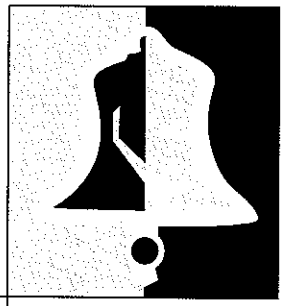
Non-group insurance: not a quick fix for health care



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Non-group insurance: not a quick fix for health care

Executive summary

Increasingly, the individual insurance market is being discussed as a mechanism for providing greater coverage for the uninsured. In an effort to better inform the discussion, this paper examines demographic and contextual aspects of the individual, or non-group, market nationally and in Colorado.

Our analysis shows that the non-group market has limited potential to reduce the number of uninsured. There are a variety of reasons – all of which illustrate the complexities that must be unraveled to produce significant reform.

The chief limitations are summarized in a May 2009 *Consumer Reports* investigation. According to the report, an estimated 14,000 Americans lose employment-based insurance every day. Many are not eligible for public insurance programs, and many can't afford COBRA payments. There are few options for maintaining coverage other than purchasing non-group health insurance. But non-group insurance can leave individuals with substantial medical debt if they fall seriously ill, and for those with less than perfect health, coverage can be extremely expensive or even impossible to get.[1]

In a similar vein, the Colorado Centennial Care Choice final report[2] concluded that to be viable, Colorado's individual market needs to strike a balance between adequate coverage and affordability. The report also points out that the state's lowest income uninsured citizens would not be able to afford non-group coverage without significant subsidies and requirements that all individuals be covered and that insurers provide coverage to them.

While tax incentives, state subsidies, insurance mandates and improved state oversight are promising strategies for expanding non-group coverage, this analysis suggests that a number of less conspicuous factors could hinder these efforts.

For instance, there is a surprising lack of diversity among enrollees. Minority populations are significantly under-represented; enrollment is unevenly distributed among occupations, age groups and education levels; and geographic disparities make coverage unrealistic for many rural residents.

Employer-based health insurance is still the most common type of coverage for American workers, but increasing health care costs are making it difficult for both employers and workers to afford quality health insurance coverage.

Public health insurance programs provide a vital safety net for low-income parents and children. While expansions have been made, they have not fully offset the number of people losing employer-based coverage, and even families with employer-based coverage are turning to public coverage for children.

On the surface, the individual market seems a simple way to address gaps in coverage and bring more people into the health care system. Coverage is not tied to an employer and is thus portable, benefits can be individually tailored and premiums seem to cost less than employer-based policies.

But it is not so simple, and indeed, even though the individual market is touted as an affordable mechanism for continuous and portable coverage, the relatively small number of people enrolled at any given time suggests that it is not an accessible product. Moreover, selling and administrative expenses in the non-group market keep premium costs high.

Overwhelmingly, people prefer employer-based health coverage. Individual coverage is generally used only as a temporary bridge between employment-based coverage – people hold a non-group policy, on average, less than eight months. Current tax policies favor employer-based coverage, and only very few non-group enrollees receive tax benefits. With unlimited ability to discount or increase premium costs based on a comprehensive assessment of one's health status, the individual market often denies coverage to people with pre-existing or chronic conditions while attracting mostly healthy people with few health care needs or expenses.

Without a candid debate and substantial restructuring, the individual market will continue as a residual market that serves a select subpopulation while excluding less healthy, lower-income and/or non-traditional workers without insurance or with less-than-adequate coverage.

This paper sorts through some of the non-group market literature while overlaying the information with national and Colorado data from the Current Population Survey.

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Summary of critical findings

- Though employer-based health insurance has declined since 2000, most workers (62 percent) prefer employer-based health benefit plans.
- Since 1994, the percentage of people enrolled in the individual market has remained around 7 percent[3], regardless of changes in employer-based coverage, Medicaid expansions or numbers of uninsured.
- Enrollment in the non-group market is transitory and used primarily as a bridge between employer-based coverage – the median length of non-group enrollment is eight months, with most people holding policy for less than six months.[4]
- The non-group market serves a limited population:
  - o Enrollees are more likely to have sales and service occupations (48 percent), whereas those with farming, fishing and forestry occupations are the least likely to be enrolled – less than 1 percent.
  - o People between 45 and 64 are more likely to be enrolled in non-group coverage than are young adults between 19 and 26 years of age.
  - o Enrollees are more likely to have attended college or have a bachelor's degree.
  - o Non-group enrollees have moderate to high family median incomes – $60,000 or more.
  - o Minority populations are significantly underrepresented. Nationally and in Colorado, more than 80 percent of non-elderly enrollees are non-Hispanic white.
  - o Healthier people are much more likely to be enrolled in a non-group plan than less healthy people. In Colorado, 74 percent of enrollees are in excellent to very good health and 2 percent are in poor health. In comparison, 77 percent of Coloradans erolled in employer-based coverage are in excellent health and 5 percent are in poor health.
- People with pre-existing or chronic conditions are often denied coverage. For those that do obtain and keep coverage, age and gender drive premium costs more than do chronic conditions.
- Non-group premiums are comparatively lower than employer-based coverage; however, benefits are not equivalent. Non-group coverage is often less comprehensive and out-of-pocket costs are generally higher than employer-based coverage.
- Non-group enrollees pay the full cost of insurance premiums but receive minimal tax benefits.
- The non-group market does not behave like the group market. Turnover is high, with most people dropping non-group coverage as soon as they are able to enroll in an employer's plan. In the individual market, because more time is spent per customer, administrative and sales expenses are high. To keep premiums down, benefits are usually less comprehensive and out-of-pocket expenses are greater.

