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Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform

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OVERVIEW — *Although the majority of Americans with health insurance obtain coverage through their employers, many individuals must negotiate the nongroup insurance market alone. Insurers use a process called medical underwriting to identify applicants with current or recent medical problems. Because these applicants are likely to cost the insurer more in claims than a healthier person, insurers may charge them higher premiums or restrict or deny coverage. This background paper reviews the practice of underwriting, state and federal regulation of insurers offering nongroup health coverage, and several proposed options for improving access to coverage for applicants who are in poor health.*

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INTRODUCTION

Most nonelderly Americans are covered by employer-sponsored group health plans. In 2003, however, 16.5 million people—6.5 percent of the nonelderly population—bought coverage directly from insurers in the nongroup or individual market.[1] Purchasers of nongroup coverage may include workers in jobs that do not offer health benefits, self-employed people, and early retirees or other people outside the workforce.

Many proposals to reduce the number of Americans without health insurance would provide tax preferences or other assistance to help more people without employer benefits buy nongroup coverage. For example, President Bush's fiscal year (FY) 2006 budget proposal would provide a refundable health insurance tax credit for low-income people and, for higher-income families, an "above-the-line" deduction for high-deductible health coverage bought in conjunction with a health savings account (HSA).[2]

The nongroup insurance market has advantages and disadvantages. Buyers can select the benefits they prefer, instead of having to choose among the limited range of benefit plans—or often a single plan—offered by their employer. And people with nongroup coverage can keep the same plan if their circumstances change; they don't need to join a new insurance plan if they switch employers. On the other hand, nongroup policies generally have higher administrative costs than comparable coverage sold to employer groups. In addition, many people seeking nongroup coverage face one key barrier: medical underwriting.

In all kinds of insurance, underwriting is the process of determining the level of risk presented by an applicant and deciding whether to sell a policy and, if so, under what terms and at what price. Nongroup health insurers commonly obtain information on an applicant's current health status, medical history, and other indicators of potential future costs. An insurer may refuse coverage to high-risk individuals; may grant coverage with an exclusionary rider, under which services for a specific condition are temporarily or permanently excluded; may impose a

"preexisting condition exclusion," which for a fixed period limits coverage of services for any medical condition the purchaser has at the time coverage takes effect; or may charge higher premium rates to purchasers perceived to be high risk.

Similar practices once prevailed among insurers selling group health coverage to small employers, usually defined as those with 2 to 50 workers. Until recently, insurers might reject a group with one or more high-risk employees; might accept the group but refuse to cover some workers; and might charge a group with high-risk employees much higher rates than other groups. Many of these practices are now restricted by federal and state regulation. There may remain barriers to coverage for high-risk small groups in some states, particularly those that allow insurers to use health characteristics to widely vary premium rates for otherwise comparable groups. However, this is just one of many factors in employers' decisions to offer coverage. In recent years, policy discussions at the federal level have focused chiefly on coverage for people without access to employer plans. For this reason, the focus in this paper is on practices in the nongroup market.

This background paper reviews underwriting in the nongroup market: why insurers underwrite, how they obtain health information, and the types of restrictions they may impose on individual applicants. It summarizes current federal and state rules governing underwriting practices and gives an overview of the very limited information available on how many potential buyers encounter higher premiums or denial or limitation of coverage for health reasons. Finally, it reviews a range of policy options that could make coverage more available and affordable for high-risk people.

As will be seen, most of the options involve some form of indirect transfer of funds from low-risk people (or taxpayers generally) to high-risk people. Some analysts think it would be more efficient simply to provide direct subsidies to high-risk people to help defray their higher premiums. Others think that tweaking the nongroup market will not help it serve high-risk people and that coverage is better provided through expanded public programs. This report is not intended to endorse any particular approach; it is meant to provide background on the options that are currently receiving the most attention from policymakers.

BASICS OF UNDERWRITING

Underwriting is common in all forms of insurance, not just health insurance. For example, an automobile insurer will charge higher rates to young, unmarried males, or it may refuse coverage to drivers with a history of accidents. Fire insurers may inspect properties, offer reduced premiums for safety features such as sprinkler systems, and so on.

Why Do Insurers Underwrite?

Two key considerations govern an insurer's behavior:

■ People are more likely to buy insurance if they have reason to believe they will incur high costs in the near future.

This phenomenon is known as "adverse selection." Nongroup health insurers must be aware that people may wait until they are sick before they start shopping for coverage.

■ A small proportion of the insured population accounts for a very large share of total claims costs.

Among nonelderly adults with employer group coverage in 2001, for example, the highest-spending 3 percent of enrollees accounted for 37 percent of total costs; the highest-spending 10 percent accounted for 60 percent of total costs.[3] In a competitive market, an insurer that could screen out the highest risks could offer lower rates to more favorable risks.

No insurer can identify in advance everyone who will have high costs. Many people will have high spending because of some unforeseeable condition or event. However, an insurer can predict that people who have certain medical problems at the time they apply for coverage will, on average, cost more than people who don't have those problems. Table 1 compares spending in 2001 for adults with employer coverage who did or did not have a history of cancer, diabetes, and/or heart disease as of the start of the year. (This is not, of course, a full list of the conditions insurers consider in underwriting, but it allows for a simplified model of how underwriting works.) The table is based on the Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Healthcare Research and Quality (AHRQ). The MEPS provides nationally representative data

TABLE 1
Private Insurance Payments, 2001, for People with and without Cancer, Diabetes, and/or Heart Disease at Start of Year

	Health Condition		
	Cancer, diabetes, and/or heart disease	None	Total
Percent of population	9%	91%	100%
Percent of total spending	34%	66%	100%
Per capita payments	$11,194	$2,266	$3,092

Source: Author's analysis of data from the Medical Expenditure Panel Survey (MEPS), Agency for Healthcare Quality Research; available at www.meps.ahrq.gov. Population estimates are for noninstitutionalized people aged 18 to 64 who had employer coverage throughout 2001, who had Medicare at no time during that year, and who participated in MEPS in both 2000 and 2001. Spending figures include private insurance spending only and have been adjusted for age and sex.

on health care utilization and spending, insurance coverage, and other characteristics of the civilian noninstitutionalized population.

After adjustment for age and sex differences, average private insurance payments for people who had one or more of the three conditions at the start of the year were nearly five times as high as for people who did not.[4] An insurer that accepted all applicants and charged everyone the same rate would have to charge an annual premium of $3,092 (plus administrative costs and profit). An insurer that could screen out people with the three conditions or set their premiums separately could offer the applicants without these conditions a premium of $2,266, nearly 27 percent less.

If everyone—healthy or sick—were equally likely to buy insurance, and if only one insurer were seeking their business, that insurer could accept every eligible participant at a uniform price. This is approximately the situation in very large employer groups. It is often thought that this has something to do with the size of the group: a large employer has a mix of low-risk and high-risk workers, and the insurer can simply charge all of them an average price. In fact the size of the group is only one factor, and perhaps not the most important one.

If an insurer were to set up a booth on the premises of a firm with 100,000 employees and offer to sell coverage to anyone who passed by, this would not be inherently different from setting up a booth to sell nongroup coverage in the center of a city with 100,000 people. The insurer would have to expect, in both cases, that the people who actually stopped by the booth and bought coverage were the highest risks and charge them accordingly. But there are at least three characteristics of large employer groups that allow an insurer to forgo underwriting:

■ Individual employees pay only part of the premium for health insurance; in 2004, 77 percent of employers paid at least 75 percent of the cost for single workers, and 21 percent paid the entire cost.[5] Because coverage is so heavily discounted, from the employee's perspective, low-risk employees are almost as likely to enroll as high-risk employees.

■ The transaction is not initiated by the individual employee, nor does the employee decide when he or she will begin coverage. In the nongroup market, people must make some effort to seek out the insurer and decide when to do so; it is reasonable, then, for the insurer to be concerned that the purchaser who is knocking on its door could be planning for surgery tomorrow. In the group market, however, every eligible employee is uniformly offered coverage on a fixed day (such as the first day of work), or during a limited annual open season, and must affirmatively accept or refuse coverage at that time. This process also increases the likelihood that low-risk as well as high-risk employees will enroll.

