; Florida's high-risk pool has been closed to new applicants for several years.

Table 22
High Risk Pools in the Study States: Enrollment, Deductibles, Limits and Premiums, 1998

State	Current enrollment	Deductibles	Annual (A) and Lifetime (L) limits on coverage	Premiums for $1,000 deductible plan			Rate caps
				Age 25 M/F	Age 45 M/F	Age 60 M/F	
CA	19,500 (waiting list)	Alternative standard options: PPO option with $500 deductible $0 deductible and $25 copayment for office visits	$50,000 (A) $500,000 (L)	$90-$148[a] (San Francisco) $169 - $246[a] (Los Angeles)	$166 - $242[a] (SF) $279 - $402[a] (LA)	$269 - $406[a] (SF) $391 - $605[a] (LA)	125 percent of the "standard average individual rate"
FL	1100 (closed to new enrollees)	$1000 $1,500 $2,000 $5,000 $10,000	$500,000 (L)	$115/$136[b] (Area 1) $224/$256 (Area 4)	$232/$275[b] (Area 1) $418/$448 (Area 4)	$508/$414[b] (Area 1) $794/$813 (Area 4)	Low risk: 200 percent maximum; medium risk: 225 percent maximum; high risk: 250 percent maximum
IA	475	$500 $1,000 $1,500 $2,000	$1,000,000 (L)	$196	$382	$600	150% maximum
LA	677 (12/96)	$1,000 $2,000	$100,000 (A) $500,000 (L)	$135/$193[a]	$265/$327	$521/$464	Not less than 150 percent initial; 200 percent maximum
MT	375 (12/96)	$1,000	$500,000 (L)	$154	$242	$383	150 percent to 400 percent, not to exceed 250 percent of average among the largest 5 insurers of individual plans
ND	1700	$500 $1,000	$1,000,000 (L)	$143	$214	$361	135 percent of the average premium in the state
UT	781	$500 $1,000	$150,000(A) $1,000,000 (L)	$158	$196	$306	150% of rate for similar benefits in private market
WA	757	$500 $1,000 $1,500	$500,000 (L)	$104 - $124	$216 - $257	$410 - $488	150% maximum

Source: Alpha Center, 1998; Communicating for Agriculture, 1997.
[a]For $500-deductible PPO option.
[b]Rates are for lowest risk tier; rates for medium and high risk enrollees are 113% and 125% of lowest tier rates, respectively.
[c] Discounted rate for New Orleans, with a $1000 deductible

Marketing and Distribution of Individual Products

Individual insurance products traditionally have been marketed and sold through a number of different channels. Our conversations with agents suggested that in some markets this may be changing. BCBS plans traditionally have relied on direct sales (applications directly to the company) and dedicated district representatives to market their plans. In Montana, our agent reported that BCBS has been purchasing small property and casualty companies to market their plans and making greater use of independent agents, in conjunction with their traditional use of a BCBS district representative. In rural Montana, Blue Cross plans were marketed through banks as bank depositor plans, although this practice was discontinued when Blue Shield acquired Blue Cross.[29] Many commercial insurers use direct mail and other approaches to market products, but increasingly these insurers — and some agents — use the Internet to attract new customers.

Insurers generally pay independent agents who place business with them a commission, calculated as a percentage of the premium on policies sold. Insurers may also run promotions and offer prizes for given volumes of business. Our conversations with agents about commissions revealed substantial variations both among insurers within a state and among states. Insurers with greater market power (such as BCBS plans) often pay lower commissions. Commissions for new business exceed those for renewals, reflecting the greater effort required of agents to place new business. However, higher commissions for new business also may signal the value to the insurer of new business compared to aging business.

- In California, both BCBS plans and commercial insurers pay 20 percent for new policies and 10 percent for renewals. California prohibits first-year commissions greater than 200 percent of renewal commissions.

- In Florida, our agent reported average commissions of 10 percent to 15 percent for new policies and 5 percent for renewals. BCBS pays 5 percent for new policies, but no commission for renewals.[30]

- Montana insurers pay commissions of 15 percent to 20 percent, and renewal commissions as low as 5 percent.

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[29]Our agent speculated that their decision to discontinue bank depositor plans concerns about operating in a grey legal area combined with a desire for tighter underwriting control.

[30]Following Florida's small-group reforms, commissions on group business had been reduced from 15 percent to 5-8 percent. Some have speculated that the lower commissions are intended to discourage agents from placing very small group business with them.

- North Dakota insurers also pay 20 percent initial commissions and 5 to 10 percent for renewals. Our North Dakota agent pointed out, however, that many of the higher commissions are for high-deductible, low-premium products.

- Our Pennsylvania agent reported that most commercial insurers pay 10 percent, but that one insurer moving aggressively into the state paid 20 percent. BCBS plans pay no commission to independent agents who place individual business with them.

- New York and Washington, commercial insurers pay independent agents average commissions of 4 to 5 percent. HMOs pay a maximum 4 percent commission in New York. In Washington, HMOs pay a $75 finder's fee. In New York, BCBS pays no commissions on business placed by independent agents (BCBS now competes with only one commercial insurer writing individual indemnity business in the state).

- In Utah, insurers continue to pay commissions of 10 percent, and some smaller insurers pay more. However, insurers generally pay no commission on the rated-up portion of a premium, so that effective commissions average about 8 percent of premiums sold.

The agents we spoke with seemed genuinely unconcerned about commission rates; several had to research commission levels before providing an answer. One agent described individual health insurance as a loss leader for agents in his state—a service sometimes performed only as a favor for existing clients, or to obtain new clients who also would buy life insurance.

Summary and Conclusions

The individual health insurance market shows many signs of its "residual" nature. National population surveys indicate that the percentage of the population that buys individual products can change dramatically, especially as rates of employer-based coverage rise and fall. While the average consumer of individual insurance is very much like the average of the general population (adults under age 44 or children, middle- or high-income, living in metropolitan areas and in families headed by wage or salaried workers), they are more likely than the general population to be older (age 55-64) and to live in rural areas and smaller cities. Also, they are more likely than the population at large to be in families headed by part-time part-year or self-employed workers, and they are more likely to hold private insurance from the same source for only part of the year. More than half are in families with income above 300 percent of poverty, but a surprising number are poor or near-poor.

Individual insurance is an important resource for people in middle- and upper-income families if they have neither employer-based nor public coverage, and especially for children in these families. In families with income above 400 percent of poverty (the largest segment of the individually insured population), 52 percent of the adults and 59 percent of the children with neither employer-based nor public coverage reported having individual health insurance at least part of the year. However, lower-income families are clearly less able to afford individual insurance: less than one-third (29 percent) of people in families with income between 200 and 300 percent of poverty purchase individual insurance when they do not have insurance from an employer or from a public program.

While a few insurers typically dominate the individual market in each state, many smaller insurers also write individual coverage and sometimes appear to find niche markets by underwriting and pricing coverage strategically. In all states, HMOs' share of the individual market is much less than their share of the group market. This difference appears largely attributable to HMOs unwillingness to write individual coverage and may contribute to the higher price of individual insurance.

Benefits, cost-sharing, and prices in the individual health insurance market can vary widely. Many insurers offer a single benefit design with a number of deductible and cost-sharing options. Some offer competing products with very different benefit designs, or they offer some benefits only as a rider. The most common rider benefits that we observed were coverage for maternity services and for prescription drugs.

While the diversity of products in the individual market may suggest abundant choice, in fact it most clearly represents insurers' eagerness to underwrite risk in this market — to segregate risk into separate (and internally homogeneous) classes and products. Nevertheless, the individual health insurance market harbors considerable differences in premiums even for similar products, suggesting how difficult it may be for consumers to understand the individual insurance market and to compare products and prices.

In states that require guaranteed issue of individual products (New York and Washington), individual insurance products are indeed widely available — especially when rates are constrained as in New York. However, while such regulation can produce a "fairer" market, it may also be smaller. Following New York's comprehensive regulation, all but one insurer has converted all individual products to managed care. Moreover, New York's individual market covers many fewer people than it did prior to reform; at least some of this decline may be attributable to insurers' having raised average premiums in response to stricter regulation.

Alternatively, in states where insurers do not guarantee issue, where riders are not prohibited, and where insurers rate on health status or claims experience, several of our agents reported very high rates of denials, exclusions, and rate-ups. In some states, BCBS plans and HMOs were reported to underwrite as or more aggressively than commercial insurers.

The propensity of insurers to deny coverage altogether, to rate-up coverage for health reasons, and to offer some benefits only as a rider has kept individual insurance premiums in these states lower than they otherwise might be. Nevertheless, they can be very high — especially for older people in high-cost areas. For example, monthly premiums for a 60-year-old male living in an intermediate-cost area generally ranged from $149 to $535, across the study states. In high-cost areas of large states, standard premiums might be as much as 50 percent higher. Moreover, some insurers will rate-up the standard premium, typically by as much as 50 to 100 percent, for risk factors such as obesity or hypertension. Cumulatively, a fully rated-up premium in a high cost area might be as much 250 percent of the standard premium in an intermediate-cost area, and some coverage (for example, maternity benefits) may be available only as a rider for additional cost. However, because insurers regard an applicant's willingness to pay very high premiums as indicating a need for even more costly health care, they are more likely to deny coverage altogether than to offer coverage with a very steep rate-up.

In some states — both those that have substantially regulated insurer practices and in those that have not — some types of coverage have become difficult for insurers to write within the basic health insurance product. For example, in some states insurers typically offer maternity coverage as a rider, sometimes with significant waiting periods (12 to 18 months) before it will pay for maternity care. In such markets, biased selection has made maternity riders increasingly expensive, and in effect maternity coverage has become prepayment for maternity care.

The underlying question of this report — whether the individual insurance market might be made a more robust source of coverage for the 41 million Americans who are uninsured — is difficult to answer simply. Nearly 60 percent of the uninsured are poor or near-poor, with family income below 200 percent of the federal poverty level. While low-income families make an effort to buy individual coverage that is disproportionate to their means, the rate at which they are uninsured is extremely high. It is likely that most low-income families would require financial assistance to buy and maintain individual insurance coverage.

