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Report to the Chairman, Committee on Labor and Human Resources, U.S. Senate

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PRIVATE HEALTH INSURANCE

Millions Relying on Individual Market Face Cost and Coverage Trade-Offs

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Health, Education, and
Human Services Division

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November 25, 1996

The Honorable Nancy Landon Kassebaum
Chairman, Committee on Labor
and Human Resources
United States Senate

Dear Madam Chairman:

In response to your request, this report provides information on the private individual health insurance market. Specifically, the report discusses the size of the market and characteristics of its participants; the structure of the market, including a review of carriers, health plans, premiums, underwriting practices, and market accessibility; and the measures taken by states and the federal government to improve accessibility.

We are sending copies of the report to interested congressional committees and are making copies available to others on request.

This report was prepared under the direction of Michael Gutowski, Assistant Director, who may be reached at (202) 512-7128 if you or your staff have any questions. Other contributors to this report are listed in appendix IV.

Sincerely yours,

William J. Scanlon
Director, Health Financing
and Systems Issues

Executive Summary

Purpose

While most Americans obtain their health insurance coverage through employer-sponsored group plans or government programs like Medicare and Medicaid, a significant minority purchase health insurance individually for themselves and their families. These participants in the individual health insurance market primarily rely on their own resources to obtain information on insurance options and to finance their health coverage.

Integrating the individual market into legislative proposals for reforming health insurance has been a thorny issue at both the state and federal levels. In part, this has stemmed from the paucity of information on the nature of this market and the characteristics of its participants. Accordingly, the Chairman of the Senate Committee on Labor and Human Resources asked GAO to report on

- the size of the individual market, recent trends in it, and the demographic characteristics of its participants;
- the market structure, including how individuals access the market, the prices, other characteristics of health plans offered, and the number of individual carriers offering plans; and
- the insurance reforms and other measures states have taken to increase individuals' access to health insurance.

Background

Participants in the individual market include self-employed people; people whose employers do not offer health insurance coverage; people not in the labor force; early retirees who no longer have employment-based coverage and are not yet eligible for Medicare; and people who lose their jobs and have exhausted or are ineligible for continuation of coverage. There is considerable controversy regarding simple questions such as how many people purchase individual insurance. Considerable variation in how the market operates and is regulated at the state level further complicates the picture.

To fill this information void, GAO analyzed data from the Bureau of the Census and other sources, and interviewed representatives of insurance carriers and state regulators in seven states. These states—Arizona, Colorado, Illinois, New Jersey, New York, North Dakota, and Vermont—were selected on the basis of variations in such characteristics as their overall population and the extent of individual insurance market reforms passed by the state. In some of these states, GAO interviewed relevant industry and consumer representatives as well. GAO also obtained

information on those states that passed individual insurance reforms from 1990 through 1995 and those states that undertook other measures to increase individuals' access to health insurance.

Results in Brief

The family farmer, the recent college graduate, the early retiree, and the worker for a firm that chooses not to offer health insurance coverage are among those who are not generally covered in a voluntary, employment-based insurance market. About 10.5 million Americans under 65 years of age (4.5 percent of the nonelderly population) relied on private individual health insurance as their only source of health coverage during 1994. Individual insurance is most common in the Mountain and Plains states, with at least 10 percent of the nonelderly in Iowa, Nebraska, North Dakota, and South Dakota having individual insurance. Also, individual insurance is more prevalent among particular segments of the labor force, with nearly 20 percent of the self-employed and 17 percent of farm workers being covered by individual insurance. When compared with those enrolled in employer-sponsored group coverage, individual health insurance enrollees are, on average, older and have lower income; however, they are similar in their self-reported health status, with three-quarters reporting their health condition as being very good or excellent.

The manner in which individuals access the individual insurance market and the wide range of available products differentiate this type of coverage from employer-sponsored coverage. Unlike the latter, which is generally obtained, administered, and largely financed by the employer, individuals must identify and evaluate multiple health insurance products and then obtain and finance the coverage on their own. Recognizing the importance of offering affordable options to individuals with different economic resources and health needs, carriers offer a wide range of health plans with a variety of cost-sharing options. Individuals in the states GAO visited could select products from no fewer than 7 to over 100 carriers, with deductibles ranging from $250 to $10,000 or more. Typically, higher deductibles translate to lower premiums but at increased financial risk to the consumer.

In the majority of states, which permit medical underwriting, individuals may be excluded from the private insurance market, may only be able to obtain limited benefit coverage, or may pay premiums that are significantly higher than the standard rate for similar coverage. Unlike employer-sponsored coverage for which risk is spread over the entire

group, carriers in these states determine premium price and eligibility on the basis of the risk indicated by each individual's demographic characteristics and health status. Carriers GAO visited declined coverage to up to 33 percent of applicants because they had conditions such as acquired immunodeficiency syndrome (AIDS) and heart disease. Moreover, if they do not decline coverage, carriers may permanently exclude from coverage certain conditions or body parts, or charge significantly higher premiums to those expected to incur large health care costs. For example, GAO found that conditions such as chronic back pain and anemia are commonly excluded from coverage or result in higher premiums.

At least 43 states have sought to increase the health coverage options available to otherwise uninsurable individuals, although these options may cost considerably more than the standard rate. Twenty-five states have created high-risk insurance programs, while many states have passed individual market insurance reforms. In eight states and the District of Columbia, all individuals may be guaranteed coverage through a carrier that acts as insurer of last resort. In at least seven states, no safety net exists to provide unhealthy individuals access to health insurance. At the federal level, the recently passed Health Insurance Portability and Accountability Act of 1996 also contains provisions intended to enhance access to the individual insurance market.

Although it is far too early to assess all of the effects of the act, it does include provisions that explicitly deal with both the individual and employer-sponsored insurance markets. Provisions directly affecting the individual market include portability and guaranteed renewal. The success of further efforts to improve access, affordability, and quality of health insurance for all Americans will depend largely on continued growth in the understanding of both of these health insurance markets.

Principal Findings

Individual Insurance Is an Important Source of Coverage for Many Americans

Individual health insurance covers a significant minority of the U.S. population. For 10.5 million Americans under 65 years of age—4.5 percent of the nonelderly population—individually purchased health insurance was their only source of health coverage in 1994, according to GAO's analysis of the 1995 Current Population Survey. Another 8.6 million nonelderly people (3.7 percent) were covered by individual plans and were

also covered by an employment-based plan or one provided through a government program either concurrently or at different periods during the year. Because of the often transient nature of this market, some of these people may have held individual insurance temporarily and then had another source of coverage during the remainder of the year, whereas others may have held both types of health coverage simultaneously. Because many of these other sources of coverage may be narrower supplemental policies rather than comprehensive health plans, GAO focused its data analysis on the 10.5 million people who exclusively held individual insurance in 1994.

The individual market insures a substantial share of the population in some states, particularly in the Mountain and Plains states. In North Dakota, nearly 14 percent of the population relies on the individual market as its only source of health coverage. In Iowa, Montana, Nebraska, and South Dakota, the proportions of the population participating in the individual market are all twice the national average. Also, most adults who purchase individual insurance are employed and often work in particular industries. For example, about 17 percent of farm workers and 7 percent of construction workers rely on this market for coverage. In contrast, less than 2 percent of workers in the durable goods manufacturing and public administration sectors purchase individual plans.

Those with individual health insurance tend to be older than those with employment-based coverage but are similar in their self-reported health status. People between 60 and 64 years of age are nearly three times as likely to have individual insurance as those 20 to 29 years old. Also, a disproportionate share of early retirees and people who have been widowed participate in the individual market—9.8 percent and 9.2 percent, respectively. Only 6 percent of those with individual insurance reported their health condition as fair or poor, while three-fourths indicated that their health was at least very good—the same proportion as those with employment-based coverage. People with disabilities are less likely to purchase individual coverage, reflecting greater reliance on government-sponsored health insurance programs and possibly also their higher costs for private coverage and medical underwriting and preexisting condition limitations.

Multiple Points of Access and Product Choices Distinguish the Individual From the Employer-Sponsored Insurance Market

The many ways in which consumers access the individual insurance market and the wide range of products available to them stand in stark contrast to the limited options in the employer-sponsored group insurance market. Employees are typically offered one plan or a choice among a few different health plans and cost-sharing options. Plans are typically selected and administered by an employee benefits manager and are largely financed by the employer.

In contrast, individuals must identify and compare health insurance products and then obtain and finance the products chosen on their own. An individual may access the market in a variety of ways, such as by contacting an insurance agent or a carrier directly in response to advertising or name recognition, obtaining conversion coverage, or joining a business organization or other group that pools the purchasing power of a number of individuals. For example, trade associations and chambers of commerce may permit self-employed individuals to participate in their small-employer pools. Other arrangements make use of individuals' common affiliation to provide access to coverage. For example, the largest individual market carrier in North Dakota sells about 76 percent of its individual coverage through a pooled "bank depositors" plan.

Individuals typically may choose from products offered by multiple carriers. In states GAO visited, individuals could choose from plans offered by at least 7 carriers in Vermont to well over 100 carriers in Arizona, Colorado, and Illinois. Blue Cross and Blue Shield plans played a prominent role in the individual markets of most of the states GAO visited. And finally, the extent of managed care in this market lags behind that in other insurance market segments, although growth has accelerated recently.

Recognizing that affordability is a paramount concern in this market and that individuals have different health needs and economic resources, carriers offer a variety of products with a wide range of cost-sharing options. Healthy consumers who do not expect to need medical care are more likely to demand products with the lowest possible monthly premiums. These products will typically have comparatively high copayments or deductibles. Other individuals may only be able to afford coverage with high cost-sharing options, regardless of their health. If they can afford to do so, consumers who anticipate needing medical care may be willing to pay higher premiums to protect themselves from large out-of-pocket costs. Products offered in the states GAO visited typically included a wide range of cost-sharing alternatives. Most commonly

selected by consumers were deductibles ranging from $250 to $2,500, although deductibles of $5,000, $10,000, and higher were also available.

Some Consumers Are Denied Individual Coverage Because of Their Health Status

In the majority of states, which permit medical underwriting, individuals may be denied coverage in the private insurance market, have available to them only limited benefit coverage, or pay considerably more than the standard rate for coverage, depending on their demographic characteristics and health status. Unlike employer-sponsored coverage for which risk is spread over the entire group, carriers in these states may assign rates to each individual on the basis of the risk indicated by characteristics such as age, gender, location, and smoking status. These rates may then be adjusted on the basis of a carrier's determination of the applicant's health status.

A carrier may deny coverage to an applicant determined to be of substandard health. The declination rates for carriers GAO visited range from zero in states where guaranteed issue is required to about 33 percent, with carriers typically denying coverage to about 18 percent of all applicants. Individuals with serious health conditions such as AIDS and heart disease are virtually always denied coverage, as those with such non-life-threatening conditions as chronic back pain and attention deficit disorder may be. At least two carriers GAO visited almost always decline any applicant who smokes.

Carriers may also offer coverage that excludes a certain condition or part of the body, or offer coverage only at a higher, nonstandard rate. Almost all the indemnity insurers GAO visited add riders to policies to exclude certain conditions either temporarily or permanently. A person with a knee injury or glaucoma may have all costs associated with treatment of those conditions excluded from coverage. More chronic conditions such as asthma may also be excluded. Some carriers GAO visited will accept applicants with some health conditions but will charge a higher premium to cover the higher expected costs. For example, one Illinois carrier charges a 100-percent surcharge over the standard premium rates to about 2 percent of its individual enrollees determined to be of substandard health.

State and Federal Initiatives Attempt to Expand Accessibility

At least 43 states have attempted to increase the health coverage options available to otherwise uninsurable individuals, although these options may be available only at a considerably higher price. Currently, about 25 states

have high-risk insurance pools that ensure individuals who need coverage can obtain it, although this coverage generally costs 50 percent more than the standard rate and may not always be available. Individuals who have been rejected for coverage by at least one carrier generally qualify for the high-risk pool.

Eighteen of the 25 states that passed some type of individual insurance reform between 1990 and 1995 attempt to limit the range over which premium rates may vary or the characteristics used to determine these rates. While New Jersey, New York, and Vermont require carriers to accept any individual who applies and to use community rating with limited or no qualification to determine premium rates, most other states still allow carriers to deny coverage to unhealthy individuals and permit premium rate variations of up to 300 percent or more. In eight states and the District of Columbia, the local Blue Cross and Blue Shield plan offers at least one product to individuals on an open enrollment basis as the insurer of last resort. Absent rating restrictions, however, carriers are not necessarily limited in the premium prices they charge for these plans. In at least seven states, some individuals may have no access to insurance coverage.

At the federal level, the recently passed Health Insurance Portability and Accountability Act of 1996 will affect the individual health insurance market. The act guarantees access to the individual market to consumers with qualifying previous group coverage and guarantees the renewability of individual coverage. For self-employed individuals, the act authorizes federally tax-deductible medical savings accounts and increases the tax deductibility of health insurance.

Recommendations

This report contains no recommendations.

Agency Comments

State insurance regulators GAO visited and the National Association of Insurance Commissioners reviewed a draft of this report and provided technical suggestions. GAO incorporated their changes where appropriate.

Contents

Figures

Abbreviations

AIDS	acquired immunodeficiency syndrome
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
EBRI	Employee Benefit Research Institute
FFS	fee-for-service
HIAA	Health Insurance Association of America
HMO	health maintenance organization
IHS	Indian Health Service
MSA	medical savings account
NAIC	National Association of Insurance Carriers
NHIS	National Health Interview Survey
PPO	preferred provider organization

Introduction

Most Americans rely on employer-sponsored health plans or government programs like Medicaid and Medicare to help them select and finance their family's health insurance coverage. But about 10.5 million Americans rely exclusively on their own resources to select and pay for their family's coverage. These participants in the market for individual health insurance must make important decisions affecting their family's health and welfare without the same supports provided to the majority of Americans who obtain their health coverage through employer-sponsored or government plans.

Who Relies on the Individual Market for Comprehensive Health Insurance Coverage?

Most participants in the individual market do not currently have access to an employer-sponsored plan or a government insurance program. Those under 65[1] who may participate in the individual market include

- self-employed people;
- people whose employers do not choose to offer health insurance coverage to workers and their families;
- part-time, temporary, or contract workers who are not eligible for health insurance coverage through their employers;
- early retirees without employer-sponsored coverage and not yet eligible for Medicare;
- people not in the labor force, including people with disabilities, who are not eligible for Medicare or Medicaid coverage;
- college students who are no longer eligible for coverage under their parents' health plans;
- unemployed people who are not eligible for Medicaid;
- people between jobs who have exhausted or are ineligible for continuation of their employer-sponsored coverage; and
- children, spouses, and other dependents ineligible for coverage or too costly to cover under an employer-sponsored plan.

Some individuals falling into these categories can rely on spouses or other family members to include them under the family coverage options of their employer-sponsored plans. Many others, however, do not have this alternative.