■ Members of employer groups are, by definition, healthy enough to work, so their average health status is likely to be better than that of the general population. Of course, this is not necessarily true of dependents or of people buying coverage from the group as a result of the 1996

Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation rules (described below).

This is not to say that the size of the group is unimportant. The key factors cited—subsidized premiums, ease of participation, and better health status—apply in small firms as well as large ones. In a small firm, however, a few high-cost participants could easily raise the average cost for the entire group; in a larger pool, there is a greater likelihood that this cost would be offset by many low-risk participants. Moreover, insurers may be concerned that some very small employers would be motivated to buy health insurance because the owner (or a dependent) needs expensive care.

How Do Insurers Obtain Information?

Most people seeking nongroup coverage buy it through an insurance agent or broker. In recent years, increasing numbers of policies have been sold through the Internet; the largest online vendor, eHealthInsurance, claims to have sold over 500,000 policies. No matter how the sale is facilitated, the starting point for the underwriting process is the application form, which commonly includes questions on medical history and other subjects. The insurer may ask about pregnancy; medication use; alcohol, drug, and tobacco use; and the occurrence of any of a long list of diseases, conditions, and symptoms, either during some number of years prior to the application or ever in the applicant's life. Insurers may also want to know about high-risk activities, such as motorcycle riding, and may ask whether the applicant has ever received a negative decision—including rejection, restricted coverage, or substandard rating—from any other life or health insurer.

Agents often help applicants complete applications, and their role in this process can involve some conflicts of interest. Agents want to sell coverage and earn a commission, so they may steer applicants toward the insurers most likely to accept them or even encourage applicants to withhold some information. On the other hand, insurers may rely on agents to screen out applicants who appear to be in poor health or have observable problems.[6]

Some insurers are now reducing the role of agents by using "teleunderwriting" to supplement or replace the written application. With this method, the applicant would speak to a trained interviewer who follows a computer-assisted script that highlights key issues and probes for further details. Teleunderwriting vendors claim that people reveal information more readily over the phone and that agents are relieved not to have to ask sensitive questions.[7]

Insurers may make their coverage and rating decisions directly on the basis of the application or other self-reported information, or they may use it to identify areas of concern in need of follow-up. If an applicant has reported a particular condition, insurers may ask for an "attending

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physician statement" from the doctor who has been treating that condition. More rarely, they may arrange for blood or urine testing. Lately some insurers have been asking for an oral fluid test, whereby an insurance agent collects fluids from the applicant's mouth with the use of a swab; the test can reveal HIV infection or undisclosed tobacco use, for example.[8] In rare instances, the insurer may require a full physical, although this is much more common in life and disability insurance than in health insurance.

It is always possible that an applicant may not respond fully or truthfully to questions on the application. If the insurer later discovers a misrepresentation or omission, it has the right to rescind or restrict a policy.[9] However, this is much more costly than identifying such applicants prospectively, because after the sale of a plan the insurer will already have paid a commission and incurred other administrative costs. For this reason, many insurers are screening applicants using large population-level databases.

The best known of these is maintained by the Medical Insurance Bureau (MIB), a membership organization that facilitates the exchange of information on insurance applicants among 500 life, health, and disability insurance companies. Each company reports to MIB on individuals who have applied for any form of coverage and on possible medical conditions or other risk indicators identified for each applicant. (Applicants agree to have this information released to MIB, so privacy requirements are not violated.) When another company receives an application from the same individual, it can query the MIB database and learn what conditions have been reported; histories are generally retained for seven years. MIB information consists only of condition codes, without further history or details, and companies do not report the action taken on applications. The inquiring underwriter may use the data as a basis for further investigation or to identify omissions from application forms. MIB has records on over 30 million individuals and has information on medical conditions for 16 to 18 million.[10]

Although MIB information is limited to people who have applied for some form of individual insurance, other sources are beginning to emerge that can provide data on a larger share of the population. For example, many insurers that provide prescription drug benefits to either groups or individuals contract with pharmacy benefit managers (PBMs) to administer those benefits. Several firms are collecting individual drug utilization information from one or more PBMs and making it available to life and health insurers. An applicant's use of medications may reveal chronic conditions, such as high blood pressure or depression. (There are concerns that these matches may be misleading, as when someone trying to stop smoking briefly takes an antidepressant.[11]) Firms offering drug profiles report "hit rates"—matches of applicants to PBM records—of 30 percent or more. [12] Because so many people receive prescription drugs, it is possible that insurers might, in the future, have information on much of the population.

Although the focus of this report is on underwriting and its effects, it should be noted that there are other ways in which insurers can discourage enrollment by high-risk applicants. Health plans can offer policies that include benefits thought to attract younger and healthier enrollees, such as well child care, and limit benefits, such as prescription drugs or home health care, that are more likely to appeal to people with chronic illnesses. One type of benefit that may be especially subject to manipulation is mental health care; plans competing in the Federal Employees Health Benefits Program (FEHBP) had frequently tinkered with mental health benefits to reduce adverse selection until these practices were restricted in 1999.[13] Health insurers can also tailor their marketing approaches to appeal to more desirable applicants. For example, it has been alleged that some plans participating in early Medicare health maintenance organization (HMO) contracting initiatives targeted their outreach to healthy seniors.[14]

How May Insurers Respond to High-Risk Applicants?

When an insurer identifies a high-risk applicant or a specific condition or problem that may lead to high costs, it may respond in a number of ways. Many of the practices discussed in this section have been restricted in at least some states or, for specified populations, by federal law; current rules are described later in this paper. In an unregulated environment, nongroup insurers may behave as follows:

Denial of coverage — An insurer could simply refuse to sell a policy to an applicant or, in the case of a family, exclude one or more family members from the policy.

Riders and exclusions — An insurer could sell a policy with a rider that excludes coverage for some specific medical condition or for some body part, either during a fixed "elimination" period (for example, during the first year of coverage) or for as long as the policy is in effect. Problems commonly subject to exclusion riders include chronic back pain and anemia.[15]

Policies may also include a "preexisting condition exclusion." This provision excludes coverage for any condition which was diagnosed or for which the policyholder received treatment during some period before the policy took effect. A preexisting condition clause has two components. The first is the "look-back" period: the length of time before the policy effective date, to which the exclusion applies. For example, if the look-back period were 12 months, an applicant who had been treated for a gallbladder problem during that period would be ineligible for coverage of any new or continuing gallbladder problem; an applicant whose last treatment for the problem occurred more than 12 months earlier, however, would be covered. The second component is duration: how long the exclusion lasts after the policy takes effect. If a policy is referred to as having a 12-month/6-month exclusion, this means that the look-back period is 12 months and the exclusion applies for the first 6 months after the policy effective date.

Problems commonly subject to exclusion riders include chronic back pain and anemia.

Although exclusion riders are imposed for specific problems known to the insurer at the time the policy is issued, general preexisting condition exclusions apply whether the insurer knew about the problem or not. If someone buys a policy and shortly thereafter files a claim for diabetes treatment, the insurer may suspect that the patient was already receiving treatment before the policy took effect. If this is confirmed, for example through contact with the treating physician, the exclusion will apply and the claim will be denied.

Substandard rating — An insurer may offer coverage to someone with medical problems only at a premium rate that is higher than the rate offered to comparable individuals without any problems. The term "comparable" must be emphasized. Insurers commonly vary premiums for the same benefit package according to the enrollee's age and sex, geographic location, and sometimes other factors not directly related to health status, such as whether the policy was issued directly or through an association plan. One national study found that in 2000, the average monthly nongroup premium for a healthy 55-year-old male was $313, compared to an average of $132 for a healthy 25-year-old male; the premium for the older male was 2.4 times as high as for his younger counterpart.[16] Despite this gap, each of these enrollees paid a standard rate for someone with his demographic characteristics. An insurer is imposing a substandard rate when it charges a 25-year-old person with health problems more than a healthy one.

How Many People Are Affected by Underwriting?

It is difficult to gauge how many people face barriers to coverage or how many people are uninsured because of underwriting and rating practices in the nongroup market. Although there have been a number of studies of the practices of particular insurers or groups of insurers in the nongroup market, there is no information on the prevalence of various practices in the industry as a whole. Moreover, different insurers may treat identical applicants differently, so an applicant unable to find coverage with one carrier may find affordable insurance through another. Finally, many other considerations may limit the number of otherwise uninsured people who buy nongroup coverage, including high costs (even before any health-related premium differential) and lack of information about available options.