Moreover, available data suggest that consumers move in and out of this market extensively: 30 to 40 percent of people with individual insurance in 1996 probably held their policy for only part of the year. This rate is as much as ten times that among people with employer-based coverage, and it

contributes to both the administrative cost of individual insurance and insurer behavior in this market. In particular, much of insurers' behavior in the individual market anticipates adverse selection. Insurers expect that many people will seek individual insurance only when they are sick and drop coverage when they have no immediate health care needs. Thus, insurers underwrite aggressively, and they exclude or limit coverage for types of care that are difficult for them to anticipate, even by extensively screening applicants for coverage. They rate coverage just as aggressively: for much of the population, "standard" rates may be unavailable. For people with ongoing health problems, individual insurance may be unavailable at any price.

It is difficult to imagine this market becoming more robust, without it first becoming more stable. This would mean that more consumers must be willing to stay in the market (even when they are healthy) and insurers must be willing to offer comprehensive products with intelligible, predictable coverage for necessary care. It is possible for regulators to constrain the supply side of this market — to require guaranteed issue, standardized products and consumer information, moderate exclusion periods, and relatively little price variation. These measures might improve consumer confidence that available insurance will cover the care that they need. However, they also may produce higher prices and correspondingly higher rates of consumer entry and exit. Thus, to make the individual health insurance market a robust source of coverage for most Americans who are now uninsured would require a parallel effort to stabilize demand — to subsidize coverage for the low-income families who comprise most of the uninsured, to examine ways for consumers to move between group and individual insurance without changing insurers, and even to mandate individual responsibility for remaining insured.

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Appendix 1
Private Health Insurance Coverage Among the Nonelderly Population by Source: All States, 1995 and 1996

State	1995						1996					
	Private insurance, total		Employer-based		Individual		Private insurance, total		Employer-based		Individual	
	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent
Alabama	2.7	71.2	2.5	65.6	0.3	8.2	2.7	72.8	2.6	69.5	0.2	5.8
Alaska	0.4	71.5	0.4	67.9	--	--	0.4	70.6	0.4	66.5	--	--
Arizona	2.4	63.7	2.2	59.6	0.3	7.1	2.4	58.0	2.2	53.6	0.3	7.3
Arkansas	1.5	67.0	1.4	63.0	0.2	7.7	1.4	61.7	1.3	56.0	0.2	7.6
California	17.7	61.9	16.4	57.5	1.9	6.6	18.3	63.7	16.7	58.1	2.2	7.7
Colorado	2.7	78.7	2.5	72.2	0.3	8.9	2.6	75.5	2.4	68.7	0.4	10.3
Connecticut	2.3	81.9	2.1	76.5	0.2	7.2	2.2	77.6	2.1	74.0	0.2	5.8
D.C.	0.3	60.5	0.3	57.1	--	--	0.3	62.5	0.3	57.5	--	--
Delaware	0.5	74.6	0.5	72.6	--	--	0.5	74.6	0.5	72.2	--	--
Florida	7.8	65.7	7.0	59.1	1.2	9.7	7.7	65.4	7.0	59.5	1.0	8.4
Georgia	4.4	67.8	4.1	64.5	0.4	5.9	4.5	68.5	4.3	65.8	0.4	6.4
Hawaii	0.8	77.6	0.7	71.7	0.1	10.3	0.7	74.7	0.7	71.2	--	--
Idaho	0.8	74.3	0.7	65.7	0.1	13.2	0.7	71.5	0.7	64.1	0.1	9.6
Illinois	7.9	76.2	7.5	72.3	0.9	8.3	8.1	76.8	7.6	72.7	0.8	7.4
Indiana	3.9	79.2	3.6	73.9	0.4	8.5	4.1	83.4	3.9	79.0	0.4	9.1
Iowa	2.0	80.5	1.8	70.9	0.4	15.1	2.1	81.0	1.8	71.3	0.3	11.9
Kansas	1.6	74.5	1.5	69.9	0.1	6.6	1.7	77.8	1.6	73.2	0.2	7.9
Kentucky	2.3	69.3	2.1	65.4	0.2	5.8	2.3	67.5	2.2	64.2	0.2	5.5
Louisiana	2.2	59.2	2.0	53.1	0.3	8.2	2.3	62.7	2.2	58.3	0.2	6.2

Appendix 1, continued
Private Health Insurance Coverage Among the Nonelderly Population by Source: All States, 1995 and 1996

State	1995						1996					
	Private insurance, total		Employer-based		Individual		Private insurance, total		Employer-based		Individual	
	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent
Maine	0.8	76.0	0.7	69.4	0.1	9.1	0.8	77.3	0.8	72.7	0.1	6.8
Maryland	3.3	73.4	3.2	70.8	0.2	4.2	3.5	77.3	3.2	72.1	0.4	8.5
Massachusetts	4.2	78.2	4.0	75.0	0.3	6.1	4.1	75.4	3.9	72.8	0.3	4.9
Michigan	6.7	79.1	6.5	76.9	0.3	3.9	6.7	79.7	6.5	77.2	0.3	3.8
Minnesota	3.4	82.0	3.1	74.4	0.4	10.2	3.4	78.8	3.0	71.0	0.5	10.8
Mississippi	1.5	61.8	1.4	57.4	0.2	9.0	1.6	65.0	1.5	59.6	0.3	11.1
Missouri	3.4	75.3	3.1	68.9	0.5	11.2	3.4	74.9	3.1	67.5	0.5	11.4
Montana	0.5	70.3	0.4	60.2	0.1	14.3	0.5	67.6	0.5	61.2	0.1	8.8
Nebraska	1.1	81.1	1.0	70.9	0.2	13.6	1.1	77.0	0.9	66.7	0.2	13.5
Nevada	1.0	72.4	0.9	68.7	0.1	7.5	1.1	75.6	1.1	74.2	--	--
New Hampshire	0.8	81.4	0.8	77.1	--	--	0.8	81.6	0.8	77.5	--	--
New Jersey	5.3	77.0	4.9	72.1	0.5	7.6	5.1	74.2	4.8	70.3	0.4	6.3
New Mexico	0.8	50.6	0.8	46.7	0.1	6.0	0.9	55.1	0.8	51.1	0.1	4.7
New York	10.9	68.2	10.2	64.0	1.1	6.9	10.6	65.7	10.1	62.5	0.8	5.1
North Carolina	4.2	71.3	3.9	66.6	0.4	7.2	4.6	73.2	4.4	70.0	0.3	5.4
North Dakota	0.4	83.0	0.4	67.7	0.1	19.0	0.4	81.7	0.4	70.4	0.1	15.2
Ohio	7.4	76.1	7.1	72.7	0.6	5.7	7.5	77.0	7.3	74.7	0.4	3.9
Oklahoma	1.8	65.3	1.6	59.6	0.2	8.9	1.9	66.9	1.7	61.9	0.2	7.0
Oregon	2.1	74.2	2.0	70.2	0.2	7.3	2.0	73.0	1.9	67.2	0.2	6.9

Appendix 1, continued
Private Health Insurance Coverage Among the Nonelderly Population by Source: All States, 1995 and 1996

State	1995						1996					
	Private insurance, total		Employer-based		Individual		Private insurance, total		Employer-based		Individual	
	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent
Pennsylvania	7.9	77.5	7.5	72.9	0.8	8.2	8.1	79.8	7.6	74.9	0.7	7.2
Rhode Island	0.6	75.9	0.6	70.5	--	--	0.6	78.8	0.6	74.6	--	--
South Carolina	2.3	68.7	2.2	64.6	0.2	5.6	2.3	70.7	2.2	66.4	0.2	6.5
South Dakota	0.5	78.7	0.4	67.7	0.1	17.1	0.5	76.8	0.4	66.2	0.1	14.7
Tennessee	3.3	68.8	3.1	64.6	0.5	11.1	3.2	66.5	2.9	61.5	0.4	9.3
Texas	10.4	61.9	9.8	58.0	1.1	6.3	10.9	62.9	10.3	59.5	0.9	5.2
Utah	1.4	80.2	1.3	73.7	0.2	9.7	1.5	82.5	1.4	76.8	0.1	8.3
Vermont	0.4	74.9	0.4	68.6	--	--	0.4	75.5	0.4	68.0	--	--
Virginia	4.0	73.7	3.7	67.9	0.5	8.4	4.1	74.1	3.9	70.7	0.3	6.0
Washington	3.6	74.2	3.4	69.2	0.4	8.4	3.8	75.2	3.5	67.9	0.5	10.2
West Virginia	1.0	65.7	1.0	63.3	--	--	0.9	65.0	0.9	62.0	--	--
Wisconsin	3.9	81.6	3.8	78.0	0.3	6.9	3.8	83.1	3.6	78.7	0.3	6.5
Wyoming	0.3	71.9	0.3	64.5	--	--	0.3	74.2	0.3	70.0	--	--
U.S., total	163.1	70.8	152.4	66.2	17.4	7.6	165.2	71.1	154.7	66.5	16.2	7.0

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

Note: Dashes indicate insufficient cell size for statistical significance. Estimates include people with coverage from more than one source.

Appendix 2

Sample Health Questions from Individual Health Insurance Applications

Typical health screening questions on applications for individual insurance are listed below. Applicants are instructed to provide details for any "yes" responses.

- "Within the past 2 years, have you or your dependents consulted with or been treated by or received medication from any physician or other practitioner; or do you intend to enter a hospital, clinic or other institution for consultation, treatment or surgery?"

- "Have you or your dependents ever had a diagnosis of or consultation, treatment or medication for disease or disorder of:..." *Authors' note: This question precedes a comprehensive checklist of grouped organs, body systems, and diseases such as Parkinson's, cancer, diabetes, and arthritis.*

- "Have you or your dependents been treated for, within the last 5 years, persistent cough, unexplained weight loss, lymph gland enlargements, shortness of breath, night sweats, disease of the immune system, AIDS or tested positive for the HIV antibodies?" *Authors' note: California and some other states prohibit carriers from requiring applicants to submit to a blood test for HIV.*

- "Are you or any of your dependents pregnant?" *Authors' note: Many carriers deny coverage to all members of a family if any member is pregnant at the time of application, even if the pregnant member is not applying for coverage.*

- "Has the proposed insured had any moving violations, a driver's license revoked, suspended, or been arrested for driving under the influence of alcohol?"