[1]The elderly seldom rely on the individual market for comprehensive health insurance coverage because almost all of them have Medicare coverage upon attaining the age of 65. Although many in the Medicare population purchase supplemental coverage as individuals, the program remains their primary source for health insurance.

The Individual Market Is an Important Source of Transitional Coverage for Some and the Permanent Source of Coverage for Others

The individual market often provides a short-term source of health insurance coverage for people during transition points in their lives. Many people initially confront the individual market while they are in college or at an entry-level job and discover that they are no longer eligible for coverage under their parents' employer-sponsored health insurance plan. They may have the option to obtain individual coverage through plans marketed through their schools or training programs, or they may obtain policies through insurance plans or health maintenance organizations (HMO) that operate in their home or school communities.

Transitional employment in part-time or temporary jobs or periods of unemployment between jobs are other cases in which the individual market is used. In many entry-level jobs, employers do not provide health insurance, requiring those who wish to obtain coverage to access the individual market. For some, the lower paying entry-level jobs become their permanent source of employment, transforming the individual market into their permanent source of coverage.

For self-employed people, the individual market is often the only viable source of coverage throughout their careers. For example, family farmers and those in other professions in which self-employment is common often rely on the individual market as a long-term source of health insurance coverage.

Early retirees may rely on the individual market for transitional coverage until they are eligible for Medicare. Of course, many early retirees benefit from continuation of coverage under their former employers' plans. A growing number of employers, however, have increased retirees' contributions toward premiums, increased their deductibles and copayments, or in some cases, entirely phased out their financial support for health benefit plans for current and future retirees. Indeed, a recent study by the Employee Benefit Research Institute suggests that the availability of a retiree health benefit may become an increasingly important factor in an employee's decision to retire early.

Insurance Premiums Loom Larger as Individuals Pay Full Premium Costs Out of Pocket

For the typical person with employer-sponsored coverage, health insurance premium payments are shared by the employer and the worker. The typical employer pays about 80 percent of premiums (70 percent for family coverage). Participants in the individual market must pay their entire premiums out of pocket. Thus, an individual's ability to pay for

coverage largely determines which type of insurance product is purchased or whether the individual can purchase coverage at all.

Those in employer-sponsored plans also benefit from the tax treatment of these plans. While health benefits are generally not considered income to the employee, employers may deduct the expense of providing such benefits to their workers. Employers, who often pay 70 to 80 percent of the cost of their employees' health plans, typically may deduct all of that contribution. In contrast, participants in the individual market generally cannot.[2] Self-employed individuals may deduct a percentage of their expenses, ranging from 40 percent in 1997 to 80 percent in 2006 and thereafter.[3]

The Consumer Confronts a Diverse and Confusing Market for Individual Health Insurance Coverage

Employers and benefit managers often provide participants in employer-sponsored plans with help in identification, selection, assessment, and enrollment in plans as well as with the negotiation of benefits and premiums. In contrast, individual market participants must access the market on their own.

To help guide them through the broad range of insurance offerings available to eligible individuals in most states, individuals often enlist the assistance of professional insurance agents and brokers. In some states, Blue Cross and Blue Shield plans and other carriers serve as direct writers of insurance. Other individuals turn to organizations such as trade associations, professional associations, or farm cooperatives as access points to the health insurance market.

In most states, a wide variety of carriers operates in the individual market, offering a broad range of products. Indeed, most healthy individuals have a broader choice of offerings than those in employer-sponsored plans. But all consumers may not be fully aware of their choices or of the avenues to access the market. To many consumers, insurance terms and options are easily misunderstood. In response, some states have issued consumer guides to help consumers better understand the market.

[2]Individual health insurance premiums may be tax deductible if combined premiums and out-of-pocket health care expenses exceed 7.5 percent of an individual's adjusted gross income and itemized deductions are used for income tax purposes.

[3]These increases in the tax deductibility of health care expenses for self-employed individuals were included in the recently passed Health Insurance Portability and Accountability Act of 1996.

Unique Characteristics of Individual Market Participants Can Lead to Higher Premiums

While most individuals have a broad range of individual insurance options available, a significant minority have few if any affordable options. An individual's health status can lead to sharply higher premiums or result in outright rejection under many plans. Medical underwriting—through which preexisting health conditions or an individual's health status may result in denial of coverage, permanent exclusion from coverage of a preexisting condition, or higher premiums—is still fairly common in the individual markets of many states.

Several states have attempted to deal with the effects of medical underwriting by creating special insurance pools for high-risk individuals or through state individual market reforms (see ch. 5). At the federal level, the Health Insurance Portability and Accountability Act of 1996 recently passed by the Congress may reduce the potential effects of medical underwriting and preexisting condition exclusions for those making the transition from an employer-sponsored plan to the individual market.

The Role of the Individual Market in Attempts to Improve Access and Affordability of Health Insurance

States have been cautious or reluctant to extend many of the protections incorporated into their small business reforms to the individual health insurance market. Extension of insurance portability to the individual market was one of the most controversial issues debated in recently passed insurance reforms at both the state and federal levels. In large measure, the continuing debate reflects the paucity of reliable information on the individual health insurance market.

The interaction between the goals of improved access and affordability of insurance takes on a magnified importance in the individual market. On the one hand, the individual market serves a significant share of older people who are not yet eligible for Medicare and individuals with poor or declining health who are most concerned about access to health insurance without medical preconditions. On the other hand, the individual market is also an important source of coverage for a significant number of younger and often healthier individuals just entering the labor force or in lower wage jobs that often do not provide employer-sponsored coverage. For most of them, premium costs are an important barrier to health insurance coverage. Yet some initiatives that improve access for the older and sicker group might result in higher premiums for the younger and healthier group, thus potentially pricing them out of the market.

The interaction between expanding access and improving affordability varies among states and depends largely on the structure and relative size

of the insurance market, characteristics of its participants, and its regulatory structure. Numerous states and the federal government have already introduced incremental reforms in the individual health insurance market, but many legislators and other observers believe that further adjustments may be needed.

Objectives, Scope, and Methodology

The Chairman of the Senate Committee on Labor and Human Resources asked us to report on

- the size of the individual health insurance market, recent trends, and the demographic characteristics of its participants;
- the market structure, including how individuals access the market, the prices, other characteristics of health plans offered, and the number of individual carriers offering plans; and
- the insurance reforms and other measures states have taken to increase individuals' access to health insurance.

Scope

Our review included both national and state-specific data. Our estimates of the size and demographic characteristics of individual market enrollees were based on nationally projectable data sets as were data concerning individual market insurance reforms, high-risk pools, and insurers of last resort. Because other aspects of individual insurance markets can vary significantly among states, we relied on case studies of the individual insurance markets in seven states. Although findings from these states cannot be projected to the nation at large, we believe they are reasonably representative of the range of individual insurance market dynamics across the country. Our confidence is based on the criteria we used to select the seven states as well as our contact with representatives of large, national insurance carriers, trade groups, and regulatory bodies (discussed further under methodology). Finally, our report focused on comprehensive major medical expense and HMO plans. Therefore, references to individual market products do not include more limited benefit products unless specifically noted.

Methodology

To determine the size and demographic characteristics of individual insurance market participants nationwide, we analyzed data from the Bureau of the Census' March 1995 Current Population Survey (CPS), a national random survey of about 57,000 households. We also analyzed the 1993 National Health Interview Survey (NHIS) conducted by the Bureau of

the Census for the National Center for Health Statistics. The findings of these two surveys were generally similar. Unless otherwise noted, we report CPS findings because the results were available for a more recent year, the number of individuals surveyed was greater, and state-level data were available. Appendix I contains more details on the methodology we used in our analyses.

To understand the structure and dynamics of the individual insurance market, we visited seven states—Arizona, Colorado, Illinois, New Jersey, New York, North Dakota, and Vermont. We selected these states judgmentally on the basis of variations in their populations, urban/rural compositions, and the extent of individual insurance market reforms implemented. In each state, we interviewed and obtained data from representatives of the state insurance department and at least one of the largest individual market carriers. From insurance department representatives, we obtained information concerning the regulation and, where applicable, reform of the individual insurance market and the number and market share of individual market carriers in the state. From carriers, we obtained information concerning products offered, including their benefit structure, cost-sharing alternatives, eligibility, and prices. In some states, we also interviewed health department officials, insurance agents, and representatives of insurance industry trade associations, consumer groups, and insurance purchasing cooperatives.

To supplement state-specific data, we interviewed representatives or obtained information from national insurance carriers and trade and industry groups, including the American Academy of Actuaries, American Chambers Life Insurance Company, the Blue Cross and Blue Shield Association, the Health Insurance Association of America, Mutual of Omaha Companies, Time Insurance Company, and Wellpoint Health Networks, Inc. We also reviewed published literature on the individual insurance market.

To identify states that passed, from 1990 through 1995, individual insurance reforms or, as of year-end 1995, other measures designed to expand access to coverage in the individual market, we obtained summaries compiled by various industry and trade groups, including the Blue Cross and Blue Shield Association and the Health Insurance Association of America. We then obtained and reviewed each state's individual insurance reform legislation and, when necessary, supplemented this review with telephone interviews of state officials to clarify certain provisions.

Our work was performed between February and September 1996 according to generally accepted government auditing standards.

Individual Market Important Source of Health Insurance Coverage for Millions of Americans

Although most Americans obtain their health insurance through employment-based health plans, individual insurance provides coverage for many Americans who may not have access to employment-based coverage. We estimate that about 10.5 million Americans under 65 had individual insurance as their only source of health coverage during 1994, with another 8.6 million having individual insurance as well as some other type of health insurance. While those with individual insurance only represent a relatively small share of the nonelderly population—4.5 percent in 1994—individual insurance is a more prominent source of health coverage in the Plains and Mountain states and among self-employed people, agricultural workers, and early retirees.

For About 10.5 Million Americans, Individual Health Insurance Was Their Only Source of Health Coverage in 1994

On the basis of our analysis of the March 1995 CPS, we estimate that about 10.5 million Americans under 65 years of age (4.5 percent of the nonelderly population) received health coverage through individual health insurance as their only source of health coverage during 1994.[4] That is, the health plan was purchased directly by an individual, not through a current or past employer or union. An additional 8.6 million Americans (3.7 percent) had individual health insurance in addition to employment-based coverage, Medicare, Medicaid, or coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) at some time in 1994.

Many people purchase individual health insurance for only a short period, such as when they are between jobs and without group insurance coverage. For example, a representative of one carrier told us that 30 percent of enrollees maintain individual insurance for less than 1 year. Thus, the 8.6 million people who had individual insurance coverage and another type of health insurance during 1994 could either have (1) had individual health insurance for part of 1994 and another type of health insurance for the remainder of the year or (2) had both individual health insurance and another type of coverage—employment-based or government-sponsored—at the same time for part or all of the year. In the latter case, it is possible that the other type of health insurance would have been the primary source of health coverage with the individual insurance being a supplemental policy. It is not possible, however, to identify how many people would be in either of these groups. For this reason, we focused our analysis on the 10.5 million nonelderly Americans who had

[4]Because the vast majority of Americans 65 or older are covered by Medicare, we focused our analysis on the nonelderly population.

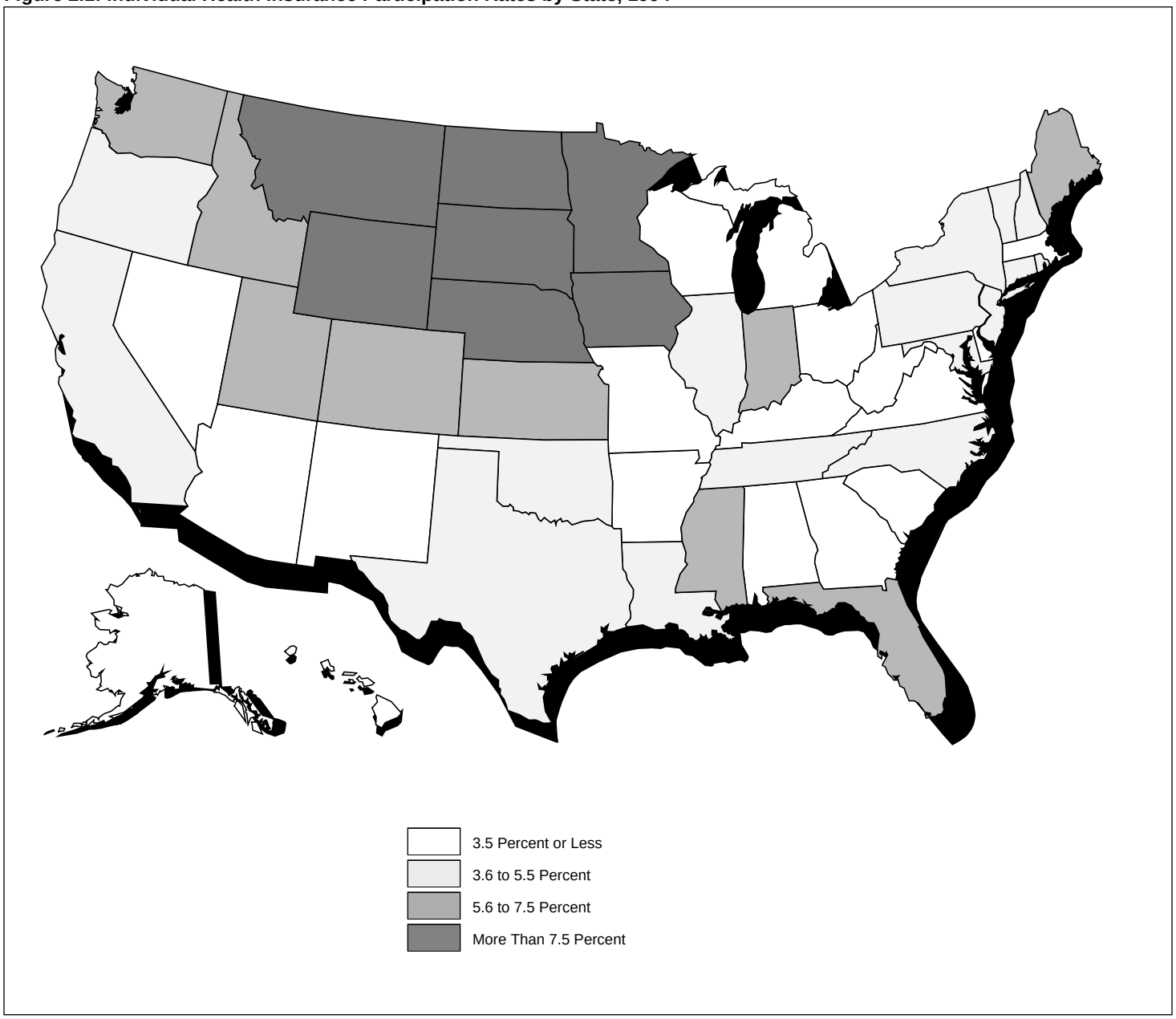
private individual insurance as their only source of health coverage at any time in 1994.[5]

Individual Health Insurance Relied on More in Mountain and Plains States

While 4.5 percent of the U.S. nonelderly population had individual health insurance as their only source of health coverage in 1994, the importance of the individual insurance market varied considerably among states. (See fig. 2.1.) In some Mountain and Plains states, individual insurance is relied on much more as a source of coverage. For example, we estimate that about one of every seven people under 65 in North Dakota has individual health insurance as his or her only source of health coverage. North Dakota is the only state where our estimates of the number of participants in the individual health insurance market exceed the estimated uninsured population. Iowa, Montana, Nebraska, and South Dakota also have estimated participation rates in the individual insurance market that are at least twice the national rate. Appendix II presents rates of individual health insurance enrollment by state.