Insurer practices — In a 2001 study, Pollitz, Sorian, and Thomas submitted applications for seven fictitious applicants, each with one or more preexisting conditions, to multiple insurers in eight different markets. They received a total of 60 insurance decisions per applicant.[17] One HIV-positive applicant was rejected by every insurer in every market. A young woman with hay fever and no other problem was rejected 8 percent of the time. Most of the offers made to applicants involved benefit restrictions, higher than standard rates, or both. One striking finding was that

different insurers in the same market treated identical applicants very differently; someone rejected by some carriers might receive a "clean" offer—unrestricted coverage at standard rates—from others. In total, 35 percent of the applications were rejected and only 12 percent received clean offers. Of course, this does not represent the insurers' overall negative action rates, because all the hypothetical applicants had at least some health problem, whereas the broader pool of real applicants would include people with no problems.

The Health Insurance Association of America (now called America's Health Insurance Plans, or AHIP) surveyed 11 of its member insurers and obtained the insurers' responses to about half a million individual applications. As Table 2 shows, the surveyed insurers rejected about 12 percent of applicants and made clean offers to 71 percent; the remaining applicants were offered coverage with an exclusion waiver, a substandard premium, or both.

Other surveys have shown similar results. A 1996 study by the General Accounting Office (GAO, now known as the Government Accountability Office) collected data from one or more individual health insurers in seven markets. The carriers studied typically rejected 18 percent of applicants, with one carrier rejecting 33 percent.[18]

TABLE 2
Reported Action on Applications, 11 Nongroup Health Insurers

Action	Percent of Applications
Standard offer	71.2%
Extra premium	5.9%
Exclusion waiver	13.5%
Extra premium & waiver	2.8%
Declined	11.8%

Source: Thomas Musco and Thomas Wildsmith, "Individual Health Insurance: Access and Affordability," (Health Insurance Association of America Brief Analysis, October 2002; available at www.heartland.org/pdf/15320.pdf. Figures add up to more than 100 percent because multiple actions are possible when an application is for several individuals. Results are for underwritten applications only; some applications never reached this stage because the application was either incomplete or withdrawn, or for other reasons.

People with a history of mental health problems may face greater barriers to coverage. A 2002 study of seven carriers by GAO found that people with mental disorders of "generally moderate severity" would be rejected 52 percent of the time, whereas people with comparably severe chronic health conditions would be rejected 30 percent of the time.[19]

In another recent study, Pauly and Nichols reported data on rate offers by one large insurer in a single state. This insurer rejected 14 percent of applicants. Of those offered coverage, 66 percent were offered the standard rate; 24 percent were offered a rate at 125 percent of the standard and 7 percent were offered 177 percent of the standard; the remaining 3 percent were offered some undisclosed higher rate.[20] The 1996 GAO study found one nongroup carrier that charged about 2 percent of enrollees 100 percent more than the standard rates. The insurers in these two studies appear to have used twice the standard rate as an upper limit. Note, however, that this is twice a standard that may already be high because of age, sex, and local health care costs. One of the hypothetical applicants in the Pollitz, Sorian, and Thomas study, a 62 year-old male with controlled high blood pressure, received offers ranging from $244 to $2,504 per month, depending on the area and the insurer.

Consumer experiences — A critique of the Pollitz, Sorian, and Thomas study by the National Association of Health Underwriters emphasized that applicants usually could have found some coverage in each market

and noted that benefit restrictions and rate increases were not always significant. A response by Pollitz and Levitt notes that the fact that some insurer(s) in an area might offer affordable coverage doesn't mean that a consumer can find (or access) that insurer.[21]

Why would different insurers in the same market reach different decisions about the same applicant? Underwriting involves a tension between avoiding undesirable risks and maximizing enrollment. An insurer that rejected every applicant who had ever had any medical problem might avoid most bad risks but would not sell many policies. Each insurer has its own strategies for balancing risk management and sales. One observer suggests that the entire industry has shifted strategies over time. In this view, tight underwriting predominated in the 1980s; in the 1990s, insurers loosened underwriting to maximize volume; more recently, standards have again become more strict.[22] However, there are no longitudinal data to confirm this impression.

In any case, variation in insurers' strategies means that studies of insurers cannot indicate how many people are actually affected by underwriting. There is surprisingly little direct data on consumer experiences. A 2001 survey by the Commonwealth Fund found that about 27 percent of working age adults had shopped for insurance in the nongroup market in the preceding three years. Of these, 53 percent had found it "very difficult or impossible" to find a plan they could afford; the figure was 62 percent for people who had specified medical problems or who had reported being in fair or poor health, compared to 46 percent for people with no medical conditions and who reported good or excellent health. Although this certainly suggests that people with health problems face greater barriers, what people think they can "afford" depends on their income, desire for coverage, and other factors. Actual denials of coverage were considerably less frequent than suggested by the data from insurers: only 4 percent of shoppers had experienced a denial. [23]

The MEPS also asks whether respondents have ever been denied health insurance because of poor health. In 2001, less than 1 percent of those asked the question said that they had.[24] (This is similar to the Commonwealth finding: 4 percent of 27 percent who shopped equals 1 percent. However, Commonwealth asked only about the last three years, whereas MEPS asked about any denial ever.) There is no way of knowing, however, how many people were discouraged from applying (by agents or by an intimidating questionnaire) or how many were not actually denied but received a substandard offer.

Because the number of people looking for nongroup coverage is limited, and because many potential purchasers would be deterred by high costs regardless of underwriting, the population actually affected is relatively small—perhaps 1 million or more people could be regarded as "uninsurable." But many millions of people who have insurance now and who have a history of health problems may be concerned that, if their circumstances should change and they lose their current coverage, an affordable

replacement may be difficult or impossible to find. In the early 1990s, there was considerable discussion of "job lock": the possibility that some people who would otherwise have changed jobs, shifted into self-employment or part-time work, or taken early retirement had remained in their current job in order to retain group health coverage. Although anecdotes suggested that this phenomenon was real, it has proved difficult to quantify.[25]

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). The "portability" provisions, summarized in the next section, were intended to address job lock by assuring that people who left a job from which they had had health coverage would be able to obtain it, either through their new employer's health plan or in the nongroup market. However, there has been no post-HIPAA study to see how well these protections have worked.

EXISTING REGULATION OF NONGROUP INSURERS

Responsibility for regulation of health insurance and employee health benefits has traditionally been divided between the federal government and the states. Under the McCarran-Ferguson Act of 1945, Congress affirmed that the sale of insurance was not interstate commerce and that the "business of insurance" was to be regulated by the states. The Employee Retirement Income Security Act (ERISA) of 1974—meant to strengthen federal regulation of pension plans—preempted state regulation of employee benefits, including health benefit plans. States can regulate commercial insurers, HMOs, and other entities selling health insurance, whether to individuals or to employers. However, they cannot regulate self-insured employer health plans. (Under a self-insured plan, the employer assumes direct risk for employees' health care costs. A self-insured plan may contract with an insurer to process claims under an administrative service agreement. It may also obtain reinsurance to cover unexpectedly high costs; see the section on reinsurance below.)

Beginning in the late 1980s and early 1990s, many states began to regulate underwriting and the rate-setting practices of insurers that sold coverage to small groups, commonly defined as employers with 2 to 50 workers. (Some states included one-person firms, thus extending protections to self-employed individuals.) A few states enacted similar regulations in the nongroup market. However, these were and are more controversial than small group reforms because of concerns that measures to improve availability of coverage for high-risk people would drive up premiums for the majority of lower-risk buyers. (This issue is also discussed further below.)

As noted earlier, HIPAA represented the first major federal intervention in the health insurance market. HIPAA prohibits or regulates underwriting practices of self-insured employers, insurers selling group coverage, and, to a more limited extent, insurers selling nongroup coverage. This section begins with a review of HIPAA requirements for the nongroup market and then summarizes state regulations.

In the late 1980s, states began to regulate underwriting and the rate-setting practices of insurers that sold coverage to small groups.