- "Have any applying persons ever received any counseling or treatment for symptoms of depression, manic depression, anxiety, panic attacks, nervousness, mental or emotional disorders, schizophrenia, behavior problems, hyperactivity, attention deficit disorder, eating disorders, bulimia, anorexia, alcohol or substance abuse, or for any other reason?"

- "Is any applicant presently a member of a support group? How long?"

- "Has any applicant used illegal, controlled drugs or substances in the last 10 years or has anyone been diagnosed as chemically dependent or alcoholic?"

- "In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?"

THE HENRY J. KAISER FAMILY FOUNDATION

UNDERSTANDING INDIVIDUAL HEALTH INSURANCE MARKETS

by
Deborah J. Chollet and Adele M. Kirk
The Alpha Center

Prepared for
The Henry J. Kaiser Family Foundation

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Understanding Individual Health Insurance Markets: Structure, Practices, and Products in Ten States

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Executive Summary

More than 16 million Americans under age 65 reported coverage from private insurance other than an employer-sponsored plan in 1996, but very little is known about this market. Available survey data suggest that the size of the individual market varies widely among the states, from 13 to 15 percent of the nonelderly population (in North Dakota, South Dakota, and Nebraska) to less than 5 percent (in Massachusetts, Michigan, New Mexico, and Ohio). Differences in the relative importance of individual insurance among the states may relate to a number of factors: the availability of group coverage; insurer practices and state insurance regulations that may make individual coverage accessible to a broader population; and the availability of public program coverage to populations with modest incomes.

The individual health insurance market shows many signs of its "residual" nature. While the average consumer of individual insurance is very much like the average of the general population (adults under age 44 or children, middle- or high-income, living in metropolitan areas and in families headed by wage or salaried workers), they are more likely than the general population to be older (age 55-64) and to live in rural areas and smaller cities. Also, they are more likely than the population at large to be in families headed by part-time part-year or self-employed workers, and they are more likely to hold private insurance from the same source for only part of the year. More than half are in families with income above 300 percent of poverty, but a surprising number are poor or near-poor.

Individual insurance is an important resource for people in middle- and upper-income families if they have neither employer-based nor public coverage, and especially for children in these families. In families with income above 400 percent of poverty (the largest segment of the individually insured population), 52 percent of the adults and 59 percent of the children with neither employer-based or public coverage reported having individual health insurance at least part of the year. However, lower-income families are clearly less able to afford individual insurance: less than one-third (29 percent) of people in families with income between 200 and 300 percent of poverty purchase individual insurance when they do not have insurance from an employer or from a public program.

This study reviews the individual health insurance markets in 10 states: California, Florida, Iowa, Louisiana, Montana, North Dakota, New York, Pennsylvania, Utah, and Washington. These states vary substantially in the size and urban/rural distribution of their populations, the size of their individual insurance markets, and the degree and type of state regulation in these markets. In general, they are representative of the range and variation of circumstances and regulation across all of the states. The study draws on a number of information sources: the Current Population Survey (U.S. Department of

Commerce, Bureau of the Census); Alpha Center's Health Insurer Database (a compilation of financial data on major medical insurers in 26 states); policy and rate information obtained from a stratified sample of major medical insurers in each state; and conversations with regulatory officials, health policy officials and insurance agents and brokers in each state.

In each state, a few insurers dominate the individual market. While Blue Cross and Blue Shield (BCBS) plans are very prominent in the individual market (holding 40 to 75 percent of the market in all states except California and North Dakota), smaller insurers (both HMOs and commercial companies) also write individual coverage and sometimes appear to find niche markets by underwriting and pricing coverage strategically. Nevertheless, the individual market in most states is substantially smaller than the number of admitted insurers; net of insurers writing very little business (less than $500,000), the number of insurers of all types writing individual major medical insurance ranged from just 7 (in Montana) to 50 (in California). In all of the states, HMOs' share of the individual market is much less than their share of the group market, a situation that may contribute to the higher cost of individual insurance.

Benefits, cost-sharing, and prices in the individual health insurance market can vary widely. Many insurers offer a single benefit design with a number of deductible and cost-sharing options. Some also offer products with clear differences in benefit design. Individual insurance products sometimes exclude maternity coverage or coverage for mental health and substance abuse services entirely. When covered, maternity and mental health coverage nearly always entailed separate (and higher) deductibles, higher copayments or coinsurance, and separate annual and lifetime limits on coverage. In some states, insurers offer coverage for maternity services or for prescription drugs only as a rider and for an additional premium.

While this diversity of products in the individual market may suggest abundant choice, in fact it most clearly represents insurers' eagerness to underwrite risk in this market — to segregate risk into separate (and internally homogeneous) classes and products. In turn, insurers' eagerness to underwrite in the individual market, to limit risk-spreading narrowly, reflects their concern about adverse selection and market instability. Nevertheless, the individual health insurance market harbors considerable differences in premiums even for similar products, suggesting how difficult it may be for consumers to understand the individual insurance market and to compare products and prices.

New federal regulation has standardized some aspects of the individual market — most notably requiring all insurers to guarantee renewal of individual insurance. However, the reach of federal law is

very limited; federal protections are likely to affect very few consumers who would buy individual health insurance. State regulation of individual insurance varies widely among the states, a factor that undoubtedly contributes to wide differences in products, rates and insurer practices:

- In six of the ten states studied — California, Florida, Louisiana, Montana, North Dakota, and Pennsylvania — insurers may deny coverage to applicants based on their health status.

- In nine of the ten states (all except New York), insurers may base premiums on the applicant's age. In these states, the premium charged to a 60-year-old may be two to four times the premium charged to a 25-year-old. Only two — Washington and North Dakota — limit the extent to which insurers may charge higher rates to older applicants, but North Dakota's limits still allow variation as great as five to one.

- In seven of the ten states (all but New York, North Dakota, and Washington), insurers may base premiums on the applicant's health status. Three states — Iowa, Louisiana, and Utah — limit the extent to which insurers may increase rates based on health risk. Only four states — California, New York, Utah, and Washington — prohibit insurers from issuing exclusion riders to particular applicants, denying coverage for some services that the policy otherwise would cover.

In states where insurers do not guarantee issue and where exclusion riders are not prohibited, insurance brokers and agents sometimes report very high rates of denials and exclusions as well as rate-ups. In some states, BCBS plans and HMOs were reported to underwrite as aggressively (or more so) than commercial insurers. Common conditions for which insurers sometimes deny coverage include: rheumatoid arthritis; chronic headaches; angina; or a recent history of kidney stones, heart attack (including angioplasty or other procedures to prevent heart attack), or stroke.

The propensity of insurers to deny coverage altogether, to rate-up coverage for health reasons, and to offer some benefits only as a rider has kept standard premiums in the individual market lower than they otherwise might be. Nevertheless, individual health insurance premiums (especially for older people in high-cost areas) can be very high. For example, monthly premiums for a 60-year-old male living in an intermediate-cost area generally ranged from $149 to $535, across the study states. In high-cost areas of large states, standard premiums might be as much as 50 percent higher. Moreover, some insurers will rate-up the standard premium, typically by as much as 50 to 100 percent, for risk factors such as obesity or hypertension. Cumulatively, a fully rated-up premium in a high cost area might be as much 250 percent of the standard premium in an intermediate-cost area, and some coverage (for example,

prescription drug benefits) may be available only as a rider for additional cost. However, because insurers regard an applicant's willingness to pay very high premiums as indicating a need for even more costly health care, they are more likely to deny coverage altogether than to offer coverage with a very steep rate-up.

In some states — both those that substantially regulate insurer practices and in those that do not — some types of coverage have become difficult for insurers to write within the basic health insurance product. For example, in some states insurers typically offer maternity coverage only as a rider, sometimes with significant waiting periods (12 to 18 months) before the rider will pay for maternity care. In such markets, biased selection has made maternity riders increasingly expensive, and in effect maternity coverage has become prepayment for maternity care.

In each of the study states, very high deductible products are available in the individual health insurance market. These products are reported to be popular in rural areas of Montana and North Dakota, but less popular in urban areas and in some states: specifically, in New York and in Florida. However, even agents who sell relatively large numbers of high-deductible plans report little demand for plans tied to federally qualified medical savings accounts (MSAs). Several agents attributed this lack of interest to the reason that people buy high-deductible plans in the first place — to minimize their initial cash outlay.

In some states, competition in the individual insurance market seems to be changing. Some markets have seen a surge in HMO and managed care penetration, with indemnity insurers developing managed care products and even large insurers competing fiercely on price to take or retain market share as smaller insurers leave the market. However, in other states, dominant BCBS plans and HMOs in general demonstrate little apparent interest in gaining a larger share of the individual health insurance market, paying agents very low commissions for new business.

The underlying question of this report — whether the individual insurance market might be made a more robust source of coverage for the 41 million Americans who are uninsured — is difficult to answer simply. Nearly 60 percent of the uninsured are poor or near-poor, with family income below 200 percent of the federal poverty level. While low-income families make an effort to buy individual coverage that is disproportionate to their means, the rate at which they are uninsured is extremely high. It is likely that most low-income families would require financial assistance to buy and maintain individual insurance coverage.

Moreover, available data suggest that consumers move in and out of this market extensively: 30 to 40 percent of people with individual insurance in 1996 probably held their policy for only part of the year. This rate is as much as ten times that among people with employer-based coverage, and it contributes to both the administrative cost of individual insurance and insurer behavior in this market. In particular, much of insurers' behavior in the individual market anticipates adverse selection. Insurers expect that many people will seek individual insurance only when they are sick and drop coverage when they have no immediate health care needs. Thus, insurers underwrite aggressively, and they exclude or limit coverage for types of care that are difficult for them to anticipate, even by extensively screening applicants for coverage. They rate coverage just as aggressively: for much of the population, "standard" rates may be unavailable. For people with ongoing health problems, individual insurance may be unavailable at any price.