[5]Some of the group with individual health insurance as their only source of health coverage in 1994 could have also been uninsured for part of the year.

Figure 2.1: Individual Health Insurance Participation Rates by State, 1994



Overall, individual insurance enrollment tends to be slightly lower in metropolitan areas than in nonmetropolitan areas. (See table 2.1.) In

particular, individual health insurance is common among people living on farms. Nearly 30 percent of people indicating that their residence was a farm had individual health insurance in 1993, according to our analysis of the National Health Interview Survey.

Table 2.1: Percentage of Nonelderly Residents Having Individual Health Insurance by Metropolitan Status, 1994

	Individual	Employment-based	Uninsured
Metropolitan	4.2	66.0	17.5
Nonmetropolitan	5.7	62.9	18.3
U.S. average	**4.5**	**65.3**	**17.7**

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

The pattern of higher enrollment in rural areas is not uniform throughout the country. The Southern region, for instance, has a relatively large nonurban population, but the proportions of the populations that had individual health insurance were lower than the national average in 12 of its 17 states. Florida is an exception; the large number of retirees under age 65 there may help explain the fact that a relatively large proportion of Florida's nonelderly population has individual insurance (6.4 percent).

In Hawaii, the only state with mandated employer-sponsored health insurance, only 1.8 percent of the nonelderly population had individual health insurance as the sole source of coverage in 1994. In several other states—Alaska, Arizona, Delaware, Kentucky, Nevada, New Mexico, Virginia, West Virginia, and Wisconsin—less than 3 percent of the population relied on individual insurance as the only source of coverage.

Individual Health Insurance Enrollees Are Generally Older and Have Lower Incomes Than People With Employment-Based Coverage

The individual insurance market is an important source of health coverage for people in their fifties and early sixties, particularly early retirees and people who have been widowed. The relative importance of the individual insurance market to people of different ages is illustrated in table 2.2. Those in the 60 to 64 age group are more than two-and-a-half times as likely to be covered by individual insurance than those in their twenties (9.6 percent versus 3.4 percent). The median age of people with individual insurance is 35, compared with 32 for people with employment-based coverage and 28 for uninsured people.

Table 2.2: Percentage of Nonelderly Population Having Individual Health Insurance by Age Group, 1994

	Individual	Employment-based	Uninsured
Younger than 20	3.7	61.5	15.4
20 to 29	3.4	58.0	27.5
30 to 39	4.3	68.8	18.5
40 to 49	5.1	73.6	14.7
50 to 59	6.4	71.3	13.9
60 to 64	9.6	61.5	14.9
Retired, under 65	9.8	58.6	16.0
U.S. average (0 to 64)	**4.5**	**65.3**	**17.7**

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

The individual insurance market is becoming increasingly important for early retirees because fewer employers are providing health coverage for them.[6] In 1994, nearly 10 percent of retirees aged 64 or younger had individual health insurance as the sole source of health coverage. A disproportionate share of people who had been widowed (9.2 percent) also had individual insurance as the only source of health coverage.

The likelihood of having individual health insurance also varies widely by race and ethnicity. Whites are more than twice as likely to have individual health insurance as are blacks or Hispanics. Blacks and Hispanics are also less likely to have employment-based coverage and are more likely to be uninsured. (See table 2.3.) The higher median income of whites makes the potentially high cost of individual health insurance more affordable for this group.

Table 2.3: Percentage of Nonelderly Population Having Individual Health Insurance by Race and Ethnic Group, 1994

	Individual	Employment-based	Uninsured
White	5.4	72.5	13.9
Black	2.0	49.2	21.8
Hispanic	2.2	40.6	35.6
Other	4.3	58.3	21.9
U.S average	**4.5**	**65.3**	**17.7**

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

[6]See Retiree Health Plans: Health Benefits Not Secure Under Employer-Based System (GAO/HRD-93-125, July 9, 1993).

The individual market is not a viable option for many of the nation's low-income families. As shown in table 2.4, those with income below the federal poverty level are much more likely to be uninsured and slightly less likely to purchase individual insurance. For this group, the cost is an important deterrent to purchasing health insurance. Moreover, Medicaid and other government programs are potential alternatives for these lowest income households.

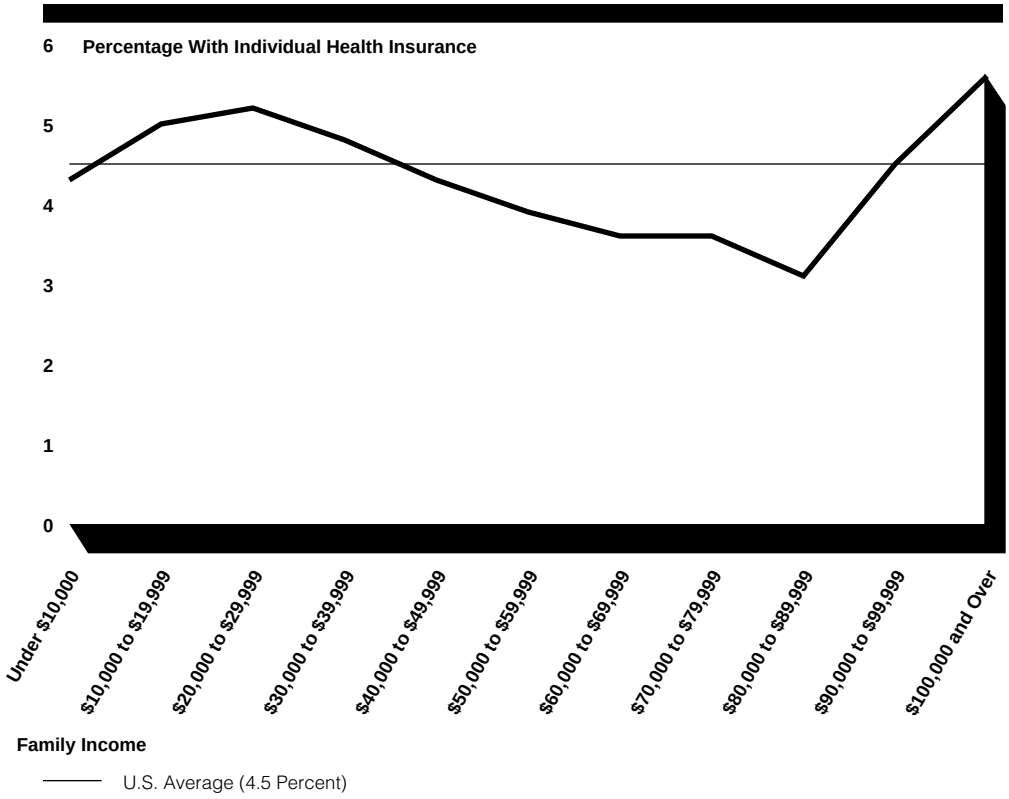
Table 2.4: Percentage of Nonelderly Population Having Individual Health Insurance by Income Group, 1994

	Individual	Employment-based	Uninsured
Below poverty level	3.7	18.5	32.5
Poverty level and above	4.7	74.5	14.7
U.S. average	**4.5**	**65.3**	**17.7**

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

Above the poverty level, the individual market becomes a more important health insurance alternative. Participation in the individual insurance market exceeds the national average for families with incomes between about $10,000 and $40,000. (See fig. 2.2.) Participation dips below the national average as income rises above about $40,000, perhaps reflecting greater availability of employment-based insurance. For those with incomes above about $90,000, participation is again at or above the national average. Overall, people with individual health insurance have a lower median family income ($34,422) than people with employment-based coverage ($48,015) but higher than people who are uninsured ($20,014).

Figure 2.2: Percentage of Nonelderly Population Having Individual Health Insurance by Family Income, 1994



Individual Health Insurance More Common in Some Segments of Labor Force, Including Self-Employed, Contingent Workers, and Farm Workers

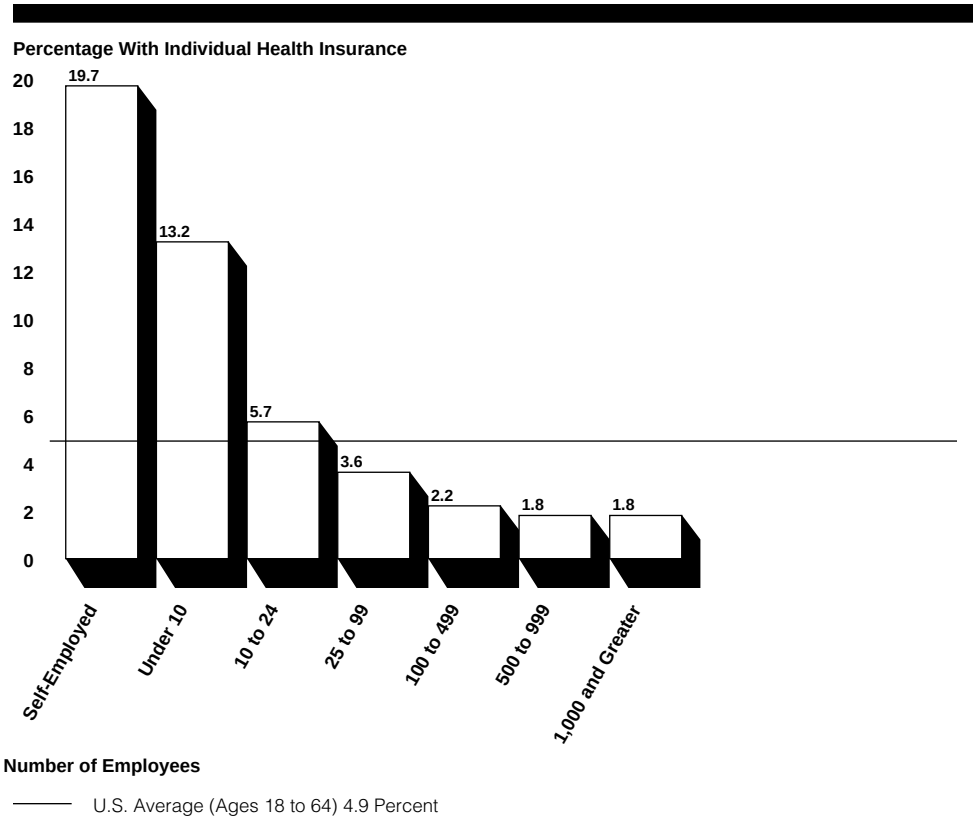
About three-quarters of those aged 18 to 64 with individual health insurance are employed, and some parts of the labor force depend more extensively on the individual insurance alternative. For example, self-employed and contingent workers, including part-time and temporary employees, are more likely to have individual health insurance. (See table 2.5.) These groups are often ineligible for employer-sponsored health plans. Furthermore, as shown in figure 2.3, individual insurance is more prevalent the smaller the employee's firm is. Employees in smaller firms are also less likely to have employment-based coverage.

Table 2.5: Percentage of Population Aged 18 to 64 Having Individual Health Insurance by Employment Characteristics, 1994

	Individual	Employment-based	Uninsured
Full-time			
Full year	4.0	80.3	13.5
Part year	4.4	59.9	27.6
Part-time			
Full year	8.0	63.8	22.9
Part year	6.6	58.7	23.8
Unemployed	6.0	39.9	24.3
U.S. average (ages 18 to 64)	**4.9**	**67.1**	**18.9**

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

Figure 2.3: Percentage of Population Aged 18 to 64 Having Individual Health Insurance by Firm Size, 1994



The inverse relationship between individual and employment-based coverage is particularly evident for selected industries. (See table 2.6.) In particular, farm workers (17 percent), personal services workers (8 percent), and construction workers (7 percent) are more likely to have individual insurance than the national average and are less likely to have employment-based coverage. Among people employed in industries in which large firms predominate, including manufacturing, government, and transportation, individual insurance is not very common. Agricultural, personal services, and construction industries tend to be dominated by smaller firms, and individual insurance plays a more important role in these workers' health coverage. Self-employment is also particularly common among agricultural workers, contributing to the high share of these workers who have individual health insurance.[7]

Table 2.6: Percentage of Population Aged 18 to 64 Having Individual Health Insurance by Industry, 1994

	Individual	Employment-based	Uninsured
Agriculture, forestry, and fisheries	16.9	44.7	33.3
Personal services, including private households	7.8	51.4	31.7
Construction	7.3	56.5	33.2
Business and repair services	7.2	60.1	27.0
Entertainment and recreation services	6.9	67.2	21.7
Finance, insurance, and real estate	5.4	81.7	10.6
Retail trade	5.1	62.9	25.9
U.S. average (ages 18 to 64)	**4.9**	**67.1**	**18.9**
Wholesale trade	4.7	78.2	14.9
Professional and related services	4.1	81.6	11.0
Transportation, communication, and other public utilities	2.8	80.9	14.0
Manufacturing: nondurable goods	2.5	80.0	14.7
Mining	2.3	84.5	12.1
Manufacturing: durable goods	1.8	84.6	11.9
Public administration	1.2	82.5	4.5

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

[7]For additional information on industrial and other differences in employment-based health coverage, see Employer-Based Health Insurance: High Costs, Wide Variation Threaten System (GAO/HRD-92-125, Sept. 22, 1992).

Self-Reported Health Status of Individual Health Insurance Enrollees Mirrors That of Employment-Based Enrollees

Most participants in the individual market (75 percent) rated their health condition as excellent or very good. Only about 6 percent rated their health as fair or poor. This pattern is nearly identical to the self-reported health status of those with employment-based health coverage. Individuals who report poor health status are disproportionately enrolled in government-funded health insurance programs or are uninsured. While 5.1 percent of those who assess their health as excellent have individual insurance coverage, only 2.5 percent of those who believe they are in poor health have individual health insurance. (See table 2.7.)

Table 2.7: Percentage of Population Having Individual Health Insurance by Self-Reported Health Status, 1994

	Individual	Employment-based	Uninsured
Excellent	5.1	71.8	14.5
Very good	4.4	68.3	17.2
Good	4.0	57.4	22.6
Fair	3.7	47.5	21.9
Poor	2.5	33.4	21.2
Disabled[a]	2.1	23.5	17.2
U.S. average	**4.5**	**65.3**	**17.7**

Note: Rows do not total to 100 percent because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

[a]Not in the labor force because of disability.