HIPAA Nongroup Market Rules

HIPAA's nongroup market rules are chiefly related to insurers' treatment of applicants who were previously covered under an employer group plan. Some HIPAA rules apply to all nongroup coverage.

Guaranteed issue and preexisting condition exclusions — A nongroup insurer may not deny coverage to, or impose any preexisting condition exclusion on, a HIPAA-eligible individual, defined as a person who has 18 months of "creditable" health coverage and whose most recent health coverage was through a group plan.[26] Creditable coverage includes any form of public or private health insurance (with minor exceptions). The coverage need not have been continuous, but there cannot have been a break in coverage of more than 63 days, and the most recent period of coverage cannot have ended more than 63 days before the date on which the individual applies for nongroup coverage. Insurers need not offer "HIPAA eligibles" every policy they sell, but they must make at least two product choices available.

The guaranteed issue rule does not apply in a state that has developed an alternative method of assuring that HIPAA-eligible people have access to a choice of health plans. Alternatives can include state guaranteed issue requirements applicable to some or all carriers, provisions for conversion coverage (see below), or at least one nongroup plan offering open enrollment. States can also meet the requirement by offering a high-risk pool. These pools, described later in this paper, are commonly designed for people denied nongroup coverage for health reasons; HIPAA eligibles may join the same pool or be separately grouped.

One major gap in HIPAA's guaranteed issue requirement is that it does not include any regulation of premium rates. A nongroup insurer must offer coverage to a HIPAA-eligible individual, but it can deter enrollment by charging HIPAA eligibles much higher rates than other applicants. HIPAA requires states that have developed an alternative compliance method to assure that coverage is affordable, for example, by regulating insurers' rating practices or offering subsidies to individuals or carriers. In states where only the federal rules apply, there is no such protection.

Guaranteed renewability — A nongroup carrier cannot cancel or refuse to renew coverage for any individual, regardless of HIPAA eligibility status, except for failure to pay premiums or fraud. An insurer that wishes to cease to offer nongroup coverage in a state may cancel all existing policies with 6 months' notice; an insurer that wants to discontinue a particular policy in a state, but not leave the nongroup market, must offer holders of that policy any other plan that it is selling in the state. Here again, HIPAA does not restrict rating practices. An insurer must offer renewal coverage, but it can raise premiums at the time of renewal for people who are in poor health or who have incurred high costs. (Many states, however, limit the extent to which renewal rates can vary by health status.)

State Regulation

Nearly all states have adopted at least some restrictions on underwriting or rating practices of nongroup insurers. Table 3 shows the number of states that had adopted each of the major types of protections as of April 2004.

Guaranteed issue — In five states, every nongroup insurer is required to accept every applicant. Another 12 states require guaranteed issue by one or more specific insurers (for example, a Blue Cross/Blue Shield plan), by a class of insurers (such as all licensed HMOs), or for specific populations, such as people who have previously held creditable insurance coverage for some period but do not meet the HIPAA eligibility requirements. Finally, 11 states require guaranteed issue only for HIPAA eligibles. (The remaining states have adopted alternative mechanisms for assuring access to coverage for HIPAA eligibles.)

Conversion coverage — Most states require insurers who sell coverage to employer groups to offer people who are leaving the group an opportunity to buy an individual policy, even if the insurer is not otherwise selling nongroup coverage. Conversion coverage differs from the HIPAA portability protections in several ways. People may qualify for conversion without meeting the HIPAA standard of 18 months of creditable coverage. Only the insurer covering the person's previous group must offer the coverage. A few states limit the premium rate insurers can charge for a conversion policy, for example, no more than 120 percent of the previous group rate; however, the new policy will generally not be as extensive as the employer plan.

Conversion is also distinct from another insurance option for people leaving group plans: federally required COBRA continuation coverage. Under COBRA, people leaving a group plan for specified reasons (change or loss of employment, divorce, disability, and so on) must be allowed to continue participation in the identical coverage for a fixed period—usually 18 months, or longer for certain

TABLE 3
Number of States with Nongroup Market Rules, 2004

Requirement	No. of States
Guaranteed Issue	
For all carriers and all applicants	5
For some carriers or specified populations	12
For HIPAA eligibles only	11
Conversion Coverage	38
Exclusions	
Riders restricted or prohibited	
For all carriers	13
For some carriers or HIPAA eligibles	16
Preexisting conditions	
Limited lookback/duration period	48
Duration reduced through credit for prior coverage	40
Rating Requirements	
Pure community	3
Adjusted community	6
Rating bands	12
Self-employed individual as small group	12

Source: Author's analysis, based on Georgetown University Health Policy Institute, "Summary of Key Consumer Protections in Individual Health Insurance Markets," April 2004; available at http://healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf. The categorization and counts of states are the author's and should not be attributed to the source.

people. This requirement applies to self-insured employer plans as well as those offered through an insurer. The enrollee can be charged a premium of no more than 102 percent of the cost of the plan (150 percent in the case of disabled people with extended coverage). The terms and price of COBRA coverage may be more attractive than a conversion policy. However, a conversion policy is guaranteed renewable, whereas COBRA coverage cannot be extended past the applicable time period. In addition, COBRA applies only to firms with 20 or more workers. However, most states have enacted "mini-COBRA" laws (separate from their conversion rules) that apply comparable rules to firms of 2 to 19 workers.[27]

Exclusion riders and preexisting condition exclusions — In 13 states, insurers are prohibited from issuing any coverage with exclusion riders; in 16 other states, riders are prohibited only for specific carriers or for HIPAA eligibles. Most states limit preexisting condition exclusions by setting maximum lookback periods, exclusion durations, or both. Permitted lookback periods are commonly 12 or 24 months; there is considerable variation in allowable duration of the exclusion, from as few as 3 months after enrollment to as many as 84 months. Most states require that the duration of the exclusion be reduced for people with prior coverage. For example, in a state that allows a 12-month exclusion, someone who had been covered elsewhere for 9 months before joining the plan would be subject to the exclusion for only 3 months.

Premium rate regulations — As of 2004, 21 states had restrictions on the extent to which nongroup insurers could vary premiums according to the health status or medical history of enrollees. Only three states require "pure" community rating under which, for a given package of health benefits, the insurer must offer the same premium to each enrollee, regardless of health, age, sex, geography, or other factors. Another six states permit adjusted or modified community rating, whereby an insurer may not use health as a rating factor but may consider age, sex, or geography (often within some limits). The remaining states use rating bands, whereby the insurer may vary rates according to health status, but only within specified limits. For example, the state may specify that the rate charged to an individual for health-related reasons cannot be more than 25 percent higher or lower than the standard rate offered to otherwise comparable enrollees. Some states allow unlimited variation for other factors and limit only the health-related variation. Others have overall limits on variation by health, age, and sex.

Self-employed people as small groups — Nearly all states regulate insurance practices in the small group market. Although small groups are usually defined as those with 2 to 50 employees, 12 states include groups of 1: self-employed individuals with no other employees. Small group insurers, in this case, must offer coverage to these individuals, and the requirements for insurers, especially in the area of premium rating, are often more stringent than those applicable to nongroup insurers.

IMPROVING ACCESS TO COVERAGE

Policymakers and analysts have proposed a number of possible solutions to the problems encountered by individuals seeking insurance outside the group market. Among these are tightly regulating insurers, creating and subsidizing high-risk pools, using reinsurance to cover losses incurred by high-cost individuals, creating of large pools of both high-risk and low-risk applicants, and encouraging more low-risk people to enter the market. Discussed here are the merits and drawbacks of these options.

Stronger Regulation of Insurers

More states could require guaranteed issue of insurance, restrict the use of exclusion riders and preexisting condition exclusions, or limit health-related variation in premium rates. Similarly, the federal government could adopt rules for a broader population than that covered by HIPAA.

Guaranteed issue or limits on exclusions would make coverage available to high-risk people, but—in the absence of rating reforms—only at a very high cost. As illustrated in Table 1, an insurer that charges separate rates to applicants with and without a history of cancer, diabetes, or heart disease at the time of application would charge the higher-risk applicants $11,194, compared to $2,266 for the lower-risk applicants. Coverage would nominally be available to the higher-risk group, but it would be financially out of reach for most potential purchasers.