It is difficult to imagine this market becoming more robust, without it first becoming more stable. This would mean that more consumers must be willing to stay in the market (even when they are healthy) and insurers must be willing to offer comprehensive products with intelligible, predictable coverage for necessary care. It is possible for regulators to constrain the supply side of this market — to require guaranteed issue, standardized products and consumer information, moderate exclusion periods, and relatively little price variation. These measures might improve consumer confidence that available insurance will cover the care that they need. However, they also may produce higher prices and correspondingly higher rates of consumer entry and exit. Thus, to make the individual health insurance market a robust source of coverage for most Americans who are now uninsured would require a parallel effort to stabilize demand — to subsidize coverage for the low-income families who comprise most of the uninsured, to examine ways for consumers to move between group and individual insurance without changing insurers, and even to mandate individual responsibility for remaining insured.

Introduction

Although more than 16 million Americans under age 65 reported coverage from private insurance other than an employer-sponsored plan in 1996, very little is known about this market: which and what types of insurers predominate, how rates and products vary within and across markets, and the extent to which individual products are available to people with health problems. Available survey data suggest that the size of the individual market varies widely among the states. In North Dakota, South Dakota, and Nebraska, 13 to 15 percent of the nonelderly population reported having individual health insurance in 1996; compared to less than 5 percent in Massachusetts, Michigan, New Mexico, and Ohio. Differences in the relative importance of individual insurance among the states may relate to a number of factors: the availability of group coverage; insurer practices and state insurance regulations that may make individual coverage accessible to a broader population; and the availability of public program coverage to populations with modest incomes, some of whom might otherwise seek individual insurance coverage.

Nationwide, the percentage of the population reporting coverage from an individual plan is volatile, reflecting the residual nature of individual insurance: that is, people buy individual insurance when group insurance and public program coverage are not available to them. Between 1992 and 1996, the percentage of the population reporting individual coverage at some time during the year declined from about 8.5 percent to 7 percent.[1] Over the last several years, changes in rates of employer coverage, individual coverage and public program coverage have largely offset one another, leaving the rate of uninsured roughly constant – between 17.4 and 17.8 percent. However, at the state level, changes in the rate of employer-sponsored insurance, individual insurance, and public program coverage can yield sizable changes in the proportion of the population that is uninsured.

The political and practical difficulties of expanding employer-sponsored coverage or public programs to cover some portion of the 41 million uninsured have led some policy analysts to consider the potential of the individual insurance market as a greater source of coverage. Greater reliance on individual insurance could resolve problems of portability, consumer choice, and equity that are more difficult to resolve in an employer-based system. Despite extensive federal and state regulation to

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[1]These estimates are derived from Alpha Center tabulations of the March Current Population Survey (CPS) for various years. The CPS is the most reliable source of information about health insurance coverage in the United States. In recent years, the Bureau of the Census has revised its questioning about health insurance. It also has adopted computer-assisted survey techniques which eliminate conflicting responses and facilitate both a different sequencing of questions and more detailed questions. The 1995 and 1996 coverage estimates presented in this report reflect the new CPS questions about sources of health insurance. They may differ from estimates published elsewhere which are calculated to be more comparable to the older question set.

continue group coverage beyond active employment and to assure portability of coverage (without restarting preexisting condition exclusions), many workers are likely to remain unprotected — either because they are employed in small firms excluded from these regulations or because they have a lapse in coverage that disqualifies them from regulatory protections. Moreover, most workers have few insurance alternatives in a group setting: nearly half of the employer-insured population has no choice among plans (Kassirer, 1993). Finally, devising equitable subsidies to encourage employer-sponsored coverage is much more difficult than devising subsidies for individuals. These considerations have led many to question whether and how the individual insurance market can be made more accessible to a broader population, bolstering the private health insurance system and forestalling the further expansion of public health insurance programs.

This study describes the size and operation of the individual insurance markets in ten states. These states were selected to represent differences in geographic region, estimated market size, and state regulation of insurance— in short, the range and variation of circumstances and regulation across all of the states. The information presented here is based on a number of sources, including public-use national survey information, state-based data on insurers that write individual coverage, and interviews with state insurance and health policy officials and with independent insurance agents in each of the study states.

As a context for considering the specifics of state insurance markets, we begin with an overview of individual insurance consumers: who buys these products? What are their personal, economic and employment characteristics? Next we examine, in turn: the structure of the individual insurance markets in the ten states; federal and state regulation of products available to individuals; the role of association plans as sources of health insurance for individuals; the design of individual insurance products; individual insurance rates; and insurer underwriting practices with respect to individual insurance products. Finally, we offer some comments about the underlying question of this report: whether and under what circumstances the private individual health insurance market might become a robust alternative source of insurance for middle-income Americans without employer-sponsored coverage.

Research Design

Our analysis of individual health insurers, products, rates and underwriting guidelines relies on several unique sources of information about insurance markets. These include Alpha Center's 1995 Health Insurer Database, structured interviews with independent insurance agents, and rate and product information obtained from selected insurers. Each of these sources is described briefly below.

- *Alpha Center Health Insurer Database.* The 1995 insurer database is derived from the annual financial reports filed by each admitted insurer in each state and compiled by the National Association of Insurance Commissioners (NAIC). In all states, each commercial insurer must file an extensive set of reports with the state every year documenting premiums written and earned, medical losses, administrative costs, surplus, reserves, and other financial information. To supplement these reports, we contacted each state and also obtained the annual financial reports that BCBS plans and HMOs must file. A substantial effort was undertaken to clean and sort the data in order to develop state-level estimates of each insurer's 1995 major medical business only. The insurer database and the methods used to compile the data are described and presented in greater detail elsewhere (Chollet, Kirk, and Ermann; 1997).

- *Agent interviews.* Insurance agents offer a uniquely personal and valuable perspective on the individual insurance market. They are familiar with the array and practices of insurers, and they understand the market from the perspectives of both the consumer and the insurer. To make use of this knowledge, we conducted semi-structured interviews with independent insurance agents in each of the study states. Agents in each state were identified from the membership list of the National Association of Health Underwriters. They were selected from that list (or by referral from that list) based on their self-reported volume of individual health insurance that they transacted, the length of their experience in that state's individual insurance market, and their knowledge of insurance regulation in their state (for example, the agent recently had served in an advisory capacity to a state legislative committee). In exchange for a flat consulting fee, agents responded to initial and follow-up interview questions regarding market trends and dynamics, the role that different insurers play, product offerings, and other market-related issues. Agents also provided product descriptions, rate information, and underwriting guidelines for selected products; and they assisted us in distinguishing major medical insurers from those writing disability or other health business as reported in the financial information that insurers report to the state.

- *Product descriptions, rates, and underwriting guidelines.* To obtain a sample of insurance products, rates and guidelines, we arrayed all Blue Cross and Blue Shield plans, HMOs, and commercial insurers that wrote individual health insurance coverage of more than $500,000 in 1995 from the largest (measured as premiums earned) to the smallest. We then sorted this array into quartiles, and requested information about the most popular product issued by at least one insurer in each quartile. For insurers in the largest quartile, we generally were able to obtain product, rate and underwriting information for more than one insurer. In total, we reviewed 60 insurance products, distributed among the ten states and representing approximately 40 to 80 percent premiums earned in the study

states' individual markets. These products offer a snapshot of the benefits, rates and underwriting practices of both large and small insurers in each state's individual health insurance market.

Who Buys Individual Insurance?

In 1996, an estimated 16.2 million Americans — 7 percent of the population under age 65 — were covered all or part of the year by an individual health insurance plan, not associated with an employer. The rate of individual insurance coverage is substantially greater among adults than among children (nearly 8 percent of adults versus 5 percent of children), and adults comprise more than three-quarters (77 percent) of the population with individual insurance (see Table 1).

Table 1
Number and Percent of Nonelderly Adults and Children with Private Insurance or Uninsured: 1996

	Employer-based insurance			Individual insurance			Uninsured		
	Number (millions)	Percent of population	Percent of covered population	Number (millions)	Percent of population	Percent of covered population	Number (millions)	Percent of population	Percent of uninsured population
Adults aged 18-64	110.4	68.1	71.4	12.5	7.7	76.7	30.5	18.8	74.3
Children under age 18	44.3	63.0	28.6	3.8	5.3	23.3	10.6	15.0	25.7
Total	154.7	66.5	100.0	16.2	7.0	100.0	41.1	17.7	100

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

The proportion of people who report individual health insurance coverage is surprisingly equal across levels of family income (see Table 2). Among adults with income between 100 percent and 200 percent of the federal poverty standard,[2] 8 percent reported having individual health insurance in 1996. Among children in families in this income range, just over 6 percent were covered by an individual insurance plan. These rates are nearly the same as those reported among adults and children in families with income above 400 percent of poverty (8.1 percent of adults and 5.3 percent of children).

[2]In 1996, the federal poverty level was $12,980 for a family of three, and $7,740 for a family of one.

Table 2 Number and Percent of Nonelderly Adults and Children with Insurance or Uninsured, by Selected Source of Insurance and Poverty Status: 1996						
Family income as a percent of federal poverty	Population under age 65 (millions)	Percent with coverage or uninsured				
		Private insurance, total	Employer-based insurance	Individual insurance	Medicaid	Uninsured
0-99 percent	33.6	20.4	17.2	3.9	45.7	33.9
100-199 percent	42.5	53.8	48.5	7.2	16.1	30.5
200-299 percent	40.9	77.5	72.7	7.3	5.3	17.6
300-399 percent	35.1	86.1	81.6	7.3	2.3	11.3
400 percent +	80.4	91.5	86.9	7.8	1.1	7.0
Total	232.5	71.1	66.5	7.0	11.2	17.7

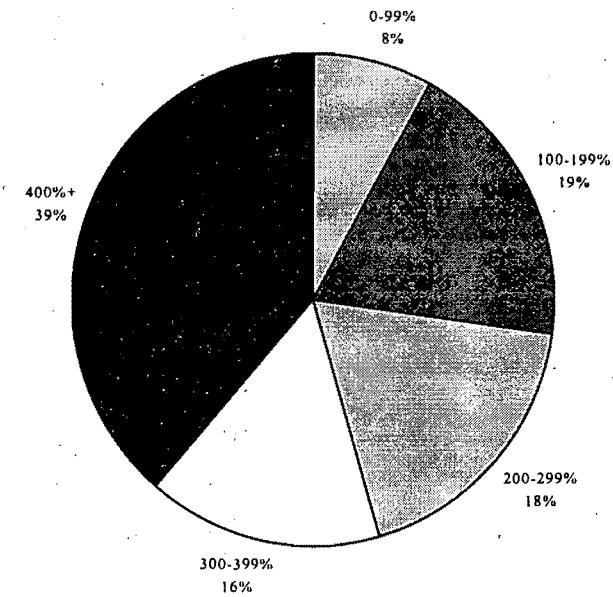
Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).
Note: Estimates include people with coverage from more than one source.