Reflecting the pattern for people reporting poor health, individuals who are unable to work because of disabilities are less likely to be covered only by individual insurance. This low rate reflects this group's greater reliance on government-sponsored health insurance programs and may reflect their higher cost for private coverage and more tenuous attachment to the labor force. Medical underwriting and preexisting condition limitations are also more common with individual insurance policies, making them unappealing for those with disabilities.

The Structure and Dynamics of the Individual Health Insurance Market

Fundamental structural differences exist between the individual health insurance market and the employer-sponsored group insurance market. These differences can have significant implications for consumers. Individuals without employer-sponsored coverage usually access the health insurance market on their own and face a variety of ways of doing so. Individuals must choose from among a multitude of complex products that are often difficult to compare. Once a product is chosen, individuals must select from a wide range of cost-sharing arrangements and pay the full price of coverage. In contrast, employees eligible for group health coverage do not face the task of accessing the insurance market—this is done for them by the employer. And because employers typically offer only one or a few health plans, the task of identifying and comparing products is greatly simplified or eliminated. Finally, the burden of selecting cost-sharing options and paying for the products is significantly eased by employer contributions and payroll deductions.

Consumers Can Access the Individual Insurance Market Through a Variety of Routes

One common approach consumers take is to purchase insurance through an agent. Agents may sell products from only one insurance carrier or offer products from several competing carriers and assist consumers in identifying the product that best meets their needs. Agents may also assist consumers in the application process.

Consumers may also purchase insurance by contacting carriers directly. In many states, dominant carriers have high name recognition and may focus marketing activities directly on individual consumers. Representatives from several Blue Cross and Blue Shield plans and large HMOs we visited such as Kaiser and FHP told us they regularly use television, radio, or print advertising to target individual consumers. Consequently, most of the individual market business for these carriers is generated through direct contact with applicants. Indemnity carriers, like Mutual of Omaha and Time Insurance, rely on agents to generate most of their individual market business.

Another important access route for individual consumers is through a business or social organization. Organizations such as chambers of commerce, trade associations, unions, alumni associations, and religious organizations may offer insurance coverage to their members. Through the pooled purchasing power of many individuals or small employers, associations can negotiate with carriers for competitively priced products that they then offer their members. For example, a small-employer health care purchasing group in Arizona offers its products to the self-employed.

Through this program, self-employed people have access to coverage on a guaranteed-issue, community-rated basis with premium adjustments permitted only for age and geography. Other arrangements make use of individuals' common affiliation to increase access to health insurance for individuals. For example, Blue Cross and Blue Shield of North Dakota has made arrangements with essentially all the banks in the state to allow depositors to obtain coverage by having their premiums deducted directly from their bank accounts. In operation since the 1960s, this bank depositors plan covers about 76 percent of the carrier's individual enrollees in the state.

Individuals leaving most employer-sponsored group plans have access to two different types of coverage. First, federal law requires carriers to offer individuals leaving group coverage the option of continuing to purchase that coverage at no more than 102 percent of the total policy cost for up to 18 months. Required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the law applies to employer groups of 20 or more. Some state laws extend similar requirements to groups of fewer than 20. Secondly, several states require carriers to offer individuals a product comparable to their group coverage on a guaranteed-issue basis. Conversion coverage tends to be very expensive, however. Because those who elect to purchase conversion coverage tend to be in poorer health than those who do not (a situation known as adverse selection), the premium prices are generally higher than for comparable individual market products.

Finally, those determined by carriers to be uninsurable in the insurance market may be able to purchase coverage through a state high-risk program. Many states offer high-risk programs that provide subsidized coverage to uninsurable individuals at rates generally about 50 percent higher than what a healthy individual would pay in the private market. These programs cover a very small percentage of the insured population and are sometimes limited by the availability of public funding.

Some Consumers Face a Broad Range of Product Choices Driven by Consumer Demand and Market Segmentation

Purchasing insurance through the individual market can be a complex process for even the most informed consumer. In addition to the multiple ways consumers can access the market, consumers are confronted with products offered by dozens and sometimes a hundred or more different carriers. Once a carrier and product are chosen, consumers must then select among a wide range of deductibles and other cost-sharing options.

Multiple Carriers Offer Individual Insurance Products

In each of the seven states we visited, individuals could choose among products offered by multiple carriers. Consumers could choose from plans offered by no fewer than 7 to over 100 carriers. Generally, HMO coverage was available in addition to traditional fee-for-service indemnity plans or preferred provider arrangements. Table 3.1 shows estimates of the number of individual market carriers in each state's individual market. Unless otherwise noted, carrier estimates include only carriers that offer comprehensive coverage.

Table 3.1: Carriers Selling Individual Products

State	Number of carriers
Arizona	141[a]
Colorado	140[a]
Illinois	145[a]
New Jersey	26
New York	41
North Dakota	12
Vermont	7

[a]Estimate also includes carriers that offer limited benefit plans and may include a small number of carriers that offer only conversion coverage in the individual market.

While some states have fewer carriers than others, it is important to note that fewer carriers do not necessarily equate to fewer choices for consumers. For example, although 145 carriers in Illinois may offer individual products, these products are not available to all consumers in the state because of medical underwriting. In addition, some of these carriers may not actively market their products or may sell only limited benefit products.[8] In contrast, New Jersey has 26 carriers offering one or more comprehensive products to which every individual market consumer in the state has guaranteed access.

[8]Limited benefit products are discussed in fig. 3.1.

The mix of carriers participating in the individual market also differs from that of group insurance markets with respect to the role of Blue Cross and Blue Shield (Blues) plans, the extent of HMO penetration, and the size of carriers. Blues plans continue to be relatively important in the individual markets of many states. In six of the seven states we visited, the Blues were the largest single carrier in the individual market. In North Dakota and Vermont, the Blues had a 76 and 58 percent share, respectively, of the market for comprehensive individual market products. Nationally, about a quarter to a third of all individual enrollees obtained their coverage from a Blues plan in 1993.[9]

The HMO share nationally in the individual market is about half of what it is in the employer-sponsored group market, although it is increasing.[10] In New York, for example, the HMO share of the individual health insurance market has increased from about 7 percent in 1992 to 40 percent in 1996. Partly in response to insurance reforms enacted there, at least one large individual market carrier withdrew its indemnity products altogether and replaced them with an HMO product, according to a New York trade association official. The trend in New York is expected to continue in response to recent state measures designed to encourage HMO participation in the individual market. In Illinois, a representative of one of the largest individual market carriers told us the carrier soon expects to introduce its first individual HMO product. In Colorado, an HMO plan is now the most popular product sold in the individual market.

Finally, whereas the group market is dominated by large, national carriers such as Aetna and Prudential, carriers in the individual insurance market tend to be smaller or regional in focus. Blues plans are typically a dominant force in state individual markets. Also, few of the largest individual market carriers in the states we visited were among the 100 largest U.S. life and health insurance carriers.[11]

[9]Our analysis of 1993 National Health Interview Survey data.

[10]Our analysis of 1993 National Health Interview Survey data.

[11]Standard & Poor's, Ratings of Large U.S. Insurers: Life & Health Insurers (1994 Assets Exceeding $1 Billion) (Insurance News Network), http://www.insure.com/ratings/lh_size.html (cited Aug. 28, 1996).

Through Choice of Cost-Sharing Options, Consumers Can Lower Premiums but at Increased Financial Risk

In contrast to employment-based group insurance, individuals may choose from multiple cost-sharing arrangements and are generally subject to relatively high out-of-pocket costs. Under employer-sponsored coverage, the range of available deductibles is narrower, and total out-of-pocket costs are capped at a lower level than under most individual market products. For plans offered by medium and large employers, annual deductibles are most commonly between $100 and $300, while limits on total out-of-pocket expenses are $1,500 or less for most employees.[12] In the individual market, annual deductibles are commonly between $250 and $2,500, while limits on total out-of-pocket costs typically start at $1,200 and may exceed $6,000 annually.

Insurance contracts require policyholders to contribute to the cost of benefits received. Under traditional, major medical expense plans, consumers must pay annual deductibles and coinsurance up to a specified total limit on out-of-pocket expenses. HMOs typically require consumers to make copayments for each service rendered until an annual maximum is reached. The cost-sharing arrangement selected by the consumer is a key determinant of the price of an individual insurance product. The more potential out-of-pocket expenses the consumer could incur, the lower the premium will be. To illustrate, table 3.2 shows how premiums for a comprehensive major medical expense policy offered by one Colorado carrier decrease as annual deductibles increase. Premiums shown are for a healthy 30-year-old, nonsmoking male living in a major metropolitan area of the state.

Table 3.2: Example of Relationship Between One Carrier's Deductibles and Premium Prices for a Healthy 30-Year-Old Male

	Option A	Option B	Option C	Option D
Annual deductible	$250	$500	$1,000	$2,000
Annual premium	1,073	835	713	565

Products offered in the states we visited typically included a wide range of cost-sharing alternatives. Most commonly selected by consumers were deductibles from $250 to $2,500, although deductibles of $5,000, $10,000, $50,000, and even $100,000 were also available. (Under the recently enacted national Health Insurance Portability and Accountability Act of 1996, high-deductible plans to be used in conjunction with medical savings accounts are defined as those with deductibles of between $1,500 and $2,250 for individuals.) HMO copayment requirements were typically $10 or $15 for a physician office visit and $100 to $500 per hospital admission.

[12]U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Private Establishment, 1993, bulletin 2456 (Washington, D.C.: U.S. Government Printing Office, Nov. 1994); KPMG Peat Marwick LLP, Health Benefits in 1995 (Washington, D.C.: KPMG, Aug. 1995).

Total annual limits on out-of-pocket costs were most commonly between $1,500 and $6,000. Table 3.3 illustrates examples of cost-sharing options available for selected commonly sold comprehensive products.

Table 3.3: Selected Commonly Sold Products and Their Cost-Sharing Options

Sample product type	Where sold	Coinsurance or copayment options	Out-of-pocket maximums	Available deductibles
FFS	Arizona	20% coinsurance	$2,500	$1,000, $1,500
		20% coinsurance	$3,500	$2,500
PPO	Illinois	0% coinsurance in network	$1,000 + deductible	$250, $500, $1,000, $2,500
		20% coinsurance out of network	$1,000 + deductible	$250, $500, $1,000, $2,500
HMO	New Jersey	$15 office visit copayment; $150 daily hospital copayment[a]	$1,500 per year	Not applicable
FFS	North Dakota	20% coinsurance	$1,500 for coinsurance; no maximum for copayments	$250, $500[b]
FFS	Vermont	20% coinsurance	$6,000 in network, $8,500 out of network; other copayments apply	$1,000

Note: FFS stands for "fee-for-service"; PPO stands for "preferred provider organization."

[a]The daily hospital copayment applies only to the first 5 days per each admission.

[b]Deductibles apply to each hospital admission and are not counted toward the out-of-pocket maximums.

Because consumers pay the entire cost of coverage, affordability is often of paramount concern. Consequently, consumers who perceive their risk of needing medical care to be minimal but want coverage in case of an accident or catastrophic illness may choose very high cost-sharing provisions to obtain the lowest possible premium. Other consumers, regardless of their health status, may only be able to afford insurance with very high cost-sharing provisions. Consumers who anticipate a greater likelihood of requiring medical care may be willing to pay higher premiums to protect themselves from large out-of-pocket expenses for coinsurance, deductibles, or copayments.

Carrier and insurance department representatives with whom we spoke suggested that the level of consumer cost-sharing has been increasing in recent years, reflecting consumers' goal of keeping premiums affordable. One national carrier representative said that deductibles seem to be increasing every year. Among the carrier's new enrollees in 1995, 40 percent chose $500 deductibles, 50 percent chose $1,000 deductibles, and the remaining 10 percent chose deductibles from $2,500 to $10,000. A representative of another national carrier said that the premiums for its $250- and $500-deductible products had become too expensive and are thus no longer offered.

State regulation also influences the range in cost-sharing options available to consumers. For example, under individual market reforms enacted in New Jersey, carriers are limited to offering only standard plans with prescribed ranges of cost-sharing options. All individual market products sold in the state are limited to deductibles of $150, $250, $500, or $1,000 for an individual enrollee. In contrast, one carrier in Arizona, where cost-sharing arrangements are not subject to state regulation, offers deductibles ranging from $1,000 to $100,000.

Benefits Covered Under Most Individual Comprehensive Products Are Generally Comparable

Comprehensive individual coverage includes major medical expense plans—traditional fee-for-service plans and preferred provider organization (PPO) arrangements—and standard HMO plans. While our study focused on comprehensive individual insurance market products, it should be noted that a wide range of less comprehensive, or limited benefit products, are also sold in the individual market. These products, which are sometimes confused with comprehensive products, are discussed in figure 3.1.

Figure 3.1: Limited Benefit Products

For this study, we focused on comprehensive major medical expense and HMO plans. Other, less comprehensive products are also sold in the individual market, however. These limited benefit plans include hospital indemnity, medical expense, and specified disease plans. They are generally used as a supplement to comprehensive plans. Hospital and medical expense plans offer a limited, usually flat reimbursement for hospital or medical/surgical expenses, respectively. An individual might purchase these products as extra protection in addition to a major medical plan. Specified disease plans provide coverage only for the particular disease. An individual with a family history of cancer might purchase a cancer-only policy in addition to a major medical plan.

Limited benefit products can represent a significant share of the individual market in some states. Because their inclusion in various data sources we reviewed was inconsistent or unclear, however, we could not specifically quantify their prevalence. One insurance regulator in Arizona said that limited benefit products constitute a “fair” share of the state's individual insurance market. One of the largest individual market carriers there estimated that about 13 percent of its individual business consists of limited benefit products. One of the largest individual market carriers in Colorado sells no comprehensive products in the state whatsoever–instead it sells only limited benefit products. In North Dakota, statewide enrollment data from 1992 indicate that more than half of individual market enrollees have only limited benefit coverage.

While limited benefit products can meet specific needs for some consumers, insurance regulators told us that such coverage can be problematic for others. Because of the wide range and complexity of products available and the lack of standardization, some consumers may purchase limited benefit products believing them to be comprehensive. These consumers could face serious economic consequences should they require extensive or prolonged medical care. Another concern is that consumers unnecessarily purchase a supplemental policy that replicates their existing coverage. Regulators told us that certain specified disease policies, in the unlikely event they will be needed, provide benefits redundant with consumers' existing coverage. A state official in New Jersey, where specified disease plans are prohibited, told us the plans are “not good public policy and are not typically in the best interests of consumers.”

Note: For more information on limited benefit products, see Health Insurance: Hospital Indemnity and Specified Disease Policies Are of Limited Value (GAO/HRD-88-93, July 12, 1988).

