



Underwriting in the Non-Group Health Insurance Market:

The Fundamentals

BACKGROUND
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KATHRYN LINEHAN, *Principal Policy Analyst*

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OVERVIEW — Non-group health insurance is coverage that individuals purchase on their own rather than as part of a group. Most states currently permit non-group insurers to underwrite, a process whereby an insurer assesses the health and other characteristics of individuals to determine their likely utilization of health services or risk; insurers then use this assessment to determine whether they will offer coverage and the premium they will charge. Policymakers have identified underwriting and related practices in non-group markets as a target for reform to enable broader access for the currently uninsured. This publication reviews the characteristics of non-group markets and insurers' strategies for managing risk presented by people seeking non-group coverage. It also outlines relevant non-group market rules now in force in the states and considers how national rules might affect current markets.

National Health Policy Forum

2131 K Street, NW
Suite 500
Washington, DC 20037

T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
Publications Director

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Underwriting practices for non-group health insurance involve the insurer assessing an individual applicant's likely utilization of health services, or risk, to determine whether to offer coverage, whether to place limits on any offered coverage, and what premium to charge. These practices are seen as one of the reasons that people with certain health conditions or past claims cannot afford coverage, or simply cannot gain access at any price, on the non-group market. Policymakers have identified reform of non-group health insurance markets as one way to create broader access to coverage for the currently uninsured. For example, in its May 2009 paper on health reform, the Senate Committee on Finance outlined policy options for expanding coverage. Among the options was reforming non-group insurance markets by limiting insurer practices that lead to differential premiums based on health status.¹

Regulation of non-group health insurance markets remains largely the province of the states.² States' laws and regulations related to underwriting and other practices in the non-group market reflect attempts to balance access to and affordability of non-group health insurance products. For non-group insurance, most states permit underwriting, which generally raises the cost for those in poor health, but lowers the cost for those in good health based on insurers' actuarial estimates. This background paper will review the features of non-group insurance markets, insurer strategies for assessing and minimizing risk, states' regulation of insurers, and the potential effects that changing rules for insurer practices could have on current non-group insurance policy holders.

WHAT IS THE NON-GROUP MARKET?

Non-group health insurance is so-called because an individual purchases a policy on his or her own—through insurance agents or brokers, online clearinghouses, or directly from insurance companies—rather than as a member of a group. About 14.3 million people, or 5.5 percent of the non-elderly United States' population, directly purchased health insurance in 2007.³ This share is small compared with the 61 percent of non-elderly Americans with employer-based group coverage. People who are self-employed or unemployed are more likely to be in the market for non-group coverage.

Within each state, the share of non-elderly people with non-group coverage varied from 2.3 percent in West Virginia to 11.5 percent in

North Dakota in 2007. Many factors, such as the presence of large industries that offer employer-based coverage, affect the share of each state's population that has employer-sponsored versus non-group coverage. The five states with the largest share of non-elderly state populations with non-group insurance are North Dakota, South Dakota, Montana, Nebraska, and Wyoming. However, owing to their small populations, these states account for only 2.5 percent of all people in the United States with non-group insurance. California is home to more non-group policy holders in the United States than any other single state.

Key Terms

adverse selection — The tendency of people who have a greater-than-average likelihood of using services to seek health care coverage to a greater extent than individuals who have an average or less-than-average likelihood of using services. Also known as anti-selection. Adverse selection occurs when less-healthy people disproportionately enroll in a risk pool.

guaranteed issue — A requirement that a health insurance policy must be issued to an individual without regard to his/her health status or previous claims experience.

non-group market — A segment of the private insurance market that includes policies sold to persons that are not members of a group plan. Also known as the individual market.

rating — The process of calculating the appropriate premium to charge purchasers, given the degree of risk represented by the individual or group, the expected costs to deliver medical services, and the expected marketability and competitiveness of the plan.

underwriting — The process of assessing the health and other characteristics of an individual or group to determine their likely utilization of health services or risk.

Methods for Insurers to Minimize Risk

One factor health insurers compete on is their ability to charge premiums that compensate them for the risk they incur, but that also remain attractive enough for low-risk individuals to buy policies.⁴ Adverse selection is the tendency of people who have a higher-than-average likelihood of using services to seek health insurance to a greater extent than individuals who have an average or less-than-average likelihood of using services. The non-group market is prone to adverse selection because seeking coverage on that market is voluntary and initiated by the individual who has better information about his or her health condition than an insurer has.⁵ To guard against the prospect of adverse selection, insurers use underwriting when an individual applies for a policy. The underwriting process allows an insurer to estimate the risk that an applicant presents and whether, and under what terms, that insurer will offer coverage.