Despite the fact that many low- and middle-income families make a substantial effort to buy individual health insurance, the need for health insurance among families at these income levels is greater still. Rates of employer-based coverage are dramatically lower among both adults and children with lower family income. Thus, their probability of being uninsured is much higher, despite a level of effort to buy individual insurance among low income families that is disproportionately great relative to their means. The percent of children who are uninsured is lower than among adults at all levels of income mostly as a result of children's greater eligibility for Medicaid and other public programs, but also because families with children are more likely to have coverage from employer plans.

Considering the individually insured population as a whole, just over half are in families with income above 300 percent of the federal poverty standard — in 1996, about $23,000 for an unrelated individual and $39,000 for a family of three (see Figure 1). However, people in poor and near-poor families comprise about 27 percent of all people under age 65 with individual coverage. No information is available to identify the type, scope, or price of insurance that they buy.

Individual insurance is an important resource for people in middle- and upper-income families if they have neither employer-based nor public coverage, and especially for children in these families (see Table 3). In families with income above 400 percent of poverty (the largest segment of the individually

Figure 1
Distribution of Individual Coverage by Poverty Status: 1996



Source: Alpha Center tabulations of March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

insured population), 52 percent of the adults and 59 percent of the children who comprise the potential individual insurance market (those with neither employer-based nor public coverage) reported having individual health insurance at least part of the year. However, in lower income families, a much lower percentage of the potential market purchases individual insurance; less than one-third (29 percent) of people in families with income between 200 and 300 percent of poverty purchased individual insurance in 1996.

Table 3 Number of Nonelderly Adults and Children with Individual Health Insurance as a Percent of the Potential Market, by Poverty Status: 1996						
Family income as a percent of federal poverty	*Total*		*Adults aged 18-64*		*Children aged 0-17*	
	Number (millions)	Percent of potential market	Number (millions)	Percent of potential market	Number (millions)	Percent of potential market
0-99 percent	1.3	10.3	1.0	11.4	0.3	8.1
100-199 percent	3.1	19.3	2.1	18.8	1.0	20.5
200-299 percent	3.0	29.2	2.2	28.3	0.8	32.3
300-399 percent	2.6	39.2	2.0	38.2	0.6	43.5
400 percent +	6.3	52.8	5.2	51.7	1.1	58.6
Total	16.2	28.3	12.5	30.0	3.8	26.2

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).
Note: Potential market is defined as the nonelderly population, minus persons who are either employer-insured or have coverage from a public program.

Adults aged 55-64 are more likely to buy individual insurance than people in any other age group, and nearly twice as likely as adults aged 25-44 (see Table 4). In 1996, nearly 14 percent of adults aged 55-64 reported having individual insurance at some time during the year, compared to about 6 percent of adults under age 44. Rates of employer-based coverage are lowest among young adults aged 18-24 (only 56 percent in 1996) and among adults aged 55-64 (66 percent). However, unlike older adults who are more likely to buy individual coverage, young adults go uninsured at considerably higher rates than any other age group — in part reflecting their lower incomes, but perhaps also a greater tolerance for risk.

Table 4 Selected Sources of Health Coverage among the Nonelderly Population, by Age of the Insured Individual: 1996					
Age	Population under age 65 (millions)	Percent with coverage or uninsured			
		Employer-based insurance	Individual insurance	Medicaid	Uninsured
Less than 18	70.3	63.0	5.3	21.0	15.0
18 - 24	24.7	56.4	6.1	10.7	29.2
25 - 44	83.1	69.4	6.3	6.9	19.2
45 - 54	32.9	74.7	8.4	4.8	13.5
55 - 64	21.5	66.1	13.9	6.2	13.6
Total	232.5	66.5	7.0	11.2	17.7

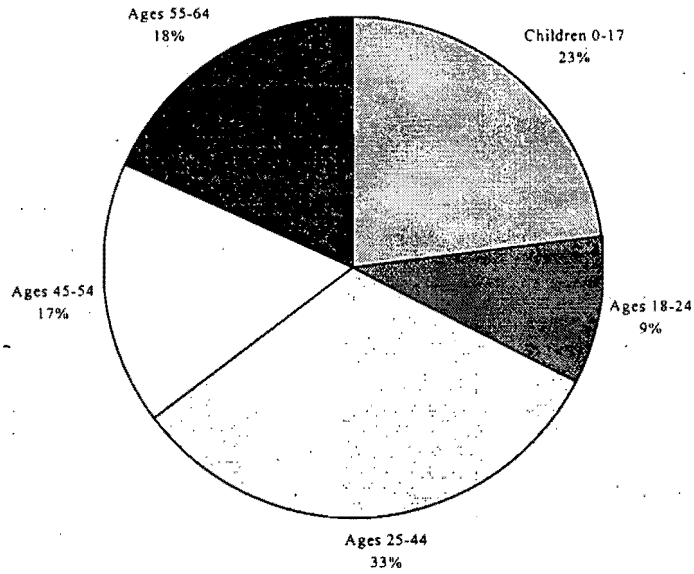
Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).
Note: Estimates include people with more than one coverage source.

Despite a much higher rate of individual insurance purchase among the near-elderly population, they represent a minority of the population that reports having individual health insurance. In 1996, just 18 percent of the individually insured population under age 65 were near-elderly – aged 55-64 (see Figure 2). Nearly two-thirds of the individually insured population (65 percent in 1966) are adults of child-bearing age (age 18-44) or children.

People who live outside of large metropolitan areas are more likely to buy individual coverage than people who live in large metropolitan areas, and at every level of family income (see Table 5). Nevertheless, metropolitan areas are the predominant market for individual insurance coverage — simply because most people live in or near large cities. Three out of four people (72 percent) who buy individual health insurance live in a large metropolitan area.

People in families headed by a part-time or part-year worker or a nonworker are substantially more likely to have individual health insurance than people in families headed by a full-year full-time worker (see Table 6). In part, the greater demand for individual insurance in these families reflects their lower access to employer-based coverage. However, in part because families headed by part-time or part-year workers or nonworkers tend to have lower income, their ability to buy individual insurance is limited and they are much more likely to be uninsured — despite greater eligibility for Medicaid and other public insurance programs. Once again considering the individually insured population as a whole, families

Figure 2
Distribution of Individual Health Insurance by Age Group: 1996



Source: Alpha Center tabulations of March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

headed by full-time full year workers comprise the majority. In 1996, 81 percent of the population under age 65 with individual health insurance lived in families headed by a full-time full-year worker.

Self-employed workers are often presumed to be an important market for individual health insurance. Indeed, people in families headed by self-employed workers are as much as four times more likely to have individual coverage than people in families headed by wage or salary worker (see Table 7). Unincorporated self-employed workers and their families are especially likely to have individual coverage: in 1996 nearly one-third (30 percent) of people in families headed by an unincorporated self-employed worker were covered by an individual health insurance plan. These families are less likely than families of incorporated self-employed workers to have employer coverage — possibly because they are less likely to have employees or otherwise to qualify for group coverage under state reform laws — and many are uninsured.

Table 5 Selected Types of Health Insurance among the Nonelderly Population in Metropolitan and Nonmetropolitan Areas, by Poverty Status: 1996					
Family income as a percent of federal poverty	Population under age 65 (millions)	Percent with coverage or uninsured			
		Employer-based insurance	Individual insurance	Medicaid	Uninsured
Metropolitan areas[a]					
0-99 percent	25.2	17.0	3.8	46.6	33.8
100-199 percent	30.2	48.1	6.2	16.9	31.2
200-299 percent	30.0	72.1	6.6	5.4	18.7
300-399 percent	27.4	81.7	6.6	2.3	11.7
400 percent +	68.1	87.3	7.4	1.1	7.0
Total	181.0	67.6	6.4	11.0	17.4
Nonmetropolitan areas					
0-99 percent	8.3	17.9	4.4	43.1	34.1
100-199 percent	12.3	49.6	10.0	14.3	28.7
200-299 percent	10.9	74.2	9.1	4.9	14.5
300-399 percent	7.6	81.3	9.6	2.4	9.8
400 percent +	12.3	84.7	10.2	1.3	7.0
Total	51.5	62.8	8.9	12.1	18.5

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

[a]Metropolitan Statistical Areas (MSAs) as defined by the Bureau of the Census.

Table 6 Selected Sources of Insurance among the Nonelderly Population, by Work Status of the Family Head: 1996					
Work status of family head	Population under age 65 (millions)	Percent with coverage or uninsured			
		Employer-based insurance	Individual insurance	Medicaid	Uninsured
Full-time, full-year worker	163.3	78.6	6.4	4.1	14.0
Part-time or part-year worker	45.6	46.6	9.1	19.4	27.9
Non-workers	23.5	21.6	7.0	44.5	23.6
Total	23.2	66.5	7.0	11.2	17.7

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

Table 7 Selected Sources of Health Insurance among the Nonelderly Population, by the Family Head's Type of Employment: 1996					
Family head: type of employment	Population under age 65 (millions)	Percent with coverage or uninsured			
		Employer-based insurance	Individual insurance	Medicaid	Uninsured
Wage or salary worker	190.0	73.8	5.2	7.7	16.3
Self-employed - incorporated	12.3	59.7	21.5	2.4	18.4
Self-employed - unincorporated	6.6	30.0	29.5	8.7	35.4
Nonworker	23.6[a]	21.6	7.1	44.4	23.7
Total	232.5	66.5	7.0	11.2	17.7

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

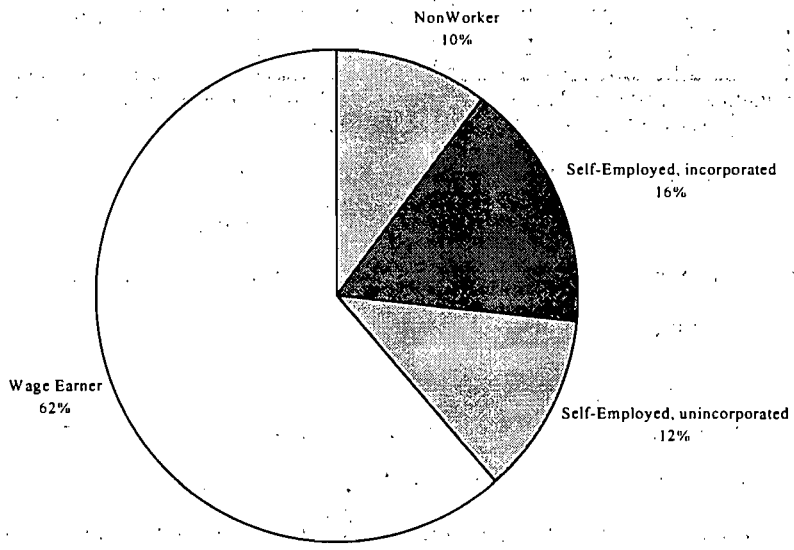
[a] Nonworker estimates include unpaid workers and therefore vary slightly from the estimates included in Table 6.