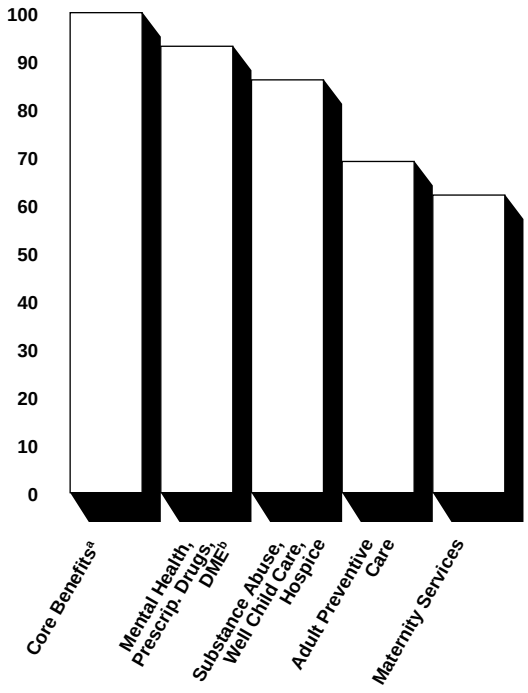
Under most major medical expense plans a wide range of benefits is covered, including in- and outpatient hospital, physician, and diagnostic services; specialty services, such as physical therapy and radiology; and prescription drugs. Standard HMO plans typically cover an equally or more comprehensive range of benefits and are also more likely to offer a broad range of preventive care, such as periodic examinations, immunizations, and health education. Moreover, these benefits were generally comparable with benefits covered under employer-sponsored group plans.[13]

We reviewed the benefit structure of commonly sold comprehensive products in the states we visited. These products included traditional indemnity or fee-for-service, PPO, and HMO plans.[14] Most of the plans covered a wide range of benefits, as shown in figure 3.2. Five benefits—hospice care, substance abuse treatment, maternity services, preventive care for adults, and well baby/child care—were less consistently covered. The latter three benefits were covered by each of the HMOs. Among plans that did not offer maternity coverage, half offered it as an additional rider.

[13]One notable exception may be maternity coverage. Limited survey data suggest this benefit is covered more frequently under group plans.

[14]Fourteen separate plans were reviewed that were representative of the comprehensive individual market products sold in these states. The New Jersey plans we reviewed were standard and thus represent the benefit structure of all plans sold in that state; likewise for the HMO plan in New York. In North Dakota and Vermont, the plans we reviewed accounted for more than half of all comprehensive individual plans sold in those markets. In the remaining states, plans we reviewed were the most popular plans sold by at least two of the largest individual market carriers. Among the plans reviewed were six traditional indemnity or fee-for-service plans, three PPO plans, and five HMO plans.

Figure 3.2: Summary of Covered Benefits



Note: Certain benefits are subject to additional limits such as a 50-percent copayment for mental health care with a $10,000 lifetime limit or a $100 deductible for prescription drugs.

[a]Inpatient and outpatient hospital and medical/surgical services; emergency care; diagnostic services; physical, occupational, and speech therapy; home health care; skilled nursing facility care; and organ transplants.

[b]Durable medical equipment.

High Premiums and Individual Health Status May Affect Access to the Private Insurance Market

Beyond characteristics such as how consumers access the market, the number and types of health plans available, and the multiple cost-sharing options, other aspects of the individual market also distinguish it from the employer-sponsored group market. Aspects such as restrictions on who may qualify for coverage and the premium prices charged can have direct implications for consumers seeking to purchase coverage and are often exacerbated by the fact that individuals must absorb the entire cost of their health coverage, whereas employers usually pay for a substantial portion of their employees' coverage. A consumer may find affordable coverage or may find coverage only at prohibitive rates. A consumer may find coverage available only if conditioned upon the permanent exclusion of an existing health condition or may be locked out of the private health insurance market entirely. Consumers may be forced to turn to state high-risk programs or an insurer of last resort for coverage—at a significantly higher premium—or go without any health insurance coverage whatsoever.

Effect of Demographic Characteristics and Health Status on Premium Prices

Substantial Variation in Premium Prices Due to Demographic Differences

Unlike the employer-sponsored market where the price for group coverage is based on the risk characteristics of the entire group, prices in the individual markets of most states are based on the characteristics of each applicant. Characteristics commonly considered to determine premium rates in both markets include age, gender, geographic area, tobacco use, and family size. For example, on the basis of past experience carriers anticipate that the likelihood of requiring medical care increases with age. Consequently, a 55-year-old in the individual market pays more than a 25-year-old for the same coverage. Similarly, females in this market may be charged a higher premium than males of the same age group because of the costs associated with pregnancy and the treatment of other female health conditions. These individuals, however, if in the group market, would usually pay the same amount as the other members of their group, regardless of their specific age or gender. Premiums may also vary geographically. In some states, premium prices are higher in urban areas

than in rural areas because of higher medical costs. Likewise, smokers are expected to incur greater medical expenses than nonsmokers and are thus often charged higher premiums in the individual market. Finally, family composition is also factored into premium price as a larger family would be expected to incur higher medical expenses than a smaller family. Treatment of this last factor is generally similar between the individual and the group markets. Carriers establish standard rates for each combination of demographic characteristics.

Table 4.1 provides examples of the range in monthly premium rates some carriers we visited charge individuals, depending on their age, gender, or geographic location, in states that do not strictly regulate carrier rating practices. The low end of the range generally represents the premium price charged to males about the age of 25 who do not live in a metropolitan area. In contrast, the high end usually represents the most expensive insured in this market, a male aged 60 to 64 who lives in a metropolitan area.

Table 4.1: Selected Examples of Variation in an Individual's Standard Monthly Premium Because of Differences in Age, Gender, or Geographic Area in States That Do Not Restrict Rating Practices

	Deductible	Range in monthly premium
Carrier A	$250	$52-220
Carrier B	Not applicable (HMO plan)	85-210
Carrier C	500	65-532
Carrier D	250	74-234

Note: To determine premium rates, Carriers A and C use age, gender, and geographic area; Carrier B uses age only; and Carrier D considers age and geographic area.

Medical Underwriting Affects Premiums and May Bar Access to the Individual Market

Absent state restrictions, carriers also evaluate the health status of each applicant to determine whether an applicant's health status will result in an increase to the standard premium rate, the exclusion of a body part or an existing health condition, or the denial of the applicant altogether. This process is called medical underwriting.

Under medical underwriting, carriers evaluate an applicant's health status on the basis of responses to a detailed health questionnaire. On the questionnaire, applicants must indicate whether they or any family member to be included on the policy have received medical advice or treatment of any kind within their lifetime or within a more limited time frame, such as the previous 5 to 10 years, and whether they have

experienced a broad range of specifically identified symptoms, conditions, and disorders. Applicants must also indicate whether they have any pending treatments or surgery, are taking any prescription medication, or have ever been refused or canceled from another health or life insurance policy. On the basis of these responses, carriers may request additional information—typically medical records—or require an applicant to undergo a physical examination. Some carriers require physical examinations regardless of applicants' responses to their questionnaires.

The information obtained through this process is used by carriers to determine whether to charge a higher than standard premium rate, exclude from coverage a body part or an existing health condition,[15] or deny the applicant coverage altogether. The criteria used to make these determinations vary among carriers and are considered proprietary. Certain conditions are commonly treated by carriers in the same manner, however. Table 4.2 lists examples of some carriers' treatment of certain health conditions in states that do not prohibit medical underwriting.

Table 4.2: Examples of Health Conditions for Which Certain Carriers May Decline Coverage, Exclude a Condition From Coverage, or Require a Higher Premium

Decline coverage	Offer coverage but exclude condition	Offer coverage but at higher premium
HIV/AIDS	Asthma	Attention deficit disorder
Rheumatoid arthritis	Cleft palate	Anemia
Parkinson's disease	Glaucoma	25% to 40% overweight
Diabetes	Ulcers	Hypertension (controlled)
Down's syndrome	Varicose veins	Arteriosclerosis (mild)

The carriers we visited generally accepted the majority of applicants for coverage at the standard premium rate. Where state mandates did not exist, however, these carriers denied coverage to a significant minority of applicants. Denial rates ranged from zero for carriers in states such as New Jersey, New York, and Vermont where the law guarantees coverage, to about 33 percent, with carriers in those states that do not prohibit medical underwriting typically denying coverage to about 18 percent of all applicants. Individuals with acquired immunodeficiency syndrome (AIDS) or other serious conditions, such as heart disease and leukemia, are virtually always denied coverage. We also found examples in which individuals with less severe conditions, such as attention deficit disorder and chronic back pain, could also be denied coverage by some of the carriers. Furthermore, at least two HMOs we visited almost always deny

[15]This exclusion is separate from the 6- or 12-month preexisting condition exclusion period carriers typically impose upon all new applicants.

coverage to any applicant who smokes. Table 4.3 lists the estimated declination rates for some of the largest carriers we visited.

Table 4.3: Declination Rates of Selected Individual Market Carriers

State	Percentage of applicants declined coverage[a]
Arizona	
Carrier A	18
Carrier B	13
Colorado	
Carrier A	5
Carrier B	15
Illinois	
Carrier A	17.5
Carrier B	33[b]
New Jersey	
All carriers[c]	0
New York	
All carriers[c]	0
North Dakota	
Carrier A	22.5
Vermont	
All carriers[c]	0

[a]Carrier representatives provided these as approximations of the percentage of applicants who are denied coverage. The declination rates for at least two carriers include those applicants declined for medical reasons as well as those denied for nonmedical reasons, such as incomplete applications.

[b]This is the carrier's declination rate for all individual products sold nationwide, not just for those sold in Illinois.

[c]The declination rate is zero since state laws require carriers to guarantee issue all products they sell to all individuals who apply for coverage.

Some officials suggested that these declination rates could be understated for at least two reasons. First, insurance agents are usually aware of which carriers medically underwrite and have a sense as to whether applicants will be accepted or denied coverage. Consequently, agents will often deter individuals with a health condition from even applying for coverage from certain carriers. In fact, officials from one carrier in Arizona told us that since agents discourage those who would not qualify for coverage from applying, their declination rate is not an accurate indicator of the proportion of potential applicants who are ineligible for coverage.

Secondly, the declination rates do not take into account carriers that attach riders to policies to exclude certain health conditions or carriers that charge unhealthy applicants a higher, nonstandard rate for the same coverage. Thus, although a carrier may have a comparatively low declination rate, it may attach such riders and charge higher, nonstandard premiums to a substantial number of applicants. In fact, a national survey of insurers showed that 20 percent of all applicants were offered a policy with an exclusion rider, a rated-up premium, or both.[16]

The majority of the indemnity insurers we visited will add riders to policies that exclude certain conditions either temporarily or permanently. For example, knee injuries related to skiing accidents may be explicitly excluded from coverage as may be a more chronic condition such as asthma. Also, a person who suffers from chronic back pain may have all costs associated with treatment of that part of the body excluded from coverage. Similarly, some carriers we visited will accept an applicant with certain health conditions but will charge him or her a significantly higher premium to cover the higher expected costs. For example, an Illinois carrier charges 2 to 3 percent of its enrollees a nonstandard rate. This 2 to 3 percent, however, pays approximately double the standard rate. Also, at least one carrier we visited charges individuals, depending on their medical history, a standard or nonstandard rate for its HMO product. The nonstandard rate is approximately 15 percent higher.

Access to the Individual Insurance Market Varies Among States and Affects Consumers Differently

Individual consumers may be affected differently by the varying methods carriers use in determining eligibility and price. A consumer may find affordable coverage, may only find coverage that explicitly excludes an existing health condition, or may find coverage only at prohibitive rates. Many consumers may be locked out of the private health insurance market entirely.

Tables 4.4 and 4.5 provide examples of what individuals may face, given particular demographic characteristics and health conditions, when attempting to purchase individual insurance from carriers in the states we visited. In addition to demographic characteristics and health status, the extent to which the state regulates the individual insurance market also influences eligibility and premium price decisions. Price comparisons among states, however, can be misleading. Premium prices also vary among states because of regional and state-specific factors. For example,

[16]U.S. Congress, Office of Technology Assessment, Medical Testing and Health Insurance, OTA-H-384 (Washington, D.C.: U.S. Government Printing Office, Aug. 1988).

differences among states in cost of living and health care utilization, among others, may also contribute to premium price differences.

Premium Rates May Vary Depending on Certain Demographic Characteristics

As discussed, carriers, absent regulation that prohibits the practice, generally base standard premium rates on the demographic characteristics of each applicant. Such demographic characteristics may include age, gender, geographic area, and family composition. Table 4.4 shows this price variation. Using the monthly premium charged to a healthy, 25-year-old male as a baseline, it compares the differences in prices certain carriers will charge to other healthy individuals on the basis of their age and gender.

Table 4.4: Examples of Selected Carriers' Monthly Premium Price Variation Attributable to Demographic Characteristics

	Baseline	Amount above baseline				
Plan type/deductible	**Male, 25**	**Male, 40**	**Male, 55**	**Female, 25**	**Female, 40**	**Female, 55**
Arizona						
PPO/$250	$57	$32	$134	$31	$50	$122
FFS/$2,500	63	25	117	15	56	116
Colorado						
HMO	99	34	108	0	34	108
FFS/$500	63	34	118	36	87	110
Illinois						
PPO/$500	100	66	243	31	92	195
New Jersey						
FFS/$1,000 low end	155	0	0	0	0	0
FFS/$1,000 high end	565	0	0	0	0	0
New York						
HMO rural[a]	164	0	0	0	0	0
HMO New York City area	234	0	0	0	0	0
North Dakota						
FFS/$250	77	37	111	0	37	111
Vermont						
FFS/$1000	175[b]	0	0	0	0	0

Note: FFS stands for "fee for service"

[a]The premium listed is the median price of the standard HMO product in most areas outside New York City. Similarly, the premium listed for New York City is the median price of the standard HMO product sold in the metropolitan area.

[b]The selected carrier in Vermont does not vary its premium rates for any of the listed demographic characteristics, although state law permits limited variation.

Carriers anticipate that the likelihood of needing medical care increases with age. In the states we visited, all the carriers except those that were prohibited by law from doing so, charged higher premiums to older applicants. For example, an Arizona PPO plan cost a 25-year-old male $57 a month and a 55-year-old male $191 a month for the same coverage, a difference of $134. Similarly, a 55-year-old male would have paid $243 more than a 25-year-old male for a PPO product from one Illinois carrier. The carriers we visited were not as consistent in their treatment of gender. Several carriers charged females a higher premium than males of the same age group because of the costs associated with the female reproductive system and pregnancy. For example, 25-year-old females in Illinois and Arizona paid $31 more each month than males of the same age for the same PPO coverage and $36 more each month for a fee-for-service plan in Colorado. All applicants to a Colorado HMO and a North Dakota fee-for-service plan, however, paid the same monthly premium, regardless of gender. Premium prices also varied depending on the geographic area where the applicant resides. For example, the monthly premium for the standard HMO product in New York may cost as much as $289 in metropolitan New York City or as little as $145 in more rural areas of the state.

As the table indicates, all applicants in New Jersey, New York, and Vermont, regardless of age or gender, would pay exactly the same amount for the same insurance coverage from the same carrier. In these states, the individual insurance reform legislation requires community rating, a system in which the cost of insuring an entire community is spread equally among all members of the community, regardless of their demographic characteristics or health status. Reform legislation in New York does allow for limited adjustments by geographic regions. In New Jersey's individual market, the premium price of the sample product for the carriers in the state ranges from $155 to $565. Although this is a fairly wide price range, all applicants are eligible for and may select from among any of these plans.