Rating restrictions would alleviate this problem but would raise rates for lower-risk buyers. Table 4 shows how rates would change under a 50 percent rating band, that is, a requirement that premiums could not be more than 50 percent higher or lower than the standard rate for health reasons.

TABLE 4
Effect of 50 Percent Rating Band on Rates for Nonelderly People with and without Cancer, Diabetes, and/or Heart Disease, 2001

	Health Condition	
	Cancer, diabetes, and/or heart disease	None
Premium without rating restriction	$11,194	$2,266
Premium with 50 percent rating band	$7,827	$2,609
Percent change	– 30%	15%

Source: Author's analysis of MEPS. Population estimates are for noninstitutionalized people aged 18 to 64 who had employer coverage throughout 2001, who had Medicare at no time during that year, and who participated in MEPS in both 2000 and 2001. Spending figures include private insurance spending only and have been adjusted for age and sex.

Note that this requirement does not mean that the highest premium can be no more than 1.5 times the lowest premium. If the standard rate were $100 per month, the maximum would be $150 and the minimum would be $50, allowing a three-to-one ratio.

The 9 percent of enrollees with the three conditions in the example would see their premiums reduced from $11,194 to $7,827. (These premiums do not include an allowance for administrative costs or profit.) But this reduction would be financed by charging higher premiums to the 91 percent of enrollees without these conditions. They would see a 15 percent increase, from $2,266 to $2,609.

Assuming that lower-risk people have a lower propensity to buy insurance, some might decide that coverage was too costly and would drop out of the pool. This could mean that there would be fewer low-risk participants to cross-subsidize the high-risk enrollees. Rates would then be further increased to make up the difference, driving even more low-risk people out of the pool. This kind of cycle of rate increases and deterioration of the average risk level in an insurance pool is known as a "selection spiral," or, in the extreme case, a "death spiral." Ultimately the insurer could wind up with only a few very high-risk participants paying very high premiums.

Did these hypothetical outcomes actually occur in the states that have adopted comprehensive reforms in the nongroup market? Although numerous studies of the effects of state reform measures have been conducted, none has entirely succeeded in isolating the effects of reform laws from other factors that may have affected insurance coverage in a given state, such as the state's economic performance. One synthesis of the available research by Fuchs finds that, in states with strict regulation, high-risk people are more likely to obtain coverage. However, enough low-risk people leave the nongroup market that the overall number of people with health insurance actually declines. The effects were less pronounced in states that phased-in reforms gradually—avoiding a sudden rate shock—and in states that used rating bands instead of pure community rating.[28] Whether the reforms are perceived as successful overall may depend on whether one's policy priorities are to maximize access for high-risk people or to maximize the proportion of the population with coverage.

Proponents of regulation contend that selection effects could be reduced if low-risk people were encouraged to remain in the pool, for example, through tax credits or other subsidies that would reduce their net premiums. Some proposals would even mandate that every individual obtain some form of coverage, thereby ensuring there would be enough low-risk purchasers in the nongroup market to cross-subsidize higher-risk buyers. These options will be considered further below.

High-Risk Pools

High-risk pools are state-operated or state-chartered programs that offer subsidized coverage to individuals who cannot obtain affordable coverage in the nongroup market. In many states, the high-risk pool also serves as the mechanism for assuring availability of coverage to HIPAA-eligible individuals (those with prior group coverage).

In 2003, 31 states operated high-risk pools, with enrollment estimated at 172,845.[29] An insurer may refer the applicant to a state-operated pool, or individuals may apply to the pool on their own. Applicants must demonstrate that they have been denied coverage for health-related reasons by one or more insurers; some states allow enrollment by people who have been offered coverage only at very high rates. Premiums paid by risk pool enrollees are typically capped between 125 and 200 percent of the "standard" premium—that is, the premium that nongroup carriers might charge an applicant of the same age and sex without medical problems.

Because the pools are designed to attract the highest-risk applicants, even these higher premiums are insufficient to meet claims costs. One source estimates that premiums cover about 55 percent of costs in an average pool.[30] Every pool relies on some form of additional funding to subsidize pool losses. Most commonly, health insurers in the state pay an assessment based on their share of total health insurance premiums earned in the state.[31] Currently, the level of assessment is usually around 1 percent of total premiums charged by the carriers.[32] Some states also use general revenues, tobacco settlement money, or other special funds.

If a high-risk pool were supported solely through assessments paid by nongroup insurers, the effect would be identical to that of the rating reforms illustrated in Table 4. In order to provide the necessary subsidies, insurers would have to raise rates for the lower-risk purchasers of nongroup coverage, which could also lead to a selection spiral. To avoid this, most states that use assessments to fund their pools require participation by insurers selling group health coverage as well as nongroup insurers. Spreading the costs across the broader population of purchasers of group and nongroup policies reduces the per capita premium increases insurers must impose to pay their assessments. However, because ERISA preempts state regulation of employee benefit plans, states cannot require contributions from self-insured employer health plans. In 2004, 54 percent of enrollees in employer plans were in fully or partially self-insured plans, meaning that a substantial share of the privately insured population is exempt from participating directly in any subsidy arrangement for high-risk individuals.[33]

Even after subsidies, risk-pool premiums can be quite high. In 2003, the median pool rate for a 35-year-old female nonsmoker was $4,287 per year; in one state the rate was $8,352. For a 53-year-old male nonsmoker, the median rate was $6,978 per year; the highest was $13,990.[34] Only a few

Even after subsidies, risk-pool premiums can be quite high.

states provide any assistance for low-income participants.[35] One study found that premiums in risk-pool states would exceed 10 percent of income for 46 percent of uninsured people and 37 percent of the "uninsurable."[36] Because subsidy funds are limited, some states also have waiting lists for pool applicants or impose preexisting condition exclusions. As a result of costs, restrictions on benefits, and waiting periods, state high-risk pools insure an average of 1.2 percent of those covered by individual insurance.[37]

One way of broadening the reach of high-risk pools is through some form of federal subsidy. The Trade Adjustment Assistance Reform Act of 2002 authorized $20 million in seed grants for states newly establishing risk pools and also provided $40 million per year for fiscal years 2003 and 2004 to be used for state grants to offset up to 50 percent of losses for new and existing high-risk pools. As of August 2004, 6 states had received seed grants and 16 received operating grants; grants totaled $34 million of the $100 million authorized.[38] Qualified programs were required to offer a choice of plans through the pool and limit premiums to 150 percent of standard rates. States also had to show that they had established some mechanism to continue funding the pool beyond FY 2004; beyond that time, federal money could not be guaranteed and pools would again be potentially limited by states' capacities to raise subsidy funds through insurer assessments or other revenues.

The Senate Committee on Health, Education, Labor and Pensions has reported S. 288, which would extend the seed grant program and increase funds for operating grants to $75 million per year through 2009. There have been a number of proposals for a permanent federal funding stream for high-risk pools. For example, AHIP has proposed a 50 percent subsidy for all qualifying state pools, along with supplemental funding for very high-cost pool enrollees. The secretary of the Department of Health and Human Services would be authorized to establish a pool in states that failed to do so on their own.

A risk pool subsidized through some broad-based federal or state funding mechanism could make coverage more accessible to high-risk people without unduly increasing the burden on low-risk purchasers. Critics of this approach note several drawbacks. First, risk pools require that insurers continue the practice of underwriting, because they must decide which applicants to accept and which to refer to the risk pool. Underwriting itself is costly, raising administrative expenses without providing any clear social benefit. Second, if risk pools continue to rely in part on funding through assessments paid by insurers, the system could actually reinforce rather than remedy competitive pressures for selective enrollment. An insurer's assessment is based on its total premium revenues, rather than on the number of applicants it refers to the high-risk pool. Therefore, an insurer with more stringent underwriting requirements can offer lower rates to the applicants it accepts, and would in turn make a lower per capita contribution to the pool than an insurer that has accepted higher-risk applicants.