Despite relatively low rates of individual insurance among families of wage and salary workers, these families predominate in the U.S., and they comprise most of the population with individual coverage (see Figure 3). Families of self-employed workers — incorporated or unincorporated — comprise just less than one-quarter of the individually insured population under age 65.

Finally, about two-thirds of the population that bought individual insurance in 1996 reported no other source of private insurance coverage during the year (see Table 8). Conversely, about one-third of both adults and children with individual insurance reported also having had coverage from an employer-based plan that year — about ten times the rate of employer-insured people who also report individual coverage. Assuming that few people hold employer-based and individual insurance concurrently, people who report both probably hold individual insurance for only part of the year. The relatively high proportion of people with individual insurance in this situation offers a rough (and perhaps conservative) measure of the rate at which consumers move in and out of the individual insurance market in any given year. In turn, the high rate of entry and exit in this market probably contributes to administrative costs (for marketing, enrollment, and disenrollment) and higher prices for individual insurance relative to employer group insurance.

In summary, the average consumer of individual insurance is very much like the average of the population: an adult under age 44 or a child, with family income exceeding 300 percent of poverty, living in a metropolitan area and in a family headed by a full-time full-year wage or salary worker. However, the population that buys individual health insurance is diverse, and this profile is in some respects misleading. While they are not the majority, individual insurance consumers are more likely than the general population to be older (age 55-64) and to live in rural areas and smaller cities. Also, they are more likely than the population at large to be in families headed by part-time part-year or self-employed workers, and they are more likely to hold private insurance from the same source for only part of the year. A surprising number are poor or near-poor.

Figure 3
Individual Insurance by Employment Status of Family Head: 1996



Source: Alpha Center tabulations of March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

Table 8
Percent of Nonelderly Adults and Children with Both Individual and Employer-Based Health Insurance, by Poverty Status: 1996

Family income as a percent of federal poverty	*Adults aged 18-64*			*Children aged 0-17*		
	Individual insurance, total	Employer-based and individual insurance	Employer and individual, as a percent of individual	Individual insurance, total	Employer-based and individual insurance	Employer-based and individual, as a percent of individual
0-99 percent	5.4	0.9	16.9	2.1	0.3	15.4
100-199 percent	8.0	2.0	25.1	6.1	1.9	30.9
200-299 percent	7.9	2.6	33.3	5.9	2.1	34.8
300-399 percent	7.9	3.1	39.5	5.8	2.1	36.6
400 percent +	8.1	3.1	42.5	6.8	2.6	38.9
Total	7.9	2.7	35.4	5.3	1.8	33.6

Source: Alpha Center tabulations of the March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

Overview of the Study States

The ten states selected for study are diverse in their population size, geographical location, urban/rural mix, and the relative size of the individual health insurance market (see Table 9). They include several of the most populous states (California, Florida, New York, and Pennsylvania), as well as several low-population states (North Dakota, Montana, and Utah). They include Western coastal states (California and Washington), central and mid-Western states (Montana, North Dakota, Utah, and Iowa), Mid-Atlantic states (Pennsylvania and New York), and states in the South and Southeast (Louisiana and Florida). The urban populations in these states vary from more than 90 percent of the state's nonelderly population (in California, Florida, and New York) to less than 28 percent (in Iowa) and 20 percent (in North Dakota). Montana has no metropolitan statistical area at all. They include states with the largest individual health insurance markets, measured as the percent of the nonelderly population reporting individual coverage — North Dakota (15 percent) and Iowa (12 percent); as well as states with relatively small markets — New York (5 percent) and Louisiana (6 percent).

Table 9
Selected Characteristics of the Ten Study States

State	Nonelderly population (in millions)	Percent of nonelderly population residing in metropolitan areas (MSA)	Percent of nonelderly population with employer-sponsored health insurance		Percent of nonelderly population with individual health insurance		Percent of nonelderly population that is uninsured	
			1995	1996	1995	1996	1995	1996
CA	28.8	98.7	57.5	58.1	6.6	7.7	22.7	22.3
FL	11.7	95.4	59.1	59.5	9.7	8.4	22.0	22.9
IA	2.6	27.6	70.9	71.3	15.1	11.9	13.1	13.2
LA	3.7	80.8	53.1	58.3	8.2	6.2	23.4	23.1
MT *	0.8	---	60.2	61.2	14.3	8.8	15.0	15.4
NY	16.1	90.9	64.0	62.5	6.9	5.1	17.1	19.1
ND *	0.5	19.9	67.7	70.4	19.0	15.2	9.6	11.5
PA	10.2	83.1	72.9	74.9	8.2	7.2	11.6	11.0
UT	1.8	80.8	73.7	76.8	9.7	8.3	12.9	13.0
WA	5.1	77.6	69.2	67.9	8.4	10.2	13.7	14.6
US total	232.5	78.4	66.2	66.5	7.6	7.0	17.4	17.7

Source: Alpha Center tabulations of the March 1996 and March 1997 Current Population Survey (U.S. Department of Commerce, Bureau of the Census).

While available data do not allow precise tracking of individual health insurance trends over the last several years, the percentage of the population with individual health insurance at any time during the year apparently has been declining over the last five years. Most recently (between 1995 and 1996), only 12 states have shown any growth at all in reported individual insurance coverage, including two of the study states: Washington and California. (Estimates for all states are provided in Appendix 1.)

State Regulation of Individual Health Insurance and HIPAA

Many states have implemented health insurance regulations intended to improve access in the individual health insurance market and affordability for people with health problems. Between 1990 and 1996, 25 states passed such reforms (Paul and Chollet, 1996). Thirteen states require all insurers participating in the individual market to guarantee issue one or more products to all applicants — although only four states (New York, New Jersey, Vermont, and Washington) require guaranteed issue of all products, and some of the thirteen states require guaranteed issue only to qualified individuals (e.g., someone continuously covered for the past 12 months). To make coverage more affordable for people who present health problems, 18 states have passed legislation limiting variation in premium rates or prohibiting the use of some "rate factors" (characteristics such as health status, claims experience, age, or gender that insurers may use to set rates). Twenty-two states limit preexisting condition exclusions, typically addressing both the "look-back" period used to define a condition as preexisting and the duration of the exclusion or waiting period. Many states limit look-back and waiting periods each to 12 months. However, in some states that limit preexisting condition exclusions, insurers are allowed to issue "exclusion riders" that exclude coverage for specified conditions for the duration of the policy period.[3]

Responding to the individual health insurance requirements of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), all but six states[4] now have some provision in law guaranteeing issue of at least one health insurance plan (from all insurers writing individual coverage, from a designated insurer of last resort, or from a state high-risk pool) and restricting preexisting

[3]A rider is an addendum to the standard insurance contract. A rider may add benefits (e.g., for maternity services or prescription drugs) for an additional premium or reduce coverage from that otherwise promised in the standard contract (e.g., a permanent exclusion rider withholding coverage for specific conditions or body systems — such as any condition related to kidney, heart, or circulatory function).

[4]California, Massachusetts, Missouri, Michigan, and Rhode Island failed to pass full, complying legislation before December 31, 1997; in these states, the individual insurance market is subject to federal regulation for compliance with HIPAA's individual market provisions. Because Kentucky's legislature meets biennially, HIPAA extended Kentucky's legislative compliance date to December 1998.

condition exclusions for "HIPAA-eligible" individuals (see Table 10).[5] The definition of "HIPAA-eligible" is sufficiently narrow to suggest that relatively few individuals leaving employer-based plans will benefit from HIPAA's guaranteed issue and portability provisions. Furthermore, HIPAA does not protect individuals who move from one insurance plan to another within the individual insurance market.

Table 10
State Strategies for Compliance with HIPAA's Guaranteed Issue and Portability Requirements

State	Compliance strategy for guaranteed issue and portability
CA	Federal fall-back[a] with federal regulation
FL	Mandatory group conversion with rate and benefit regulation of conversion product for HIPAA eligibles
IA	Risk pool; guaranteed issue of standard and basic products to HIPAA-eligibles
LA	Risk pool
MT	Risk pool (separate pool for HIPAA-eligibles)
NY	Guaranteed issue, all products
ND	Risk pool
PA	Guaranteed issue Blue Cross Blue Shield
UT	Risk pool and regulated, capped guaranteed issue for HIPAA-eligibles
WA	Guaranteed issue, all products

Source: Karen Pollitz and Nicole Tapay, Institute for Health Care Policy and Research, Georgetown University, 1997; Alpha Center, 1998.

[a]HIPAA's federal fall-back provisions require that all insurers writing major medical products in the individual market guarantee issue of two products to HIPAA-eligible individuals. These may be either their two highest-volume products or two "representative" products. These products are defined as having 85-100 percent and 100-120 percent, respectively, of the actuarial value of the insurer's average major medical product (calculated as the average of all of the insurer's major medical products, weighted by enrollment).