The prices listed in table 4.4 generally are carriers' standard rates charged to individuals with the specified demographic characteristics. Absent state restrictions, most carriers will also evaluate the health status of each applicant to determine whether to charge an increase over the standard premium rate, to exclude a body part or existing health condition from coverage, or to deny the applicant coverage altogether. Some carriers also regard smoking to be a risk characteristic and consider it when they determine an applicant's eligibility and premium price. Table 4.5 provides

examples of what a 25-year-old male with varying habits or health conditions might experience in terms of availability and affordability of coverage in the individual insurance market in the states we visited. Again, the baseline is the monthly premium price charged to a healthy, 25-year-old male.

Table 4.5: Examples of Selected Carriers' Monthly Premium Price Variation for a 25-Year-Old Male, Attributable to Health Characteristics

		Amount above baseline				
	Baseline					
Plan type/deductible	Healthy	Smoker	Preexisting knee injury	Preexisting diabetes	Cancer within 3 years	High-risk pool[a]
Arizona						
PPO/$250	$57	$0	Exclude condition or deny coverage	Exclude condition or deny coverage	Deny coverage	Not available
FFS/$2,500	63	27	Exclude condition	Deny coverage	Deny coverage	Not available
Colorado						
HMO	99	Deny coverage	$0	Deny coverage	Deny coverage	$52[b]
FFS/$500	63	7	Exclude condition	Exclude condition	Deny coverage	88
Illinois						
PPO/$500	100	25	0	Charge higher premium	Deny coverage	122
New Jersey						
FFS/$1,000 low end	155	0	0	$0	$0	Not applicable
FFS/$1,000 high end	565	0	0	0	0	Not applicable
New York						
HMO rural[c]	164	0	0	0	0	Not applicable
HMO New York City area	234	0	0	0	0	Not applicable
North Dakota						
FFS/$250	77	0	0	Deny coverage	Deny coverage	69[d]
Vermont						
FFS/$1,000	175	0	0	0	0	Not applicable

(Table notes on next page)

Note: FFS stands for "fee-for-service."

[a]The price differential is for a 25-year-old, healthy male. Older individuals in the three states we visited with high-risk pools may pay considerably more for this same coverage. For example, a 60-year-old male in Illinois will pay $895 a month for coverage through the high-risk pool—$673 more than what the 25-year-old pays for the same plan and $467 more than a healthy, 60-year-old man would pay for coverage from one large carrier in the state.

[b]This difference may be understated because the high-risk pool plan also has a $300 deductible, whereas the HMO plan with which we compared it has no deductible.

[c]The premium listed is the median price of the standard HMO product in most areas outside New York City. Similarly, the premium listed for New York City is the median price of the standard HMO product sold in the metropolitan area.

[d]This difference may be understated because the high-risk pool plan has a $500 deductible, whereas the plan with which we compared it has a $250 deductible.

Three of the 11 carriers shown in table 4.5 charge smokers $7 to $27 more each month for the same coverage, and one HMO automatically denies coverage to all smokers. At least two of the carriers will attach a rider to a policy that explicitly excludes coverage of a preexisting knee condition and will not cover any costs associated with treatment of that part of the body. While three of the carriers automatically deny an applicant with preexisting diabetes, one will accept the applicant but will charge him or her a significantly higher premium to cover the higher expected costs. And finally, an applicant who had cancer within the past 3 years would almost always be denied coverage from all carriers except those in the guaranteed-issue states of New Jersey, New York, and Vermont. Individuals in these states, regardless of their health condition, will generally pay the same amount as healthy individuals for similar coverage.

In non-guaranteed-issue states, applicants who have a history of cancer or other chronic health conditions are likely to have a difficult time obtaining coverage. In many of these states, high-risk insurance pools have been created to act as a safety net to ensure that these otherwise uninsurable individuals can obtain coverage, although at a cost that is generally 50 percent higher than the average or standard rate charged in the individual insurance market for a comparable plan. Individuals in Colorado, Illinois, and North Dakota who are denied coverage from one or more carriers can obtain insurance through the high-risk pool for $52 to $122 more each month.[17] Arizona is the only state we visited that did not have guaranteed issue or a high-risk pool. Unhealthy individuals in this

[17]Each of these states has a mechanism to subsidize the operation of their respective high-risk pool. Absent these subsidies, the difference in premium prices would probably be significantly higher.

state who are most in need of coverage are not guaranteed access to any insurance product and will most likely be uninsured.

Once Covered, Individuals May Face Obstacles to Continued Coverage

Several state insurance regulators and a representative of the National Association of Insurance Commissioners (NAIC) expressed concern that some carriers may use closed block durational rating, a carrier rating practice used in the individual health insurance markets of many states. Under this practice, carriers offer a guaranteed renewable product at an artificially low rate to attract large numbers of new enrollees and increase their market share. These carriers eventually increase premium rates to more adequate levels and close the block of business by no longer accepting any new applicants. Because insurance pools rely on a steady influx of new, healthy applicants to maintain rates, the rates in the closed block rise even faster. Healthy members of the block tend to migrate—and are sometimes actively solicited by the carriers—to lower priced products that are not similarly available to the unhealthy members of the block. The unhealthy members must either remain in the closed block with its spiral of poorer risks and increasing rates or leave the carrier and face the uncertain prospect of obtaining coverage from another carrier on the open market. Consequently, this practice allows carriers to shed poorer risks and retain favorable risks.

Though legal in most states, some regulators strongly object to this practice. They suggest it penalizes those individuals who have dutifully purchased and maintained their health coverage but eventually become unhealthy. Some states, through guaranteed-issue requirements and premium rate restrictions, have prohibited this practice.

Carriers Suggest Medical Underwriting Helps Keep Private Health Insurance Affordable

Although medical underwriting results in the exclusion of individuals from the private health insurance market, many carrier representatives and analysts suggest that it plays a role in keeping insurance premiums more affordable for most individuals. They contend that coverage of uninsurable individuals is a public policy concern and should be addressed through public initiatives such as high-risk pools, not through the private sector insurance market.

Insurance industry representatives explain that where states prohibit carriers from using medical underwriting, individuals are essentially guaranteed access to insurance regardless of their health status. They suggest that guaranteed access to coverage can result in adverse selection.

Adverse selection refers to the tendency of some individuals to refrain from purchasing insurance coverage while they are younger or healthier because they know it will be available to them in the future should their health status decline. If a significant number of younger, healthier individuals decide to forgo coverage, the average health status of those remaining in the insured pool diminishes. Higher claims costs for this less healthy group will result in higher premium prices, which in turn, could force additional healthy individuals to forgo coverage. The resulting spiral of poorer risks and higher premiums could make insurance less affordable for everyone.

Many state insurance regulators and analysts disagree with this premise or suggest that its impact is overstated by the insurance industry. They present data to support their position as do insurance industry representatives to support theirs. The appropriate degree of regulatory intervention in private insurance markets will continue to be a subject of debate, underscoring the importance of thorough, ongoing evaluation of the impact of various state insurance reforms.

State and Federal Initiatives Attempt to Expand Access to Coverage for Individuals

A wide range of initiatives to increase access to various segments of the heath insurance market have been undertaken by states and more recently the federal government. While almost all of the states have enacted insurance reforms designed to, among other things, improve portability, limit waiting periods for coverage of preexisting conditions, and restrict rating practices for the small employer health insurance market,[18] they have been slower to introduce similar reforms to the individual market. From 1990 through 1995, a number of states passed similar insurance reforms in the individual market, and by year-end 1995, about 25 states created high-risk insurance pools to provide a safety net for otherwise uninsurable individuals. Eight states and the District of Columbia have Blue Cross and Blue Shield plans that provide all individuals a product on an open enrollment basis. At least seven states have no insurance rating restrictions, operational high-risk pool, or an insurer of last resort. Table 5.1 catalogs state initiatives to increase individuals' access to health insurance. Recent legislative efforts at the federal level also attempt to increase individuals' access to this health insurance market.

Table 5.1: State Initiatives to Increase Individual Insurance Market Access as of Year-End 1995

State	Operational high-risk pool[a]	Blues act as insurer of last resort	Insurance reforms		
			Guaranteed issue	Rating restrictions	Other reforms[b]
Alabama					
Alaska	X				
Arizona					
Arkansas	X				
California	X	X			X
Colorado	X				X
Connecticut	X				X
Delaware					
District of Columbia		X			
Florida	X				
Georgia					X
Hawaii					
Idaho			X	X	X
Illinois	X				
Indiana	X				X
Iowa	X		X	X	X

(continued)

[18]For more information about the various reforms passed in the small employer market, see Health Insurance Regulation: Variation in Recent State Small Employer Health Insurance Reforms (GAO/HEHS-95-161FS, June 12, 1995).

State	Operational high-risk pool[a]	Blues act as insurer of last resort	Insurance reforms		
			Guaranteed issue	Rating restrictions	Other reforms[b]
Kansas	X				
Kentucky			X	X	X
Louisiana	X			X	X
Maine			X	X	X
Maryland		X			
Massachusetts		X			
Michigan		X			
Minnesota	X			X	X
Mississippi	X				
Missouri	X				
Montana	X				
Nebraska	X				
Nevada					
New Hampshire			X	X	X
New Jersey			X	X	X
New Mexico	X			X	X
New York			X	X	X
North Carolina		X			
North Dakota	X			X	X
Ohio			X	X	X
Oklahoma	X				
Oregon	X			X	X
Pennsylvania		X			
Rhode Island		X			
South Carolina	X			X	X
South Dakota					
Tennessee					
Texas					
Utah	X		X	X	X
Vermont			X	X	X
Virginia		X			X
Washington	X		X	X	X
West Virginia				X	X
Wisconsin	X				
Wyoming	X				X

(Table notes on next page)

[a]Communicating for Agriculture, Inc., Comprehensive Health Insurance for High-Risk Individuals, ninth edition, 1995. Georgia and Texas have also passed legislation creating high-risk pools, but have yet to fund them. We have not included Maine and Tennessee in this column although they had high-risk pools in operation since 1988 and 1987, respectively. Maine terminated all remaining policies in its high-risk pool as of December 31, 1994, largely because of the passage of its individual insurance reforms, which included a guaranteed-issue provision. Also, Tennessee merged the participants in its high-risk pool into the TennCare Medicaid program as of June 30, 1995.

[b]See table 5.2 for a detailed listing of enacted insurance reforms.

About Half of the States Have Passed Individual Insurance Reforms, but Provisions Vary

To improve the availability and affordability of health insurance coverage to individual consumers, a number of states have passed legislation in recent years to modify the terms and conditions under which health insurance is offered to this market. These reforms may seek to restrict carriers' efforts to limit eligibility and charge higher premiums because of an individual's health history or demographic characteristics. We identified 25 states that from 1990 through 1995 had passed one or more reforms in an effort to improve individuals' access to this market. We found substantial variations in the ways states approached reform in this market, although reforms commonly passed included guaranteed issue, guaranteed renewal, limitations on preexisting condition exclusions, portability, and premium rate restrictions. More states may soon enact reforms in this market because of NAIC's recent recommendation of two model laws for reforms in the individual insurance market.

An explanation of the reforms follows. Table 5.2 catalogs the reforms passed by each state.[19]

[19]Certain limited consumer protection measures may predate 1990 and therefore not be included in table 5.2. For example, some states have preexisting condition limitations applicable to the individual market included under existing state insurance statutes.

Table 5.2: State Individual Market Insurance Reforms Passed From 1990 Through 1995

State	Effective date	Guaranteed renewal	Guaranteed issue	Preexisting condition exclusion	Portability	Premium rate restrictions
California	1/1/94	—	—	12/12	—	—
Colorado	7/1/94	—	—	12/12	90	—
Connecticut	10/1/93	—	—	12/12	—	—
Georgia	4/21/95	X[a]	—	—	—	—
Idaho	1/1/95	X	X 2 plans	6/12	30	X
Indiana	1/1/96	—	—	12/18[b]	30	—
Iowa	4/1/96	X	X 2 plans	12/12[c]	—	X
Kentucky	7/15/96	X	X all plans[d]	12/12	60	X
Louisiana	1/1/94	X	—	12/12	60	X
Maine	12/1/93	X	X all plans	12/12	90	X
Minnesota	7/1/93	X	—	6/12[e]	30	X
New Hampshire	1/1/95	X	X all plans	3/9[f]	0[g]	X
New Jersey	8/1/93	X	X 5 plans[h]	6/12	30	X
New Mexico	1/1/95	X	—	6/6	31	X
New York	4/1/93[i]	X	X all plans	6/12	60	X
North Dakota	8/1/95	X	—	6/12	90	X
Ohio	1/14/93	X	X 1 plan	6/12	30	X
Oregon	10/1/96	X	—	6/6	60	X
South Carolina	1/1/92[j]	—	—	5 yr/2 yr	—	X
Utah	1/1/96	X	X 1 plan[k]	6/12	90	X
Vermont	7/1/93	Not applicable[l]	X all plans	12/12	0[m]	X
Virginia	7/1/95	—	—	12/12	30	—
Washington	1/1/95[n]	X	X all plans	3/3	3 months	X
West Virginia	6/9/95	X	—	—	—	X
Wyoming	7/1/95	X	—	—	—	—

(Table notes on next page)

Note: For details on the premium rate restriction reforms that states passed, see appendix III.

[a]Coverage cannot be terminated because of individual claims experience.

[b]This provision changes to 12/12 on January 1, 1998.

[c]Applies only to the standard and basic benefits plans.

[d]Under the recent legislative changes, products only have to be offered on a guaranteed-issue basis to applicants who have been Kentucky residents for the 12 months immediately preceding the policy's effective date.

[e]It is 6/18 for individuals not previously covered by a health insurance plan.

[f]The waiting period may be no more than 3 months for individuals who incur no medical treatment expenses for the preexisting condition within that time. Otherwise, the waiting period may be no more than 9 months.

[g]If the individual, employee, or dependent did not have a health benefits plan during a period of unemployment prior to the effective date of new coverage, the lack of coverage during the period of unemployment shall be disregarded.

[h]One plan must be a basic benefits plan, one a managed care plan, and the three other plans will include enhanced benefits of proportionally increasing actuarial value. A federally qualified HMO is permitted to offer a basic benefits plan in lieu of the five plans.

[i]The preexisting condition and portability provisions took effect on January 1, 1993.

[j]The preexisting condition provision was effective July 13, 1981.

[k]The guaranteed-issue provision will be phased in beginning May 1, 1997.

[l]Vermont has continuous open enrollment.

[m]The preexisting condition period must be waived if substantially similar coverage under a prior policy was in effect for the previous 9 months. The law does not provide for a lapse in coverage.

[n]Guaranteed-issue and rating restriction provisions went into effect January 1, 1996.