One alternative to a high-risk pool is to allow uninsurable people to "buy in" to a public program, such as Medicare or Medicaid, by paying a premium. The Clinton administration proposed allowing people aged 62 to 64 (and some younger displaced workers) to buy Medicare coverage. Although this proposal did not specifically target the uninsurable, people just below age 65 may be especially likely to have difficulty obtaining affordable private coverage. Tennessee's TennCare program for Medicaid beneficiaries has allowed people to buy in to the program if they were determined by the state or a state-contracted underwriter to be unable to obtain private insurance for health reasons. Participants with income above the federal poverty level pay an income-based premium ranging from $20 to a maximum of $550 per month. TennCare as a whole has faced continual financial pressures; a broad package of enrollment cuts proposed by Governor Bredesen includes eliminating the buy-in option for uninsurable people above poverty.[39]

Reinsurance

A health insurer (or a self-insured employer health plan) can buy reinsurance or stop-loss coverage to limit its potential risks for very high costs. There are two kinds of stop-loss coverage, individual and aggregate; an insurer may purchase either or both.

Under individual stop-loss, the reinsurer assumes full or partial liability when costs for any single enrollee during a year exceed a specified dollar threshold. The original insurer is usually required to retain at least some liability for costs above the threshold so that it will have an incentive to continue managing the patient's care. For example, the reinsurer might pay 90 percent of individual expenses in excess of $25,000; if the individual had accumulated $100,000 in bills, the primary insurer would pay $32,500 ($25,000 plus 10 percent of the remaining $75,000) and the reinsurer would pay $68,500. Under aggregate stop-loss, the reinsurer steps in when total costs for a whole group of enrollees exceed some limit—for example, 120 percent of premium revenues.

Reinsurance may be purchased by small to mid-sized self-insured employer plans, for which a handful of high-cost cases could drive total plan costs above the level the employer finds acceptable. Or, it may be bought by insurers in the small group or individual market who have a relatively small number of cases across which to spread risk. In either case, the reinsurer is in effect pooling the risks of a number of smaller primary insuring entities. Although private reinsurance is thought to be common in health care, there is little data on how many insurers or employers participate in these arrangements or how much risk they are transferring.[40] One report suggests that the general reinsurance market tightened after September 11 and that as many as half of the firms that had been offering medical reinsurance left the market by 2004; those that remained were raising premiums and imposing higher loss thresholds.[41]

Private reinsurance protects each participating insurer from a high-cost event or a randomly excessive incidence of such events. Because revenues from the pool of participants must be enough to cover the reinsurer's losses, reinsurance does not reduce the overall cost of insurance. (On the contrary, it raises costs, because the reinsuring entity has administrative costs and desires a profit.) Reinsurance merely ensures that no one participant will suffer unduly high losses due to bad luck.

Some states have experimented with subsidized reinsurance programs for individuals or small groups, under which payments from the participating insurers are supplemented with funds from other sources that help cover part of the reinsurer's losses. In Connecticut and Idaho, for example, the funding mechanism is comparable to that used in many high-risk pools; losses are covered by assessments on health insurers in the state, including insurers not participating in the arrangement. The Healthy New York program uses tobacco settlement funds to provide reinsurance for carriers selling nongroup coverage to modest-income individuals; the program assumes 90 percent of costs between $5,000 and $75,000 for any individual enrollee. In Arizona, the state-subsidized Health Care Group provides aggregate stop-loss coverage to carriers enrolling small groups and self-employed individuals; it also helps these carriers buy individual stop-loss in the commercial market.[42]

The health insurance proposal offered by Senator Kerry in his presidential campaign would have created a federal reinsurance program for any employer group, large or small, that offered coverage to all employees and met other specific conditions. The program, subsidized through federal general funds, would have covered 75 percent of costs in excess of $30,000 in 2006, rising to $50,000 in 2013. The plan was designed to reduce employer costs by about 10 percent.[43]

Some analysts have suggested that a public health reinsurance program could be modeled on the mortgage insurance offered by the Federal Housing Administration.[44] Mortgage insurance protects lenders against losses in the event that a borrower defaults and the proceeds from a foreclosure are insufficient to cover the loan balance. This protection for lenders seems similar to the protection reinsurance provides to health insurers; it is important to note, though, that mortgage lenders also engage in underwriting, attempting to screen out bad credit risks the same way that insurers screen out bad health risks. Mortgage insurance, like conventional reinsurance, protects against unpredictable risks in a market from which predictable risks have already been screened out.

Although a publicly subsidized reinsurance plan can reduce overall premiums—as any public subsidy could—it would not necessarily remove the incentives for insurers to avoid enrolling chronically ill people who can be expected to incur above-average costs. Table 5 (see next page) shows how rates for people with and without the three high-cost conditions used in the Table 1 example might be affected by a reinsurance

Although a publicly subsidized reinsurance plan can reduce overall premiums, it would not necessarily remove the incentives for insurers to avoid enrolling chronically ill people.

TABLE 5
Effect of Reinsurance on Average Annual Private Insurer Payments, 2001, for Nonelderly People with and without Cancer, Diabetes, and/or Heart Disease at Start of Year

	Health Condition		
	Cancer, diabetes, and/or heart disease	None	Total
Per capita payments without reinsurance	$11,194	$2,266	$3,092
Per capita payments after 75% reinsurance	$ 8,006	$2,184	$2,723
Percent change	– 28%	– 4%	– 12%
Per capita payments after 100% reinsurance	$ 6,943	$2,157	$2,599
Percent change	– 38%	– 5%	– 16%

Source: Author's analysis of MEPS. Population estimates are for noninstitutionalized people aged 18 to 64 who had employer coverage throughout 2001, who had Medicare at no time during that year, and who participated in MEPS in both 2000 and 2001. Spending figures include private insurance spending only and have been adjusted for age and sex.

scheme comparable to the Kerry proposal. Reinsurance would pay 75 percent of costs for any individual in excess of $25,000. (This threshold is used, instead of $30,000, because the example uses 2001 dollars.)

Reinsurance would reduce the primary insurer's average enrollee costs by about 12 percent, roughly the same proportion estimated for the Kerry proposal. The reduction would be larger for people with the chronic conditions because they are more likely than others to have costs above the reinsurance threshold. Even so, the net amount to be paid by the private insurer would be nearly four times as high for the chronically ill enrollees as for the others. An insurer who screened out or charged separate rates to the chronically ill applicants could charge $2,184 for those without chronic conditions instead of $2,723 if all applicants were charged the same rate, a difference of nearly 20 percent.

This is partly because many of the chronically ill have expenses above the reinsurance threshold, and the primary insurer must pay 25 percent of these costs. However, as the last rows show, even a reinsurance plan that paid 100 percent of costs above the threshold would leave a considerable incentive for insurers to continue underwriting. Reinsurance reduces, but cannot eliminate, the incentive for underwriting because it addresses unpredictable risk, whereas underwriting corrects for predictable risk.

Broader Pooling

There have been many proposals to bring nongroup purchasers together in some type of broad pool. Some proposals would either allow individuals to buy coverage through the Federal Employees Health Benefits Program (FEHBP), which insures over 4 million federal employees and annuitants, or establish a similar purchasing program specifically for uninsured individuals. President Bush's FY 2006 budget proposal includes grants to states to set up pools of this kind.[45] Others would allow individuals to form their own purchasing associations, which would negotiate with insurers on behalf of participants.

In theory, either arrangement could offer less costly coverage, because of economies of scale and because a larger pool of buyers would have greater purchasing power with insurers than individuals. However, it is not clear that either option could in itself improve access for high-risk individuals, unless it were part of a broader program including subsidies and/or regulation of the existing nongroup market.

FEHBP or similar pools — FEHBP offers participants a choice among contracting health plans, including several national fee-for-service plans and, where available, one or more local or regional HMOs. Government contributions are set through a formula based on a percentage of average plan premiums; enrollees pay the difference between this amount and the full premium for the plan they have selected. Plans must accept all FEHBP-eligible applicants and must charge uniform individual and family rates.

Because the newly covered non-federal individuals or groups would differ from current enrollees, their participation could affect premium rates for federal employees and annuitants. To avoid this, most proposals to open FEHBP assume that the new enrollees would be separately pooled—that is, different premium rates would be established for the non-federal group. In effect, then, the proposals could construct a parallel health program, using the same contracting health insurers and administration.