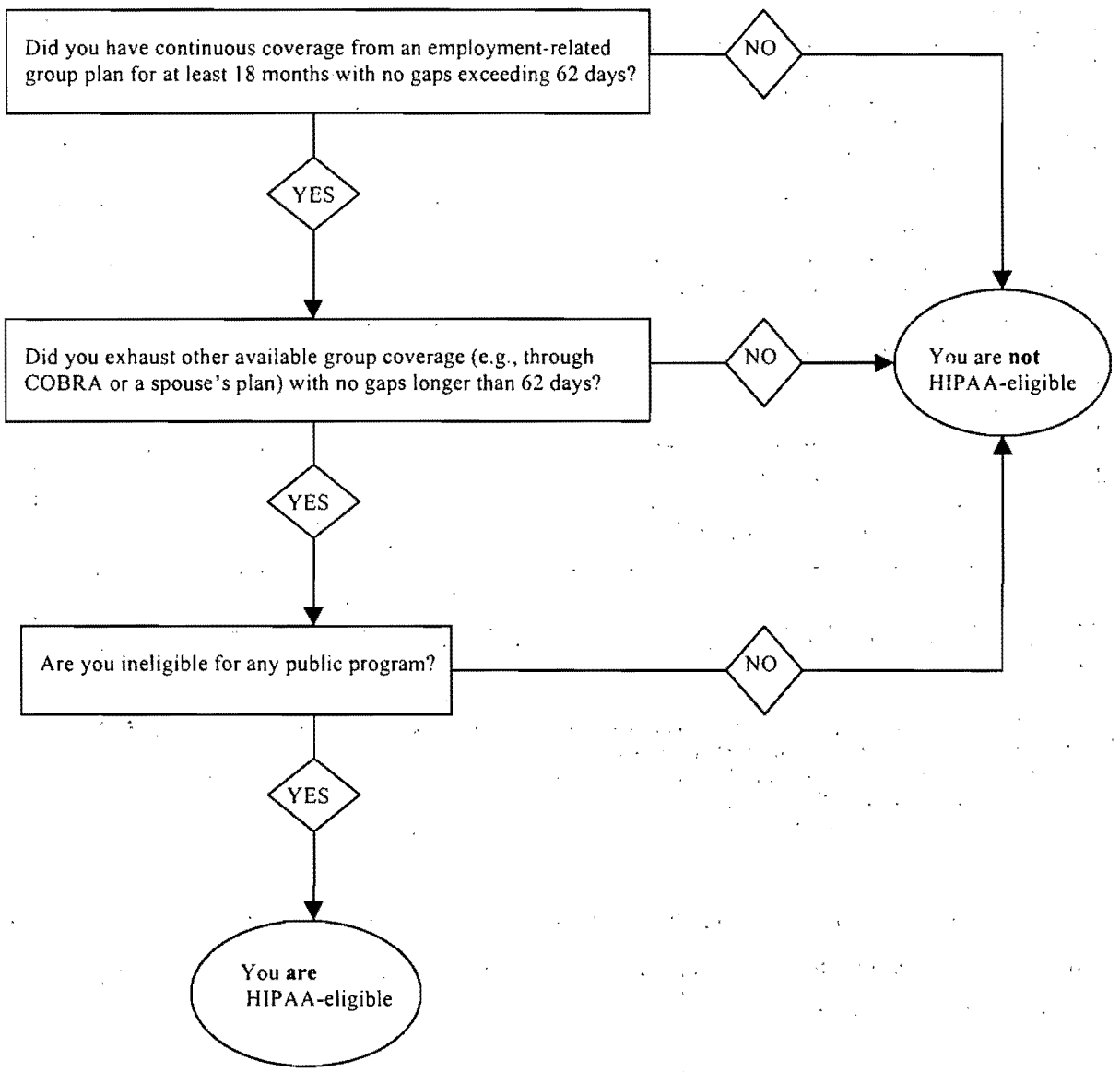
Figure 4 depicts the sequence of conditions that defines individuals protected by HIPAA's portability and guaranteed issue requirements. In general, both public policy analysts and private insurance analysts agree that very few individuals are likely to pass these screens in a given year. In states with

[5]HIPAA defines an eligible individual as someone who: (1) has 18 or more months of creditable coverage under a group health plan, governmental plan or church plan; (2) is not eligible for group coverage Medicare or Medicaid, and otherwise without other health insurance; and (3) has exhausted all available COBRA coverage (or other similar state continuation program).

"mini-COBRA" laws (which extend COBRA continuation to groups of fewer than 20 employees), still fewer individuals are likely ever to qualify for HIPAA protections. Still, as a result of HIPAA, individual coverage is now guaranteed renewable in all states. Only 15 states had required guaranteed renewal in the individual market prior to HIPAA compliance. The following section describes the regulation of the individual market undertaken by each of the 10 study states.

Figure 4

Determining HIPAA Eligibility in the Individual Market



Regulation of Individual Health Insurance in the Study States

Among the study states, both New York and Washington have relatively high levels of regulation in the individual market (see Table 11). Both have implemented rate reforms and require guaranteed issue and renewal of all individual products. New York requires that all insurers community rate individual products, offering the same premiums to all consumers regardless of age, gender, or health condition. In New York, individual health insurance rates vary only by product, family composition and geographic location. Insurers may not consider individual health status, claims experience, age, gender or other factors in setting rates. New York allows a 12 month waiting period on preexisting condition limitations (common among states that limit preexisting condition exclusions), but a relatively short look-back period — just 6 months.

Like New York, Washington also requires guaranteed issue of all products in the individual market. However, Washington does not require community rating. Washington permits relatively wide rate variations of 4:1 (for age and geography), but it prohibits insurers from using health status or claims experience to set rates. Washington limits preexisting condition exclusions to a 3 month look-back and 3 month waiting period — much shorter than the usual limits. Washington imposes similar regulation in its small-group market and defines small groups as one or more, extending the state's small-group protections to self-employed individuals.

Iowa and Utah passed legislation in 1995 and 1996, respectively, to guarantee issue and to limit individual insurance rate variation. However, in both states, these regulations are less comprehensive than in Washington or New York. Iowa requires guaranteed issue and renewal of a standard and basic plan, but individuals must have one year of qualifying coverage or a qualifying event to be eligible for regulatory protection. Iowa limits rate variation to 2:1 for health status and claims experience — allowing more variation than New York's pure community rating law, but not necessarily less than in Washington. Washington's regulation allows a total 4:1 variation on age and other allowable factors, but prohibits rating on health status; Iowa constrains rating on health status, but does not constrain rate variation for age, geography, or gender.

Utah began requiring insurers to guarantee issue in the individual health insurance market in 1997, but allows insurers to limit or "cap" the number of uninsurable applicants (based on each insurer's own underwriting guidelines) to whom they must issue policies. Utah requires insurers to issue coverage to any applicant whom the state high risk pool certifies as representing less than 200 percent of the average cost of comparable coverage statewide. Utah's legislation also limits rate variations to 25 percent above or below an index rate (equivalent to rate bands of 1.7:1), although insurers may further adjust premiums

for age, gender, family, and geographic location. Utah has set the same limits on preexisting condition exclusions (6 month look-back and 12 month waiting period) as New York.

None of the other study states require guaranteed issue of individual products, although Florida does require guaranteed issue in the small-group market (as well as modified community rating) and defines small groups to include self-employed individuals. Also, Florida's small-group limitations on preexisting condition exclusions are more favorable than for individuals, as long as coverage is continuous: a maximum 6-month look-back and 12-month exclusion in the small-group market, versus the 24-month look-back and waiting periods allowed in the individual health insurance market. When coverage is discontinuous, Florida allows 24-month look-backs and 24-month waiting periods for groups of one or two.

Table 11
Selected State Regulation of Individual Health Insurance: 10 Study States

State	Group market (defined as 1+)[a]	Individual market
CA		• Limit on preexisting condition exclusions (12 months/ 12 months; 6/6 for families with 3 or more covered lives)[b] • Exclusion riders prohibited • Guaranteed renewal (HIPAA)
FL	• Guaranteed issue • Modified community rating • Limit on preexisting condition exclusions (6 months/ 12 months if continuously covered) • Guaranteed renewal (HIPAA)	• Durational rating prohibited • Limit on preexisting condition exclusions (24 months/ 24 months) • Guaranteed renewal
IA		• Limited guaranteed issue[c] • Rate bands (2:1) for health status, claims experience and duration • Limit on preexisting condition exclusions (12 months/ 12 months) • Guaranteed renewal (HIPAA)
LA		• Rate bands (1.2:1 for claims experience, health status and duration) • Limit on preexisting condition exclusions (12 months/ 12 months) • Guaranteed renewal • Portability: group➡individual, individual➡group, and individual➡individual
MT		• Limit on preexisting condition exclusions (36 months/ 12 months) • Guaranteed renewal (HIPAA)
NY[d]	• Guaranteed issue (all products) • Pure community rating with variation only for geography and family composition • Limit on preexisting condition exclusions (6 months/ 12 months) • Exclusion riders prohibited • Guaranteed renewal	• Guaranteed issue (all products) • Pure community rating with variation only for geography and family composition • Limit on preexisting condition exclusions (6 months/ 12 months) • Credit for prior coverage towards waiting period • Exclusion riders prohibited • Guaranteed renewal

State	Group market (defined as 1+)[a]	Individual market
ND	• Rate bands (1.7:1 for experience, health status and duration) • Limit on preexisting condition exclusions • Minimum loss ratio (75 percent) • Guaranteed renewal (HIPAA)[c]	• Modified community rating and rate bands (5:1 for age, industry (occupation), geography, family composition and "healthy lifestyles") • Minimum loss ratio (65 percent) • Limit on preexisting condition exclusions (6 months/ 12 months) • Durational rating prohibited • Guaranteed renewal (HIPAA)
PA		• Guaranteed renewal (HIPAA)
UT		• Guaranteed issue (basic benefit plan, enrollment cap) • Rate bands (1.7:1 for experience, health status and duration) • Limit on preexisting condition exclusions (6 months/ 12 months) • Exclusion riders prohibited
WA	• Guaranteed issue (all products) • Modified community rating and rate bands (4:1 for age, family size and geography) • Limit on preexisting condition exclusions • Guaranteed renewal	• Guaranteed issue (all products) • Modified community rating and rate bands (4:1 for age, family size and geography) • Limit on preexisting condition exclusions (3 months/ 3 months) • Exclusion riders prohibited • Guaranteed renewal

Source: Blue Cross and Blue Shield Association, *State Legislative Health Care and Insurance Issues: 1997 Survey of Plans* (December 1997); and Alpha Center communications with state Departments of Insurance.