Subject to state laws and regulations, insurers use the information collected during the application process to determine individual premiums. Where state laws permit, an applicant is typically asked a set of basic

health questions. Questions may be asked about specific conditions, such as heart conditions or cancer, that are related to costly services. Insurers can also obtain information on non-group health insurance

applicants through external data sources, including a large national database owned by member insurance companies.⁶ The database, which contains information on individuals who have purchased life, health, or disability insurance on the non-group market, is designed to provide companies with information that is relevant to the underwriting process.

Once a person has applied for coverage and has submitted health information, the insurer can make an offer of coverage or can decline to provide coverage at any price, unless guaranteed issue is required. Guarantee issue is a requirement that a health insurance policy must be issued to an individual without regard to his or her health status or previous claims experience. If the applicant is offered coverage, a premium is determined through the insurer's rating process. This process takes into account the risk presented by the individual, the expected costs of delivering medical services, and the insurer's profit strategy. An applicant will either be offered the standard base rate or some higher rate (also known as a "rate-up") because of existing health conditions. Subject to state laws and regulations on the duration of the exclusion or the look-back period (the period into which insurers are permitted to look back for evidence of a condition), an insurer may also exclude coverage for pre-existing conditions, sometimes called an exclusionary rider. According to one estimate, in markets where underwriting is permitted and guaranteed issue is not required, about 70 percent of applicants are offered standard rates, about 15 to 20 percent are offered policies at higher rates or with pre-existing condition exclusions, and about 10 to 15 percent of applicants are not offered coverage at all.⁷

Insurers can also engage in other practices to attract good risks and avoid bad ones. For example, they can try to select enrollees through marketing features that appeal to healthy individuals, such as discounts on health club memberships. They can also structure cost sharing to deter an individual with a condition likely to incur high costs. For example, the insurer could charge high copayments on costly biologics. Similarly, a plan's network of providers could be designed to be unattractive to costly patients by excluding certain facilities or specialists. Policymakers and regulators may attempt to place limits on plans' ability to compete on risk selection through restrictions on benefit variation and requirements for minimum network standards. However, these requirements may be challenging to monitor and enforce. In addition, they may present trade-offs, including limited

choice of plan types, reduction in benefit design innovation, dilution of insurers' leverage over providers, and interference with insurers' ability to steer patients to certain providers.

Non-Group Insurance Rating Rules

Some states have adopted rating rules that limit the magnitude of rate-ups that insurers can apply and the factors (for example, health status) by which insurers can vary premiums based on the information collected from applicants. Rating rules fall into three general categories:

- **Community rating**, sometimes called **pure community rating** requires a plan's premiums to be the same for all enrollees.
- **Adjusted community rating** requires a plan's premiums to be the same for all enrollees of a certain class. Premiums can vary only by certain allowed classes such as age, family composition, geographic location, and smoking status.
- **Rate bands** limit how much premiums can vary overall, or how much they can vary based on certain factors such as age or gender. (See text box, next page.)

As shown in the Appendix (see page 10), 33 states (including DC) have no limits on rating in the non-group market and 18 have limits such as some form of community rating or rate bands. Rate bands, which are used in 11 states, are the most common type of restriction. States may define the factors that are allowed, the widths of the bands (in other words, the amount of variation allowed by that factor), and whether they apply to individual factors or overall rates. For example, non-group market base rates in Minnesota can be 25 percent higher or lower depending on health status, 50 percent higher or lower depending on age, and 20 percent higher or lower depending on geography.⁸ Five states have adjusted community rating and two states—New York and New Jersey—have pure community rating. Among states with limits on rating that specify the factors by which insurers can vary premiums, age and geography are the most commonly allowable. Other allowable rating factors in some states include health or smoking status, gender, and family composition.

In total, six states require at least some insurers to guarantee issue all of their non-group policies, while eight states require that some insurers guarantee issue some products. All of the seven adjusted

Example of Allowed Variability of Premiums Under Rate Bands

In this example, a state permits insurers to vary health insurance premiums based on age, geography, gender, and health status. The allowable variation between the highest and lowest premiums based on these factors is defined by ratios written into law. This particular state allows 3:1 variation for age, 4:1 for geographic area, 1.2:1 for gender, and 2:1 for health status. Rate bands can be applied individually, or an overall limit can be applied.

Rate bands applied individually — If rate bands by category are allowed with no overall limit, the difference between the lowest and highest premium that can be charged is 1:28.8 (obtained by multiplying the upper limit of each of ratios for the four factors: $3 \times 4 \times 1.2 \times 2 = 28.8$). In dollar terms, if the lowest per-person monthly premium charged is \$100, then the highest premium can be \$2,880.

Overall limit applied — If, in addition to the factor rate bands above, there is an overall restriction on total premium variation of 6:1, then in dollar terms, if the lowest per-person monthly premium charged is \$100, then the highest premium can be \$600.