An FEHBP-like program would operate in competition with the existing, largely unregulated nongroup insurance market. Participating plans would have to guarantee issue and use uniform rates for all non-federal participants, whereas nongroup carriers outside the system could continue to exclude high-risk applicants and use health-based premium rates. Although the FEHBP-like program might be able to reduce administrative costs and bargain for lower rates for plans, these factors would almost certainly not be enough to offset the savings nongroup insurers achieve through underwriting. Healthier people would be able to find better rates outside the program. The program would likely attract higher-risk enrollees and suffer a selection spiral.

These effects could be reduced if participants in the FEHBP-like program were offered subsidies not available to people buying coverage outside

the program. For example, one recent proposal by Davis and Schoen would provide income-based health insurance tax credits only for participants in what the authors call the Congressional Health Plan; in addition, rates under the plan would be reduced through some form of federally subsidized reinsurance.[46] These two subsidies could reduce premiums to the point at which low-income people would find the program attractive. This could prevent selection problems, but the political barriers are formidable; existing insurers are unlikely to watch silently while large subsidies are directed solely to a new publicly organized competitor.

Insurers are unlikely to watch silently while large subsidies are directed solely to a new publicly organized competitor.

Association plans — Proposals to authorize a different kind of pooling approach, association health plans (AHPs), have been passed by the House of Representatives in the last four Congresses and are likely to be considered again in 2005. The most recently passed bill (H.R. 4279 in the 108th Congress) would have allowed an AHP formed by a trade or professional organization to contract with health insurers to provide benefits to the AHP's member companies. (Larger AHPs would have been allowed to self insure.)

Many association plans already exist in both the small group and nongroup markets and are offered by trade organizations and other entities.[47] However, the insurance companies from which the associations buy coverage are subject to state regulation. In addition, the insurers or the associations themselves may engage in underwriting to hold premiums down. Under the AHP proposal, insurers selling coverage to AHPs would be exempt from state small group reform laws. That is, insurers could decide whether or not to sell coverage to any particular AHP; could sell the AHP different coverage from that made available to other AHPs or non-AHP small employers in the same state; and could offer AHP-specific rates regardless of any community rating or rating-band rules in that state. (The AHP itself could not discriminate against member companies, or individual employees of those companies, on the basis of health status.) The AHP would also be exempt from most state-mandated benefit laws, which require that insurers cover specific providers or services.

Although the AHP proposal passed by the House was directed at small employers (and possibly self-employed individuals), there are similar proposals that would create association plans in the nongroup market. Again, the plans would have to be open to anyone eligible to join the association, but insurers could choose whether to work with the AHP and could offer different rates to AHPs from those offered to other nongroup buyers. President Bush's FY 2006 budget proposal would make AHPs available to civic, faith-based, and community organizations; although details are not yet available, this presumably is meant to support AHPs targeted at individuals rather than employer groups.[48]

Proponents of AHPs contend that they would allow many small employers or individuals to band together and negotiate better prices for health coverage. Exemption from state mandates and from consumer protections, such as state-established appeal rules, might also reduce costs,

meaning that coverage would be more affordable for members. Opponents of small group AHPs contend that AHPs would split up the pool of small group insurance buyers and would weaken the small group rating reforms enacted by most states. If some types of businesses have healthier workers than others, insurers could offer an AHP formed by those businesses better rates, whereas other small businesses in the state would be left paying higher prices.[49] Similar effects could be expected for nongroup AHPs in the minority of states that have enacted nongroup rating regulation. Finally, some analysts question whether bringing multiple employers together will produce the anticipated administrative savings. The American Academy of Actuaries has pointed out that an AHP would have to perform all the administrative functions that a small group insurer does for each participating employer, probably at the same cost.[50] What the AHP saved in premiums might have to be made up through an administrative fee charged by the AHP to its members.

Promoting Participation by Low-Risk People

Some people contend that the incentives for insurers to engage in underwriting would be reduced if larger numbers of low-risk people could be encouraged to buy insurance. In this view, a tax credit or other subsidy would make coverage more affordable and attractive for healthy people. So many more low-risk applicants might enter the market that they could more easily cross-subsidize the high-risk people who buy insurance now. Whether this is true may depend in part on the generosity of the subsidy relative to available premiums. If the subsidy is small and relatively few new buyers enter the market, the ability of insurers to spread risks might not be greatly affected. Moreover, the overall risk level of the insurance pool would change only if many more low-risk people than high-risk people entered the market as a result of the credit; whether this would happen is uncertain.[51]

Broader participation in the market might also be encouraged by offering lower-cost plans with reduced benefits. This is one of the rationales for recent efforts to promote the sale of plans that combine a health savings account (HSA) with a high-deductible insurance plan. However, even if these plans did bring healthier people into the insurance market, improved pooling might not result, for two reasons. First, some analysts contend that healthier people would select HSAs and high-deductible plans, whereas sicker people would continue to prefer more comprehensive coverage; the effect could be that the two groups would separate into different pools. Second, a high-deductible plan actually magnifies spending differences between low-risk and high-risk people. Because low-risk people would rarely reach the deductible, nearly all claims would be for a few high-cost participants. An insurer selling high-deductible coverage would thus have an even stronger incentive than other insurers to screen out high-risk applicants.

Another option that would assure greater participation by low-risk people would be an "individual mandate": a requirement that every person obtain coverage. This was a key element of former President Clinton's health care plan, as well as of some competing congressional proposals offered during the health care debate of 1993–1994. More recently, some form of mandate, accompanied by subsidies, has been endorsed by a variety of groups, including the Progressive Policy Institute and the New America Foundation; the latter proposal has reportedly attracted the attention of California's Schwarzenegger administration.[52] A less stringent alternative to a mandate, proposed by Etheredge, among others, would provide for automatic enrollment with an opt-out; uninsured people would automatically be assigned to subsidized insurance but could decline the coverage.[53]

If everyone had to obtain coverage, insurers would no longer need to be concerned about adverse selection.

If everyone had to obtain coverage, insurers would no longer need to be concerned about adverse selection: people who did and did not need costly services would be equally likely to enroll. Unfortunately, this still would not eliminate the incentive for insurers to engage in underwriting. No matter how big the market is, the disparities in predictable costs for people with and without known medical problems are so large that insurers would still be able to profit from screening for high-risk applicants. So long as any insurer in the market was underwriting, others would face competitive pressure to follow suit.

Bringing low-risk people into the market, either through subsidies alone or through subsidies plus a mandate could help make coverage more accessible and affordable to high-risk applicants, but perhaps only in a heavily regulated market. Risk spreading will occur only if insurers are required to guarantee issue (so that low-risk and high-risk people are in the same pool) and use community rating. Without subsidies, these reforms have apparently driven lower-risk buyers out of the market, leading to actual reductions in the number of people with coverage. Adding subsidies may make these reforms more workable. Guaranteed issue and community rating make healthier people pay more than their own expected costs; this arguably represents a sort of hidden tax, which an insurance subsidy could help offset.[54]

CONCLUSION

Insurance traditionally protects against the risk of unforeseeable losses. Insurers do not sell fire insurance to people whose houses are already on fire, or life insurance to people who are already terminally ill; nor, in an unregulated market, do they sell health insurance at standard rates to people who are already sick. Why are gaps in access to other kinds of coverage not a matter of concern to policymakers, but limited access to health insurance is a major issue?

The answer, of course, is that this society relies on health coverage, not just to perform the classic function of insurance, but to ensure access to medical

care and to help people with very high predictable—traditionally "uninsurable"—costs. There are other ways of advancing these goals that do not involve insurance, such as increasing funding for community health centers and other sources of free care, or finding more equitable ways of distributing the burden of uncompensated care among providers and/or payers. If policymakers prefer to promote access to nongroup coverage for high-risk people, it may be helpful to think of the issue not as an insurance problem, but rather as one of finding fair and sustainable ways of subsidizing people who cannot afford to pay their own expected costs.

Regulatory approaches, such as requiring guaranteed issue or limiting health-based rate variation, place the entire burden of subsidizing high-risk enrollees on lower-risk purchasers in the nongroup market. The result can be that healthier people leave the market, resulting in no net gain in coverage. This problem might be alleviated if tax credits or other assistance to individual buyers reduce the effective premium to the point where insurance remains attractive to low-risk people.