[a]Only those small-group reforms extended to groups of one (e.g., self-employed individuals) are listed.
[b]Respectively, the look-back and waiting periods for application of preexisting condition exclusions. All study states that limit preexisting condition periods also require that prior coverage be credited towards the waiting period.
[c]Iowa insurers are required to guarantee issue of a standard and basic product (defined in regulation), and only to individuals with qualifying coverage (group, individual or high-risk pool) or with a qualifying event within the last 30 days.
[d]New York gives insurers the option of including self-employed individuals in the group market (i.e., writing business for self-employed groups of one) or defining the group market as groups of 2 or more. However, if the insurer uses 2+ employees as the standard for group coverage, then they have to write individual coverage.
[e]North Dakota also requires small-group guaranteed issue, but only for groups of 3 to 25.

While neither North Dakota nor Louisiana require guaranteed issue to individuals (self-employed or otherwise), both have implemented rating reforms and limit preexisting condition exclusions. Effective in August 1995, North Dakota requires modified community rating and limits preexisting condition exclusions to a 6 month look-back and 12 month waiting period. North Dakota also defines small groups as one or more, although small-group rate bands do not extend to groups of one. Finally, North Dakota enforces a minimum loss ratio (65 percent in the individual market and 75 percent in the small-group market), restricting insurers' ability to raise their average rates.

Compared to North Dakota, Louisiana imposes still tighter rate bands for experience (1.2:1). However, Louisiana limits preexisting condition exclusions only to the usual 12 month look-back and waiting periods. Louisiana does not recognize groups of one in the small-group market.

Four of the study states (California, Montana, Florida, and Pennsylvania) have relatively unregulated individual insurance markets (although Florida extends some small-group regulatory protections to self-

employed workers). Montana and California limit waiting periods for preexisting conditions in the individual market to 12 months (Florida has a waiting period of 24 months), and California prohibits permanent exclusion riders. Of the ten study states, Pennsylvania is the least regulated: it has enacted no reforms in the individual market (nor in the small group market) beyond those required by HIPAA.

Association Plans

Association plans are generally perceived as a significant source of health insurance for people seeking individual coverage. However, the role of association plans in the insurance market is poorly understood. Typically, insurers market association plans to individuals through association literature, direct mail solicitation, or through an agent and may underwrite (that is, accept or deny and rate) each applicant individually. In the states that we considered, two types of association plans generally are available to individuals: (1) professional groups or other affiliation groups that vary in how narrowly they define their membership; and (2) associations that appear to be groups of a particular insurer's invention.

Because insurers issue certificates of coverage to consumers under a master group policy, many states recognize all association plans as group business (GAO, 1996). Some states (such as California) regulate association plans that include only individual members and qualified dependents as individual coverage, but regulate association plans that include members and their employees (groups of 2 or more) as group business.[6]

We identified no state that requires insurers to report association business separately from their total group or individual health insurance business. Thus, few if any states have a true measure of the extent to which association plans in fact serve individual insurance consumers. In some states, Blue Cross and Blue Shield (as well as some commercial insurers in those or other states) write most of their individual insurance through one or more associations, but report this as group business.

To the extent that association plans are exempt or granted exceptions from various state and federal laws, they may represent an attractive business for insurers. In states that regard association plans as group business, most association business may be governed by large-group insurance regulations — merely because association plan sizes can easily surpass statutory definitions of small groups (typically 2

[6]California requires that insurers writing both association and non-association business for employers (groups of two or more) also offer the same products in the small group market and rate them the same way. Association plans that include individuals and their dependents are considered individual business and these regulations do not apply.

to 50 lives). In states that have undertaken extensive small-group or individual insurance reform, the regulations governing large-group insurance business may be the least restrictive.

Federal regulation. HIPAA considers association plans which include only individuals and qualified dependents as individual insurance; all of HIPAA's individual insurance provisions relate to such associations. HIPAA defines a *bona fide* association as one that (1) has actively existed for five or more years; (2) is formed and maintained for purposes other than obtaining insurance; (3) does not condition membership on health status; (4) makes insurance available only in connection with a member of the association; and (5) otherwise meets requirements of state law. HIPAA establishes somewhat different rules governing guaranteed issue for *bona fide* associations versus non-*bona fide* associations, but its guaranteed renewal rules are the same for both:

- *Guaranteed issue:* An insurer that writes coverage *only* for one or more *bona fide* associations must guarantee issue to any member of that association and their qualified dependents. Otherwise, these insurers are not subject to HIPAA's individual insurance rules. Insurers in all other situations (they write non-*bona fide* association business and/or non-association individual business) must heed HIPAA's individual insurance rules, which vary depending on whether the state has accepted the federal standard (or fall-back) or an acceptable alternative under HIPAA. Insurers in either situation may deny association coverage to any applicant (HIPAA-eligible or otherwise) who is not a member of the association.[7]

- *Guaranteed renewal:* Insurers may decline to renew individual insurance certificates in an association plan, if the insured individual leaves the association. However, HIPAA does require insurers to renew an association master contract or, if the plan is canceled, offer the association all other products that it sells in the individual market.

- *Rating factors:* HIPAA prohibits insurers from using health status to establish insurance rates within group plans, but it is silent with respect to the rate factors that insurers may use to set rates for individual health insurance products. Thus, insurers may continue to consider health status to set rates within individual association plans, subject to state law.

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[7]In states that have adopted HIPAA's federal standard in the individual market (about 12 states), there appears to remain some question about whether insurers that write both association and non-association individual business must consider association plans in determining their "most popular plan" under HIPAA — that is, whether insurers may offer HIPAA-eligible applicants who are not association members an individual plan modeled on the design of their most popular non-association plans. Unless otherwise governed by state law, these may be less comprehensive than their association plans.

State regulation. Many (perhaps most) states have passed "fictitious group" or "fictitious association" laws which prohibit plan sponsors and insurers from forming groups solely for the purpose of buying or selling insurance. Otherwise, the states appear to vary significantly in their regulation of association plans offered to individuals. Montana and North Dakota regard insured association plans as group insurance. In these states (and, we presume, in other states that consider associations of individuals as group business) association plans are exempt from the states' small-group insurance regulation — including rules governing guaranteed issue, product and rate variation and acceptable rating factors. However, they are in general subject to regulation imposed on all fully-insured groups (such as mandated benefits and minimum loss ratios). New York also regards associations of individuals as group business. Moreover, in New York, insurers are required to pool together relatively small association plans with their small group business to calculate and set small-group community rates.[8]

Association plans can play an important role in the states' insurance markets. In California, one agricultural association — which also is organized as an insurance company — is a major marketer of high-deductible policies to members (as well as lower-deductible products); anyone who pays dues may become a member of this association. In some states (for example, in Montana) the rates available through an association can be lower than the rates on products available outside the association. In other states (for example, in North Dakota, where association plans were described as an important source of individual coverage and a practical way to organize and communicate with an otherwise scattered rural population) rates and benefits are reported to be generally comparable to those available outside associations.

In both Pennsylvania and Utah, association plans were viewed as especially susceptible to adverse selection spirals.[9] One potential reason is the voluntary nature of consumer participation in the association plan: as the association block of business ages (with relatively few new entrants into the plan), the insurer or a competitor may offer healthier members lower rates for individual coverage outside the group. This practice of selecting out better risks leaves only sicker members in the

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[8]In New York, if an association plan has fewer than 10,000 lives (with diversified occupations) or fewer than 15,000 lives (with undiversified occupations), insurers must include that association plan in their calculation of the community rate. Larger associations may be experience-rated as large-group business.

[9]An adverse selection spiral can result when the insurer raises the price of insurance to reflect an increase in the pool's average claims experience. If the insurer raises the price to everyone in a pool that includes people with a range of health risks, low-risk enrollees will exit the plan, leaving a smaller pool of enrollees with higher average health care costs. This sequence — a rate increase followed by worsening average experience, necessitating another rate increase — is called an adverse selection spiral. Insurance pools in an adverse selection spiral ultimately will fail and close.

association plan, and the insurer may be forced ultimately to cancel the association plan. This phenomenon may explain a perception among some insurance agents whom we interviewed for this report that association plans which market to individuals generally are "here today, gone tomorrow."

Who Sells Individual Insurance?

The market for individual coverage is fundamentally shaped by the number and types of insurers selling products in the market and the roles played by different types of insurers such as Blue Cross and Blue Shield plans and HMOs. This section examines some of the basic characteristics that define each state's individual health insurance market: how many insurers write individual coverage and the distribution of market share among insurers. As both regulation and competition have changed those markets since 1995, we also consider agents' perceptions about the general condition and stability of their states' markets—how these markets are changing as insurers exit or enter, and as market share shifts among types of insurers. We conclude by examining the role that Blue Cross and Blue Shield insurers play in the individual market and the impact of emerging HMOs and other forms of managed care.

Number and Types of Insurers

The number of insurers doing business in a state is a fundamental characteristic of the market. Greater competition—characterized by more insurers and more evenly distributed market share—is assumed to yield greater choice among products and more favorable prices. Given the study states' different population sizes, economies and insurance regulations, it is not surprising that the number of insurers selling individual coverage varies as well. In California, 50 insurers wrote individual insurance products in 1995. In Montana and North Dakota, respectively, 7 and 8 insurers wrote individual coverage. However, controlling for state population, rural states support a greater number of insurers relative to their populations than more populous states: North Dakota's individual health insurance market has 15 insurers per million population, while California's has fewer than 2 (see Table 12).

While the study states' markets differ in size, market share in all of them is highly skewed toward a few large insurers. The largest five insurers accounted for at least two-thirds of the market in all of the study states, and more than 85 percent of the market in four states: Montana, North Dakota, Utah, and Washington. Conversely, the smallest 50 percent of insurers held less than 25 percent of the market in all of the study states, and less than 12 percent of the market in all states but the study's least populous and most rural states: Montana and North Dakota (see Table 13).