Adapted from: Mary Beth Senkewicz, "Senate Health Bill Would Preempt States' Small Group Rating Rules," Center for Budget and Policy Priorities. April 26, 2006; available at www.cbpp.org/cms/index.cfm?fa=view&id=224.

and pure community rating states also have some kind of guaranteed issue requirement for at least some populations and plans (see notes to the Appendix for specific details). Guaranteed issue accompanies community rating because community rating is undermined if applicants can be denied coverage based on health status. Some states also limit insurers' ability to exclude coverage for pre-existing conditions when the policy is issued. States may define the duration of the look-back period; they may also limit the duration of the period during which treatment of the pre-existing condition is not covered.

CONCLUSION

Variation in non-group market rules affects the number of people enrolled, the risk profile of those with coverage, the comprehensiveness of coverage, and premiums paid in each state. In states where insurers can underwrite with no limits on rating and no guaranteed issue requirements, younger, lower-risk, healthy individuals

may pay relatively lower premiums and may have a greater range of plan choices than individuals in poor health. In such low-regulation states, older, higher-risk, sicker individuals likely face higher premiums or greater likelihood of coverage denials. To the extent that states restrict rate variation and require guarantee issue, sicker individuals may have more access to coverage. Their premiums may be lower than in a state without rating rules, but their premiums also reflect the higher costs of an above-average risk pool and may deter coverage, especially among lower-risk individuals. Given the varying landscape of current state regulations and the extent to which premiums and levels of coverage reflect insurers' ability to underwrite and vary premiums based on that information, any federal changes to rating or issuance rules will have different state-by-state effects on premiums, current policy holders, and the uninsured.

ENDNOTES

1. Committee on Finance, U.S. Senate, "Description of Policy Options: Expanding Health Care Coverage: Proposals to Provide Affordable Coverage to All Americans" May 14, 2009, p. 2; available at <http://finance.senate.gov/sitepages/leg/LEG%202009/051109%20Health%20Care%20Description%20of%20Policy%20Options.pdf>.
2. Title I of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 contained provisions that pertain to access, portability, and renewability of insurance coverage on the non-group market. For additional information see Mark Merlis, "Fundamentals of Underwriting and Rating in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform," National Health Policy Forum, Background Paper, April 13, 2005, available at www.nhpf.org/library/details.cfm/2480; and Lisa Sprague, "HIPAA Coverage Provisions," National Health Policy Forum, The Basics, March 25, 2008, available at www.nhpf.org/library/details.cfm/2597. For additional discussion of federal laws that affect private health insurance, see Kaiser Family Foundation, "How Private Health Coverage Works: A Primer 2008 Update," April 2008; available at www.kff.org/insurance/upload/7766.pdf.
3. Share is calculated as the number of non-elderly with non-group coverage divided by the total number of non-elderly. National Health Policy Forum calculations based on data from Kaiser State Health Facts, "Health Insurance Coverage of Nonelderly 0-64, states (2006-2007), U.S. (2007)"; available at www.statehealthfacts.org/comparable.jsp?ind=126&cat=3&sub=39&yr=85&typ=1.
4. Katherine Swartz, "Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance," *Inquiry*, 38, no. 2 (Summer 2001): pp. 133-145.
5. Mark V. Pauly and Len M. Nichols, "The Nongroup Health Insurance Market: Short On Facts, Long On Opinions and Policy Disputes," *Health Affairs*, Web Exclusives (October 23, 2002): pp. w325-w344; available by subscription at <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w2.325>.

6. "About MIB Group, Inc.," available at www.mib.com/html/about_mib_group.html.
7. John Bertko, "Health Insurance Market Rating Practices," testimony before the Committee on Finance, U.S. Senate, September 23, 2008; available at <http://finance.senate.gov/hearings/testimony/2008test/092308jbtest.pdf>.
8. National Association of Health Underwriters, "Healthy Access Database: Traditional Private Health Insurance," available at <http://www.nahu.org/consumer/healthcare/topic.cfm?catID=22>; and Minnesota law, Code 62A—Accident and Health Insurance, Section 6—Individual Market Regulation, Subd. 3—Premium Rate Restrictions, available at <http://law.justia.com/minnesota/codes/59a/62a-s65.html>.