High-risk pools, because they are usually subsidized by group as well as nongroup insurance buyers, spread the costs more broadly. But self-insured employers are exempt from contributing, and revenues from insurer assessments have often been insufficient to reduce premiums to levels that many high-risk applicants can afford. Broader-based subsidies could help, but only if they are sustained over time. In addition, this approach requires continued underwriting by insurers, which is both intrusive and costly.

Reinsurance, if it is funded solely by primary insurer contributions, simply shuffles costs among participating insurers and thus has the same drawback as rating reform: it requires that high-cost participants be subsidized solely by low-cost participants. Again, this problem could be addressed by drawing on external subsidies. However, reinsurance helps only with outlier costs (predictable or unpredictable). There would remain incentives to screen out populations whose costs are routinely well above average.

Broader population pooling, through an FEHBP-like program or some form of voluntary association plans, might produce economies of scale that could lower prices for all participants. An FEHBP-like arrangement, however, cannot offer affordable protection to high-risk people if it is in competition with an unregulated nongroup market that continues to select the best risks. Voluntary pooling might be workable if there were subsidies—such as an individual tax credit that could be used only for pool premiums—to make the pool attractive to low-risk buyers. AHPs may present the converse problem, siphoning off low-risk individuals or groups and leaving only the higher risks in the ordinary market.

Finally, **promoting participation by low-risk people**—through premium subsidies, lower-cost plans, or some form of individual mandate—might make any of the other approaches more workable. But bringing low-risk people into the market will not in itself improve access for high-risk people, because there would remain incentives for insurers to fragment the pool.

ENDNOTES

1. Carmen DeNavas-Walt, Bernadette D. Proctor, and Robert J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2003* (Washington: U.S. Census Bureau, 2004), Current Population Reports, Consumer Income, P60-226.

2. *Budget of the United States, Fiscal Year 2006* (Washington: Office of Management and Budget, 2005). A refundable tax credit is one that can exceed the taxpayer's tax liability, with the excess refundable to the taxpayer. An above-the-line deduction is available to taxpayers who do not itemize deductions. For an overview of tax system proposals, see Beth Fuchs, Mark Merlis, and Julie James, "Expanding Health Coverage for the Uninsured: Fundamentals of the Tax Credit Option," National Health Policy Forum, Background Paper, August 28, 2002; available at www.nhpf.org/pdfs_bp/BP_TaxCredits_8-02.pdf.

3. Data for people with employer coverage are used in this and later illustrations because the set of people with private nongroup coverage consists of people who have passed underwriting screens, and thus already excludes many of those with the highest potential costs.

4. The adjustment uses a regression, with the logarithm of spending as the dependent variable and age and a dummy for sex as independent variables; a smearing factor was used to correct predicted values for retransformation bias.

5. The Kaiser Family Foundation and Health Research and Educational Trust (Kaiser-HRET), *Employer Health Benefits: 2004 Annual Survey* (Menlo Park, CA: Kaiser Family Foundation, 2004).

6. Deborah W. Garnick, Katherine Swartz, and Kathleen Carley Skwara, "Insurance Agents: Ignored Players in Health Insurance Reform," *Health Affairs,* 17, no. 2 (March/April 1998): 137–143.

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8. Hank George, "The Advantages of Oral Fluid Testing," presentation before LOMA Health Underwriting Study Group, Orlando, FL, March 2004; accessed November 11, 2004, at ftp://www.loma.org/HUSG_OralFluidInHealthUnderwriting.pdf.

9. Some insurers used to engage in "post-claims underwriting," meaning they would obtain little health information at the time of application, asking only vague or broad questions, and then cancel policies when enrollees began to file claims. Most states have restricted this practice, requiring that insurers routinely ask detailed medical questions and warn applicants of the consequences of withholding information.

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15. U.S. General Accounting Office (GAO), *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs,* GAO/HEHS-97-8, November 1996.

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24. Author's analysis.

25. For a review of the literature on job lock, see Kevin T. Stroupe, Eleanor D. Kinney, and Thomas J. Kniesner, *Chronic Illness and Health Insurance Related Job Lock* (Syracuse: Center for Policy Research, Maxwell School of Citizenship and Public Affairs, Syracuse University, 2000).

26. Coverage through a group plan includes COBRA continuation coverage.

27 For details of state mini-COBRA laws, see www.cobrahealth.com/statelawdirectory.htm (accessed March 8, 2005).

28. Beth C. Fuchs, "Expanding the Individual Health Insurance Market: Lessons From the State Reforms of the 1990s," Robert Wood Johnson Foundation, Policy Brief no. 4, June 2004, 3.

29. One of these pools is closed to new applicants; another is available only to HIPAA eligibles. Communicating for Agriculture and the Self-Employed, *Overview—State High Risk Health Insurance Pools Today*; accessed December 1, 2004, at www.selfemployedcountry.org/riskpools/overview.html.

30. Communicating for Agriculture, *Overview*.

31. Some states allow insurers to reduce premium taxes by the amount of the assessment, with the net effect that the state is indirectly subsidizing the pool.

32. Roderick E. Turner and Cori E. Uccello, American Academy of Actuaries, testimony before the Committee on Ways and Means, U.S. House of Representatives, Hearing on Health Care Tax Credits to Decrease the Number of Uninsured, February 13, 2002.

33. Kaiser/HRET, *Employer Health Benefits*. Of course, self-insuring employers must cover the costs of high-risk individuals within their own pool. Most employers purchase some form of private reinsurance or stop-loss coverage, which has the effect of spreading losses across a pool of multiple self-insured plans. A few states have indirectly drawn funds for

their high-risk pools from the self-insured population by assessing the reinsurance companies that sell coverage to many self-insured employers.

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35. Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: Commonwealth Fund, 2001).

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40. The Lewin Group, "Establishing an Analytical Framework for Measuring the Role of Reinsurance in the Health Insurance Market," prepared for the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, March 20, 1997.

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43. Kenneth E. Thorpe, "Federal Costs and Savings Associated with Senator Kerry's Health Care Plan," August 2, 2004; accessed November 29, 2004, at www.sph.emory.edu/hpm/thorpe/kerry8-23-04.pdf.

44. See, for example, Katherine Swartz, "Government as Reinsurer for Very-High-Cost Persons in Nongroup Health Insurance Markets," *Health Affairs Web Exclusives* (October 23, 2002): W380-W382.

45. *Budget of the United States, Fiscal Year 2006*.

46. Karen Davis and Cathy Schoen, "Creating Consensus on Coverage Choices," *Health Affairs Web Exclusives* (April 23, 2003): W3-199–W3-211.

47. In either case, insurers commonly require that the association exist for some purpose, such as providing educational programs or other services for members, and that members have something in common with one another. In insurance parlance, this makes the association a "true group," as opposed to a pseudo-group whose only shared interest is in buying insurance.

48. Office of Management and Budget, "Health Care," summary; accessed February 7, 2005, at www.whitehouse.gov/omb/pdf/Health-06.pdf.

49. See, for example, Mary Beth Senkewicz, National Association of Insurance Commissioners, testimony before the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations, U.S. Senate, Hearing on Association Plans, April 2, 2004. Critics of AHPs cite other concerns not immediately related to risk selection, including potential solvency problems and erosion of consumer protections.

50. Karen Bender, American Academy of Actuaries, letter to Rep. John A. Boehner, Chairman, House Committee on Education and the Workforce, April 29, 2003.

51. In an unregulated market, with premium rates based on health status, a fixed-dollar insurance subsidy would help low-risk people proportionately more than high-risk people. This might mean that lower-risk people would be more likely to use the credit. However, high-risk people are much more prone to want insurance; some analysts think currently uninsured low-risk and high-risk people might be equally likely to enter the market in response to a credit. Council of Economic Advisers, *Health Insurance Credits,* February 14, 2002.

52. As reported by Lou Dobbs, "California weighs health insurance experiments," Cable News Network, January 21, 2005; see www.cnn.com/2005/US/01/20/california.health (accessed January 24, 2005).

53. Lynn Etheredge, "A Flexible Benefits Tax Credit For Health Insurance And More," *Health Affairs Web Exclusives* (March 22, 2001): W1–W10.

54. If an insurance credit effectively gives money to low-risk people so that they can cross-subsidize high-risk people, one might ask whether there are not simpler and more direct ways of targeting assistance to high-risk people, for example, through direct subsidies for high-risk pools.