Guaranteed Issue

Guaranteed issue requires all carriers that participate in the individual market to offer at least one plan to all individuals and accept all applicants, regardless of their demographic characteristics or health status. We found that 11 states required all carriers participating in the individual market to guarantee issue one or more health plans to all applicants. This provision, however, did not necessarily guarantee coverage to all individuals on demand. To limit adverse selection, carriers in most states did not have to accept individuals who qualify for employer- or government-sponsored insurance. Also, some states only required carriers to accept all applicants during a specified and usually limited open enrollment period.

States also varied in the number of plans they required carriers to guarantee issue. In states such as Idaho, the legislation explicitly defined a basic and standard benefits plan that each carrier must offer all individuals. Other states, like Maine and New Hampshire, required carriers to guarantee issue all health plans they sold in the individual market. New Jersey explicitly defined and limited the number and type of plans carriers offered in the market.

Guaranteed Renewal

Guaranteed-renewal provisions prohibit carriers from not renewing coverage to plan participants because of their health status or claims experience. Exceptions to guaranteed renewal include cases of fraud or failure to pay premiums. A carrier may choose not to renew all of its individual policies by exiting a state's market but is then prohibited from reentering the market for at least 5 years.

Preexisting Condition Limitations

Twenty-two states limited the period of time coverage can be excluded for a preexisting condition. States typically defined a preexisting condition as

- a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment during the 12 months immediately preceding the effective date of coverage;
- a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 12 months immediately preceding the effective date of coverage; or
- a pregnancy existing on the effective date of coverage.[20]

Most reform states allowed carriers to exclude coverage for a preexisting condition for up to 12 months. Some states, however, such as Oregon and Washington, limited this exclusionary period to 6 or 3 months.

Portability

Portability provisions require carriers to waive any preexisting condition limitations for covered services if comparable services were previously covered under another policy, and this previous policy was continuous to a date not more than a specified number of days before the new coverage went into effect. Among states that had passed portability reforms, the specified number of days ranged from 0 to 90. Six states had enacted

[20]Not all states explicitly list a pregnancy as a preexisting condition in their legislation, which may leave pregnancy defined as a preexisting condition open to interpretation in these states.

portability provisions of 30 days, the most common duration among reform states.

Premium Rating Restrictions

Eighteen of the 25 states included provisions in their legislation that in some way attempted to limit the amount carriers can vary premium rates or the characteristics that can be used to vary these rates. Among the seven states we visited, New Jersey, New York, and Vermont restricted carriers' rating practices and generally required all carriers to community rate their individual products with limited or no qualifications. Under community rating, carriers must set premiums at the same level for all plan participants. That is, all participants are generally charged the same price for similar coverage regardless of age, gender, health status, or any other factor. North Dakota had limited rating restrictions, and Arizona, Colorado, and Illinois essentially had no rate limitations in place.

Most of the 18 states with restrictions, however, allowed carriers to vary, or modify, the premium rates charged to individuals within a specified range according to differences in certain demographic characteristics, such as age, gender, industry, geographic area, and smoking status. For example, New Hampshire only allowed carriers to modify premium rates for differences in age, while South Carolina allowed carriers to use differences in age, gender, geographic area, industry, smoking status, occupational or avocational factors, and any additional characteristics not explicitly specified, to set premium rates.

Most of the 18 states, however, limited the range over which carriers may vary rates among individual consumers. Carriers usually establish an index, or base rate, and all premium prices must fall within a given range of this rate. For example, in Idaho premium rates were permitted to vary by no more than +/-25 percent from the applicable index rate and only for differences in age and gender. Carriers in Louisiana were allowed to vary premium rates more liberally. The state's legislation allowed carriers to vary premium rates +/-10 percent because of health status and allowed unlimited variation for specified demographic characteristics and other factors approved by the Department of Insurance.

High-Risk Pools May Be an Option for Those Denied Coverage but Remain Relatively Expensive and Enroll Few

In addition, about 25 states have created high-risk insurance programs that act as a safety net to ensure that individuals who need coverage can obtain it, although at a cost that is generally 50 percent higher than the average or standard rate charged in the individual insurance market for a comparable plan. To qualify for the high-risk pool, applicants generally have to demonstrate they have been rejected by at least one carrier for health reasons or have one of a number of specified health conditions. Officials from at least two of the state insurance departments we visited suggested that their states' high-risk pools ensure the availability of health insurance to all who needed it and prove that no access problem exists—provided the individual can afford the higher priced coverage.

Although high-risk pools exist as a safety net for otherwise uninsurable individuals, they essentially enroll an insignificant number of individuals. In fact, in at least 22 of these 25 states, less than 5 percent of those under 65 with individual insurance obtain coverage through the high-risk pool. Only in Minnesota does the pool's enrollment exceed 10 percent of the individually insured population. The low enrollment in these high-risk pools may be due in part to limited funding, lack of public awareness, and their relative expense. Some states limit enrollment and may have waiting lists. For example, California has an annual, capped appropriation to subsidize the cost of enrollees' medical care and curtails enrollment in the program to ensure that it remains within its budget. Also, insurance department officials in each of the states we visited with high-risk pools recognized the public is often unaware that these pools exist, even though carriers are often required by law to notify rejected applicants of it. Officials in two of these three states were generally unaware of the extent to which carriers complied with this requirement. And finally, although these programs provide insurance to individuals who are otherwise uninsurable, they remain relatively expensive, and many people are simply unable to afford this higher priced coverage.

Several Blues Plans Act as Insurers of Last Resort

In addition to the 11 states that require all carriers to guarantee issue at least one health plan to all individuals, the Blue Cross and Blue Shield plans in 8 states and the District of Columbia voluntarily offer at least one product to individuals during an annual open enrollment period, which usually lasts 30 days. Although these plans accept all applicants during this open enrollment period, they are not limited in the premium price they can charge an individual applicant.

Seven States Have Passed No Initiatives to Ensure Unhealthy Individuals Access to the Market

Our analysis also shows that by the end of 1995, seven states neither had passed reforms that attempted to increase access to the individual insurance market[21] nor had an operational high-risk pool or a Blues plan that acted as insurer of last resort. In these states, individuals who are unhealthy, and thus most likely to need insurance coverage, may be unable to obtain it. These states are Alabama, Arizona, Delaware, Hawaii,[22] Nevada, South Dakota, and Texas.

Federal Legislative Efforts May Also Increase Individuals' Access to Coverage

In addition to state efforts, recently passed federal legislation also attempts to increase access to the individual health insurance market. The Health Insurance Portability and Accountability Act of 1996 will affect the individual market in several ways. It will, among other things, guarantee access to the individual market to consumers with previous qualifying group coverage, guarantee the renewal of individual coverage, authorize federally tax-exempt medical savings accounts (MSA), and increase the tax deduction for health insurance for self-employed individuals.

Under this act, individuals who have had at least 18 months of continuous coverage[23] have guaranteed access to an individual market product and do not need to fulfill a new waiting period for preexisting conditions if they move from a group plan to an individual market plan. It is important to note that although this law guarantees portability, it in no way limits the premium price carriers may charge individuals for this coverage. Also, with some exceptions, the legislation requires all carriers that provide individual health insurance coverage to renew or continue in force such coverage at the option of the individual.

In addition, self-employed individuals who purchase health insurance will, beginning in 1997, have the option of establishing tax-deductible MSAs. An MSA is an account into which an individual deposits funds for later payment of unreimbursed medical expenses. To be eligible for the tax deduction, self-employed individuals must be covered under a high-deductible health plan (defined as a health plan with an annual deductible of $1,500 to $2,250 for an individual and $3,000 to $4,500 for family coverage) and have no other comprehensive coverage. As noted in chapter 3, many participants in the individual market already purchase high-deductible health coverage. An individual with an MSA can claim a tax

[21]Of these seven states, South Dakota has since passed comprehensive individual insurance reform.

[22]As stated in ch. 2, Hawaii is the only state with mandated employer-sponsored health insurance. Therefore, all employed individuals have access to health insurance through their employer.

[23]Breaks in coverage of up to 63 days are permitted under the statute.

deduction for 65 percent of his or her health plan's deductible for self-only coverage and 75 percent for family coverage.

Finally, the act increases the tax deductibility of health insurance for self-employed individuals, who constitute about one-fourth of individual market participants. Currently, self-employed individuals may deduct 30 percent of the amount they paid for health insurance for themselves as well as for their spouse and dependents. Beginning in 1997, these individuals may deduct 40 percent of this cost; 45 percent in 1998 through 2002; 50 percent in 2003; 60 percent in 2004; 70 percent in 2005; and 80 percent in 2006 and thereafter.

Concluding Observations

While employer-sponsored group plans are still the dominant source of health insurance coverage for most Americans, millions depend on an accessible and affordable individual market outside the workplace. Many Americans, including family farmers, self-employed individuals, and those working for small firms that do not offer coverage, must rely on the individual market as their permanent source of health insurance coverage. Others rely on this market between jobs and during other periods of transition. Recent trends suggest a growing share of the U.S. population will probably turn to the individual market at some point in their lives. The days of rapid expansion of both private employer and government program coverage are probably behind us. Meanwhile, employer downsizing continues, job mobility increases, and the ranks of part-time and contract workers grow.

The individual insurance market is complex, and consumers, unlike those who have access to employer-sponsored plans, are largely on their own in obtaining and financing coverage. Consumers can access the market in a variety of ways; must choose among multiple, usually nonstandardized, products offered by multiple carriers; and must select one of many cost-sharing options, each of which will have a different impact on the amount of money consumers will ultimately pay. Further adding to the complexity of this market is its high geographic variability. Depending on the state or even on the markets within a state, consumers may face an entirely different set of choices.

Many consumers face barriers to coverage in the individual market. Absent state restrictions, carriers base coverage and pricing decisions on each individual's demographic characteristics and health status. Thus in most states, those who are older or in poor health may be charged significantly higher premiums or may be denied coverage altogether. Among those with coverage in the individual market, many may be underinsured. Increasingly sold are very high deductible plans with lower premiums but greater financial risk for consumers. Many consumers may purchase these plans because they cannot afford premiums otherwise, suggesting that, unlike under medical savings accounts, a reserve to pay the high deductibles may not exist. Some consumers can only obtain coverage that permanently excludes the very medical condition for which they are most likely to need care. And other consumers—intentionally or unintentionally—purchase limited benefit policies as their only source of coverage.

Twenty-five states have recently passed legislative reforms for their individual health insurance markets and more are likely to follow. The reforms vary widely in scope from limited measures, such as those intended only to limit the length of preexisting condition waiting periods a carrier may impose, to comprehensive reforms requiring carriers to provide coverage to all who apply and use community rating to set premiums. Some states use other measures to increase individual market access or affordability, such as high-risk pools and insurers of last resort. At the federal level, the Health Insurance Portability and Accountability Act of 1996 is a recent example of federal legislation that will affect the individual health insurance market. The act guarantees access to the individual market to consumers with qualifying previous group coverage and guarantees the renewability of individual coverage. For the self-employed, the act authorizes federally tax-deductible medical savings accounts and increases the tax deductibility of health insurance. The importance of the individual insurance market to millions of Americans is a factor to be considered in weighing any further incremental measures to improve the accessibility and affordability of private health insurance.

Methodology for Estimates of Individual Health Insurance Enrollment

Our estimates of the number and percentage of people with individual health insurance in 1994 and their characteristics are based on data from the Bureau of the Census' March 1995 Current Population Survey (CPS). The CPS sample for the March 1995 survey of about 57,000 households with over 150,000 individuals was designed to be nationally representative of the civilian noninstitutional population of the United States. Because the elderly rely on Medicare rather than on individual or other types of insurance, we excluded people aged 65 and over from our analysis. As a result, our analysis was based on 131,455 people under 65 years of age, weighted to reflect the U.S. population of about 231 million nonelderly people.

Because our estimates are based on a sample of the population, they are subject to sampling errors. The standard errors (a measure of sampling error) for our estimates are generally about 1 percentage point or less. To minimize the chances of citing differences that could be attributable to sampling errors, we only highlight differences that are statistically significant at the 0.05 level.

The March 1995 CPS questions concerning health insurance coverage were significantly revised from previous annual surveys. These revisions improved the questions that focus on individual health insurance coverage but make it misleading to compare trends in the size and characteristics of the individual health insurance market with previous CPS surveys. The 1995 questionnaire asked: "At anytime during 1994, (were you/was anyone in this household) covered by a plan (you/they) PURCHASED DIRECTLY, that is, not related to current or past employer?"[24] Previously, the survey did not ask specifically about health coverage purchased directly. Instead, earlier surveys asked (1) whether anyone in the household was covered by private health insurance and (2) whether this coverage was offered by a current or former employer or union.

[24]The March 1995 CPS, for the first time, also reported on what type of health insurance coverage respondents had during the past week. Because of discrepancies in these results, however, Census has acknowledged that the results of this question remain subject to revision.

National Health Interview Survey Data on Individual Health Insurance

The National Health Interview Survey (NHIS), a nationally representative survey of the civilian noninstitutionalized population conducted by the Bureau of the Census for the National Center for Health Statistics, periodically asks questions regarding health insurance coverage.[25] In general, our analysis of the NHIS data provided results regarding individual health insurance similar to those we found using the CPS data. For example, using the 1993 NHIS data, we estimated that about 4.3 percent of the nonelderly population had individual insurance compared with 4.5 percent in 1994 using CPS data. As for CPS, estimates based on NHIS also indicate higher than national average rates of individual insurance coverage for particular segments of the population, including self-employed individuals and agricultural workers.

Tables I.1 to I.8 show the CPS estimates along with estimates based on NHIS. While the estimates are generally similar, observed differences could be attributable to several factors, including sampling errors and the slightly different populations and time periods covered (1994 for CPS versus second half of 1993 for NHIS). Furthermore, several important differences in the design of the two surveys can influence their results. For example, in contrast to CPS, which asked about insurance coverage held over the past year, NHIS asked about insurance coverage held over the past month. In addition, NHIS did not specifically ask whether the respondent directly purchased individual health insurance. Instead, the survey asked whether anyone in the family was covered by a private health insurance plan and whether that coverage was obtained through a current or former employer or union. In preparing the NHIS estimates, we assumed that the individual policy was directly purchased if the private insurance was not obtained through an employer or union.

[25]The 1993 NHIS surveyed about 43,000 households, but the health insurance coverage questions were implemented as a supplement in the second half of the year so that the sample size for these data is approximately half that of the entire survey.

Table I.1: Comparison of CPS and NHIS Estimates of Type of Insurance, Nonelderly

	CPS (1994)		NHIS (1993)[a]	
	Millions	Percent	Millions	Percent
Employment-based	150.8	65.3	151.5	67.8
Medicare	2.8	1.2	2.3	1.0
Medicaid	21.6	9.3	20.0	8.9
CHAMPUS/IHS[b]	4.4	1.9	4.3	1.9
Individual	10.5	4.5	9.6	4.3
Uninsured	40.8	17.7	35.4	15.8
Total	**230.8**	**100.0**	**223.6**	**100.0**

Notes: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Some people may receive coverage from several sources. To avoid double counting, we prioritized the source of coverage reported by CPS. For our analysis, employment-based coverage was considered primary to other sources of coverage, and respondents were classified as having employment-based coverage even if they also have other types of coverage. The other types of health insurance coverage were prioritized in the following order: Medicare, Medicaid, CHAMPUS/IHS, and individual insurance.