State	Rating Restrictions	Guaranteed Issue?
Alabama	—	—
Alaska	—	—
Arizona	—	—
Arkansas	—	—
California *	—	Some Products
Colorado	—	—
Connecticut	—	—
Delaware	—	—
District of Columbia	—	—
Florida †	—	Some Products
Georgia	—	—
Hawaii	—	—
Idaho ‡	Rate Bands	Some Products
Illinois	—	—
Indiana	—	—
Iowa	Rate Bands	—
Kansas	—	—
Kentucky	Rate Bands	—
Louisiana §	—	—
Maine	Adjusted Community Rating	All Products
Maryland	—	—
Massachusetts	Adjusted Community Rating	All Products
Michigan ¶	—	Some Products
Minnesota	Rate Bands	—
Mississippi	—	—
Missouri	—	—
Montana	—	—
Nebraska	—	—
Nevada	Rate Bands	—
New Hampshire	Rate Bands	—
New Jersey **	Pure Community Rating	All Products
New Mexico	Rate Bands	—
New York	Pure Community Rating	All Products
North Carolina	—	—
North Dakota	Rate Bands	—
Ohio ††	—	Some Products
Oklahoma ††	—	—
Oregon §§	Adjusted Community Rating	Some Products
Pennsylvania	—	—
Rhode Island ¶¶	—	Some Products
South Carolina	—	—
South Dakota	Rate Bands	—
Tennessee	—	—
Texas	—	—
Utah ***	Rate Bands	Some Products
Vermont	Adjusted Community Rating	All Products
Virginia	—	—
Washington †††	Adjusted Community Rating	All Products
West Virginia †††	—	Some Products
Wisconsin	—	—
Wyoming	—	—

APPENDIX: Non-Group Market Rating and Guaranteed Issue Rules by State, 2008

Sources: Kaiser State Health Facts “Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals), 2008” (www.statehealthfacts.org/comparetable.jsp?ind=354&cat=7) and “Individual Market Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals), 2008” (www.statehealthfacts.org/comparetable.jsp?ind=353&cat=7); and National Association of Health Underwriters, “Healthy Access Database: Traditional Private Health Insurance” (www.nahu.org/consumer/healthcare/topic.cfm?catID=22).

Notes: The information in this chart is not applicable to HIPAA-eligible individuals. A HIPAA-eligible person must have had at least 18 months of prior coverage, not interrupted by a gap of more than 63 consecutive days. The last day of prior coverage must have been in a group health plan. In addition, upon leaving group coverage the person must elect and exhaust available COBRA continuation coverage or similar state continuation coverage. A HIPAA-eligible individual cannot be eligible for any other group coverage or Medicare.

Data on rating and guarantee issue are as of December 2008. In a few states, all individual market insurers must guarantee issue all individual market plans that the insurer sells to all applicants. In others, states’ guaranteed issue requirements are much less restrictive. See notes specific to individual states’ rating and issuance policies.

* In California, premiums for the standardized policy, the policy that insurers and HMOs (health maintenance organizations) must guarantee issue to individuals exhausting high-risk pool coverage, are restricted at 110 percent of the standard rate; individual market insurers and HMOs must guarantee issue a standardized policy to those exhausting high-risk pool coverage.

† In Florida, eligible individuals who are uninsured for six months or who have lost employer-sponsored insurance, can buy a guaranteed issue limited benefit policy through the Cover Florida Health Care Program.

‡ In Idaho, premiums for standardized policies, or “high-risk pool” policies, are capped at 2.5 times the standard rate for underwritten non-group market policies. Non-group market insurers must guarantee issue standardized policies—basic, standard, and catastrophic high-risk pool policies—to the medically uninsurable.

§ The statutory rate bands are not enforced in Louisiana.

¶ In Michigan, only Blue Cross Blue Shield of Michigan must community rate its products. After 24 months in existence, HMOs are required to guarantee issue to a limited number of applicants during an annual 30 day open enrollment period.

** In New Jersey, premiums for basic and essential plans may have 3.5:1 variations for age, gender, and geography.

Notes continued, next page >>

Appendix notes, continued

^{††} In Ohio, premiums for guaranteed issue policies are capped at 2.5 times the standard rate for underwritten non-group market policies; non-group market insurers must guarantee issue standardized policies on a periodic basis. Non-HMOs are required to guarantee issue standardized policies (up to a limited number of enrollees as determined by the state) for one 30-day period, annually. HMOs are required to guarantee issue standardized policies annually until reaching a state-determined limited number. For HMOs, this period could extend beyond 30 days.

^{‡‡} In Oklahoma, HMOs are required to community rate their products.

^{§§} In Oregon, non-group market insurers must guarantee issue portability policies to individuals with six months of prior coverage.

^{¶¶} In Rhode Island, non-group market insurers must guarantee issue all products to those with 12 months of continuous creditable coverage, provided the applicant is not eligible for alternative group coverage, Medicare, or any other state health insurance plan.

^{***} In Utah, individual market insurers that have not met the enrollment cap must guarantee issue at least one individual market policy to those that are otherwise not eligible for any other type of health insurance coverage.

^{†††} In Washington, insurers in the non-group market must guarantee issue all products to applicants achieving a minimum score on a state-mandated health status questionnaire. Those applicants not eligible for guaranteed issue plans are referred to the high-risk pool.

^{‡‡‡} In West Virginia, HMOs with more than five years in the market or with enrollment not less than 50,000 individuals must guarantee issue during an annual 30-day open enrollment period.