[a]Estimated percentages were based only on the number of people whose insurance status could be categorized from survey responses (approximately 90 percent of weighted sample). Population estimates were obtained by applying these percentages to the entire nonelderly population (223.6 million).

[b]The CHAMPUS category also includes Indian Health Service (IHS) and direct military health coverage.

Table I.2: Percentage of Nonelderly Residents Having Individual Insurance Coverage by Metropolitan Status

	CPS (1994)	NHIS (1993)
Metropolitan	**4.2**	**3.9**
Central city	•	3.5
Noncentral city	•	4.1
Nonmetropolitan	**5.7**	**5.8**
Farm	•	29.3
Nonfarm	•	4.6
U.S. average	**4.5**	**4.3**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Table I.3: Percentage of Nonelderly Population Having Individual Health Insurance by Age

	CPS (1994)	NHIS (1993)
Younger than 20	3.7	3.5
20 to 29	3.4	4.1
30 to 39	4.3	3.8
40 to 49	5.1	4.3
50 to 59	6.4	5.9
60 to 64	9.6	8.7
U.S. average (0 to 64)	**4.5**	**4.3**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Table I.4: Percentage of Nonelderly Population Having Individual Health Insurance by Race and Ethnic Groups

	CPS (1994)	NHIS (1993)
White	5.4	4.8
Black	2.0	1.9
Hispanic	2.2	2.9
Other	4.3	5.3
U.S. average	**4.5**	**4.3**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Table I.5: Percentage of Nonelderly Population Having Individual Health Insurance by Income Group

	CPS (1994)	NHIS (1993)
Below poverty level	3.7	3.8
At or above poverty level	4.7	4.4
U.S. average	**4.5**	**4.3**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Table I.6: Percentage of Self-Employed Population Aged 18 to 64 Having Individual Health Insurance

	CPS (1994)	NHIS (1993)
Self-employed	19.7	19.7
U.S. average (ages 18 to 64)	**4.9**	**4.7**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Table I.7: Percentage of Population Aged 18 to 64 Having Individual Health Insurance by Industry

	CPS (1994)	NHIS (1993)
Agriculture, forestry, and fisheries	16.9	19.1
Personal services, including private households	7.8	8.2
Construction	7.3	6.3
Business and repair services	7.2	5.2
Entertainment and recreation services	6.9	8.3
Finance, insurance, and real estate	5.4	4.7
Retail trade	5.1	5.0
Wholesale trade	4.7	5.0
Professional and related services	4.1	4.3
Transportation, communication, and other public utilities	2.8	1.7
Mining	2.3	3.8
Manufacturing	2.1	1.8
Public administration	1.2	1.4
U.S. average (ages 18 to 64)	**4.9**	**4.7**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Table I.8: Percentage of Population Having Individual Health Insurance by Health Condition

	CPS (1994)	NHIS (1993)
Excellent	5.1	4.9
Very good	4.4	4.4
Good	4.0	3.6
Fair	3.7	3.2
Poor	2.5	1.9
U.S. average (ages 0 to 64)	**4.5**	**4.3**
Not in labor force due to disability	2.1	2.3
U.S. average (ages 18 to 64)	**4.9**	**4.7**

Note: CPS asked about insurance coverage at any time during 1994; NHIS asked about insurance coverage during the preceding month in 1993.

Other Estimates of the Size of Individual Insurance Market

The Health Insurance Association of America (HIAA) estimates that 10.4 million Americans receive individual health insurance. In addition, HIAA notes that an additional 5.4 million Americans received individual "hospital only" indemnity coverage in 1992.[26] While HIAA's results are

[26]See Health Insurance Association of America, "The Cost of Group-to-Individual Portability: Why Do HIAA and AAA Estimates Differ?"; and Source Book of Health Insurance Data: 1994 (Washington, D.C.: 1995), p. 37.

similar to our findings, the estimates are not directly comparable. First, our analysis of CPS is based on how many people received individual health insurance only at some point during the previous year, whereas HIAA's estimate is compiled from insurer-reported enrollment figures. In addition, HIAA excludes health coverage that is obtained through an association of other individuals (not employers). From an insurer's perspective, these association plans are group health insurance. From many enrollees' perspectives, however, these plans are similar to individual health insurance since they generally pay the entire premium and the plan is not offered through their employment. In addition, some states are beginning to regulate these health plans as individual health insurance. We anticipate this trend will accelerate as states adopt standardized individual reform statutes based on the model act recently recommended by the National Association of Insurance Commissioners.

The Employee Benefit Research Institute (EBRI) reports that 16.4 million nonelderly Americans received "other private" health insurance during 1994, based on an analysis of the March 1995 CPS, and notes that "this category consists primarily of individually purchased private insurance."[27] Several differences in methodology account for the differences in EBRI's estimates and ours. Most importantly, EBRI's analysis was based on the original Census data from the March 1995 CPS, whereas our analysis included supplemental data provided by Census after EBRI's analysis was completed. The supplemental data enabled us to more accurately identify people with individual insurance coverage. For example, it enabled us to excluded people who received health coverage through a person in another household from the individual health insurance category because only a small minority of these people would have had individual health insurance. This could result in a small underestimate of the number of people with individual health insurance during 1994. Assuming that the same share of this group had individual health insurance as the nonelderly population with health coverage, then our estimates would be understated by about 400,000 people. Another difference in the numbers reported by EBRI is that their "other private" category also includes people who would have received Medicare, Medicaid, or CHAMPUS as well as individual health insurance, whereas our analysis is based on people who had individual health insurance only.

On the basis of EBRI's analysis, the American Academy of Actuaries estimated that 13.1 million to 14.8 million Americans received individual

[27]"Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1995 Current Population Survey," EBRI Issue Brief Number 170 (Washington, D.C.: EBRI, Feb. 1996).

health insurance. This estimate assumed that 80 to 90 percent of those privately insured in the United States by means other than through an employer would be considered to have individual health insurance.[28]

[28]American Academy of Actuaries, "Comments on the Effect of S. 1028 on Premiums in the Individual Health Insurance Market" (Washington, D.C.: 1996).

Estimates of Individual Health Insurance Enrollment by State, Nonelderly Population, 1994

State	Number of people with individual insurance	Percentage of nonelderly population[a]		
		Individual	Employment-based	Uninsured
New England	**490,137**	**4.3**	**72.7**	**13.9**
Maine	72,714	7.1	65.3	16.1
New Hampshire	48,668	4.9	74.9	12.6
Vermont	28,445	5.4	73.6	10.9
Massachusetts	185,794	3.5	72.4	15.0
Rhode Island	33,356	4.1	72.0	13.9
Connecticut	121,160	4.4	75.3	12.2
Middle Atlantic	**1,542,709**	**4.7**	**67.2**	**15.7**
New York	751,529	4.7	62.5	18.2
New Jersey	380,968	5.5	70.8	14.9
Pennsylvania	410,212	4.0	71.8	12.5
East North Central	**1,545,573**	**4.0**	**72.2**	**13.0**
Ohio	322,895	3.3	72.2	13.0
Indiana	388,907	7.3	70.6	12.1
Illinois	427,344	4.1	70.4	14.7
Michigan	275,104	3.3	71.9	12.7
Wisconsin	131,323	2.9	79.0	10.7
West North Central	**1,096,972**	**7.0**	**70.1**	**13.1**
Minnesota	313,749	7.8	72.2	12.8
Iowa	238,726	10.0	71.2	11.4
Missouri	129,170	3.0	71.8	13.9
North Dakota	74,895	13.7	64.3	10.6
South Dakota	65,125	10.0	68.1	12.3
Nebraska	149,477	10.1	68.3	12.6
Kansas	125,829	5.6	65.3	15.0
South Atlantic	**1,778,284**	**4.4**	**65.3**	**17.2**
Delaware	12,048	2.0	73.7	15.5
Maryland	169,876	3.8	73.9	13.7
District of Columbia	16,760	3.1	58.7	17.6
Virginia	170,355	2.8	71.0	13.7
West Virginia	36,838	2.4	62.0	20.0
North Carolina	266,574	4.4	65.3	15.5
South Carolina	112,911	3.5	69.4	16.5
Georgia	229,063	3.5	64.9	18.2
Florida	763,859	6.4	58.9	20.4
East South Central	**578,592**	**4.1**	**63.4**	**18.3**

(continued)

State	Number of people with individual insurance	Percentage of nonelderly population[a]		
		Individual	Employment-based	Uninsured
Kentucky	77,441	2.3	64.5	17.5
Tennessee	244,798	5.1	65.1	15.1
Alabama	115,974	3.1	65.0	22.1
Mississippi	140,379	6.2	55.7	19.9
West South Central	**1,062,166**	**4.1**	**57.3**	**25.5**
Arkansas	68,797	3.3	62.4	21.5
Louisiana	205,693	5.2	55.5	21.3
Oklahoma	148,818	5.3	59.8	22.1
Texas	638,858	3.7	56.7	27.4
Mountain	**714,485**	**5.1**	**65.7**	**18.7**
Montana	66,295	9.1	64.1	17.8
Idaho	69,849	6.9	67.1	16.6
Wyoming	39,882	8.9	64.3	17.6
Colorado	230,434	6.7	69.8	13.8
New Mexico	43,672	2.9	53.4	26.6
Arizona	109,664	2.9	60.2	24.0
Utah	116,847	6.7	74.7	12.8
Nevada	37,843	2.8	72.6	17.7
Pacific	**1,642,223**	**4.4**	**58.6**	**21.7**
Washington	337,995	7.2	63.7	15.2
Oregon	123,039	4.4	67.2	19.3
California	1,150,284	4.1	56.4	23.4
Alaska	14,147	2.5	63.2	17.2
Hawaii	16,758	1.8	71.4	11.6
United States	**10,451,139**	**4.5**	**65.3**	**17.7**

Notes: Standard errors for our estimates of the percentage of the nonelderly population with individual health insurance range from 0.3 in California and New York to 1.3 in North Dakota. Therefore, confidence intervals at the 95-percent level for the state estimates range from about +/-0.6 to 2.6 percentage points, and small differences between states may not be statistically significant.

Percentages do not total to 100 across the rows because Medicare, Medicaid, and CHAMPUS categories are not included. Employment-based and uninsured categories are included for comparison purposes.

This table groups states according to standard Census regions. For the sake of simplicity, in the body of this report we use “Plains states” to refer to the 7 states in the West North Central Census region and “Southern region” to refer to the 17 states in the South Atlantic, East South Central, and West South Central Census regions.

State Restrictions Related to Premiums

State	Premium rate restriction
Idaho	Premium rates may not vary by more than 25 percent of the applicable index rate for age and gender only. The Director of Insurance may approve additional case characteristics.
Iowa	Premium rates may not vary by more than 100 percent from the applicable index rate for demographic characteristics approved by the Commissioner of Insurance. The legislation does not specify these characteristics, but they include age, gender, and geographic location.
Kentucky	Premium rates may not vary by more than a 5:1 ratio for all case characteristics. Allowable case characteristics (and maximum allowable variation if specified) are age (300 percent), gender (50 percent), occupation or industry (15 percent), geography, family composition, benefit plan design, cost containment provisions, whether or not the product is offered through an alliance, and discounts (up to 10 percent) for healthy lifestyles.
Louisiana	Adjusted community rating is required with variation of +/-10 percent currently allowed for health status, and unlimited variation allowed for specified demographic characteristics and other factors approved by the Department of Insurance.
Maine	Adjusted community rating is required with variation allowed of no more than +/-20 percent of the community rate for age, smoking status, occupation, industry or geographic area.
Minnesota	Premium rates may vary from the index rate +/-25 percent for health status, claims experience, and occupation, and +/-50 percent of the index rate for age. Premium rates may also vary by up to 20 percent for three geographic areas.
New Hampshire	Adjusted community rating is required with a maximum variation of 3:1 allowed for age only.
New Jersey	Community rating is required.
New Mexico	Until July 1, 1998, premium rates may vary for age, gender (no more than 20 percent), geographic area of the place of employment, smoking practices, and family composition (by no more than 250 percent). Thereafter, every carrier shall charge the same premium for the same coverage to each New Mexico resident, regardless of demographic characteristics or health status. The only allowable rating factor will be age—whether the person is over or under the age of 19.
New York	Pure community rating is required within specified geographic regions.

(continued)

State	Premium rate restriction
North Dakota	Premium rates charged to individuals within a class for the same or similar coverage may not vary by a ratio of more than 5:1 for differences in age, industry, gender, duration of coverage, geography, family composition, healthy lifestyles, and benefit variations. Gender and duration of coverage may not be used after January 1, 1997.
Ohio	Premiums charged to individuals may not exceed 2.5 times the highest rate charged to any other individual with similar case characteristics.
Oregon	Each carrier must file a geographic average rate for its individual health benefit plans. Premium rates shall not vary from the individual geographic average rate, except for benefit design, family composition, and age. Legislation does not limit this variation but indicates that age adjustments must be applied uniformly.
South Carolina	Premium rates charged to individuals with similar demographic characteristics may not vary by more than 30 percent. The legislation specifically states that age, gender, area, industry, smoking, and occupational or avocational factors may be used to set premium rates but does not prohibit the use of additional characteristics. The only exception is durational rating, which is explicitly prohibited.
Utah	A variation of +/-25 percent is allowed for health status or duration of coverage. Carriers may also vary premiums because of differences in age, gender, family composition, and geographic area by actuarially reasonable rates, as defined in NAIC guidelines. Premiums may also be rated-up 15 percent for industry. The index rates carriers use for their individual business may be lower than or equal to, but not any higher than, the index rates they use for their small-employer business.
Vermont	Adjusted community rating is required with maximum allowable variation of +/-20 percent for limited demographic factors.
Washington	Adjusted community rating is required with variation allowed for geographic area, family size, age, and wellness activities. Permitted rates for any age group cannot exceed 425 percent of the lowest rate for all age groups on January 1, 1996; 400 percent on January 1, 1997; and 375 percent on January 1, 2000, and thereafter. The discount for wellness activities cannot exceed 20 percent.
West Virginia	Premium rates charged to individuals with similar demographic characteristics may not vary by more than 30 percent. The legislation specifically states that age, gender, area, industry, smoking, and occupational or avocational factors may be used to set premium rates but does not prohibit the use of additional characteristics. The only exception is durational rating, which is explicitly prohibited.

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Related GAO Products

Health Insurance Portability: Reform Could Ensure Continued Coverage for Up to 25 Million Americans (GAO/HEHS-95-257, Sept. 19, 1995).

Health Insurance Regulation: National Portability Standards Would Facilitate Changing Health Plans (GAO/HEHS-95-205, July 18, 1995).

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