Introduction

As the economic crisis deepens, increasing numbers of middle-income Americans fear losing their health coverage along with their jobs. Despite discussions to provide everyone with affordable health insurance,[5] the fact remains: once employer-based insurance is gone, obtaining affordable quality health care can be difficult if not impossible.

Before the 2009 stimulus package, an analysis by the Kaiser Commission on Medicaid and the uninsured found that for every one-percentage-point rise in the national unemployment rate, the number of uninsured grows by 1.1 million.[6]

Continuous health coverage is an ideal, and policymakers have long recognized that gaps in insurance coverage create barriers to accessing health care services. For those ineligible for Medicaid and Medicare, federal laws such as the Health Insurance Portability and Accountability Act (HIPAA) and the Consolidated Omnibus Budget Reconciliation Act (COBRA) were passed to help bridge gaps when employer-based insurance is lost.

Most recently, for many who became unemployed, the American Recovery and Reinvestment Act of 2009 dedicated $24.7 billion to provide a 65 percent federal subsidy for premiums under COBRA for up to nine months.

But what happens when COBRA coverage ends, or you can't afford to pay the premium cost or your next employer doesn't offer health insurance?

Many will seek coverage through the individual market. Purchasing insurance directly from a carrier has advantages – choosing a tailored plan that fits with

one's lifestyle (rather than having to select from a limited number of plans chosen by an employer), portability (so changing jobs does not mean lost health benefits) and cheaper premiums (compared to the cost of employer-based premiums).

But the individual market, as it currently functions, is not a viable option for many, and its low usage suggests that it is not a popular product. People with chronic or pre-existing conditions such as asthma, diabetes or pregnancy may not be able to buy individual health insurance. For those who purchase non-goup coverage, cheaper premiums often mean limited, less comprehensive benefits, and as people age, non-group premiums tend to increase more sharply than do employer-based premiums, making affordability a greater concern.

This paper identifies demographic characteristics using Current Population Survey (CPS) data. It also describes contextual patterns of use by incorporating available literature to provide a primer and guide for policy decision-making.

There are six sections, each describing various parts of the individual, or nongroup, market – both terms are used interchangeably.

Section 1 identifies and describes the current situation regarding the two primary sources of health insurance for the non-elderly (19 to 64) population: employer-based and public health coverage. Employer-based health coverage continues to erode as health care costs continue to grow. While public program enrollment in Medicaid and SCHIP has increased, it has not fully offset the decline in employer-based coverage. Though the growth in the number of uninsured has slowed slightly since 2006, numbers will grow as the economic crisis deepens.

Section 2 begins the conversation about the individual market. This section examines the trends and population characteristics of non-group enrollees nationally and in Colorado using CPS data and findings from the research literature. The data show that enrollment has remained about 7 percent since 1994 – in periods of growth as well as economic downturns. Enrollees are likely to be non-Hispanic white, older, better educated, have moderate to high incomes and report having excellent to very good health.

Section 3 takes a closer look at the individual market by examining usage patterns and existing federal and state regulations.

Coverage in the individual market is almost always temporary – most people return to employer-based coverage as soon as they are able. Unless one is HIPAA-eligible, coverage in the individual market is not guaranteed. For those with pre-existing or chronic conditions, policies can be expensive and fall short in covering health needs. While Colorado has a high-risk insurance pool, high premium costs – 140 percent of the standard market rate – make affordability a concern.

Section 4 examines the impact of medical underwriting practices on coverage and affordability. Because the individual market is largely unregulated, insurers have a great deal of latitude to underwrite policies using an individual's medical history. Though pre-existing and chronic conditions increase premium costs, age, gender and geography are considered greater risks.

The insurance industry notes that individual market premiums are less costly than group or employer-based premiums. Preference for group coverage over individual coverage suggests, however, that lower premium costs alone do not encourage greater participation. Moreover, research shows that subsidies such as health care tax credits do not diminish people's preference for employer-based coverage, and subsidies have only a small effect on decreasing the number of uninsured.

Section 5 examines the market shares held by carriers offering individual health insurance products in Colorado. The state has an individual market with many sellers going after relatively small amounts of business. High turnover and aggressive medical underwriting create a market that allows carriers a greater ability to segment customers according to their health and potential profitability, resulting in a market that serves primarily healthier and higher-income people.

Section 6 highlights concerns and factors to consider.

Section 1

Sources of health insurance for U.S. non-elderly

Historically, employer-based insurance has been the primary way people obtain health coverage. While this is still largely the case, employer-based insurance has eroded substantially since 2000, and the number of uninsured has increased. Without employer-based insurance, those eligible may enroll in Medicaid or

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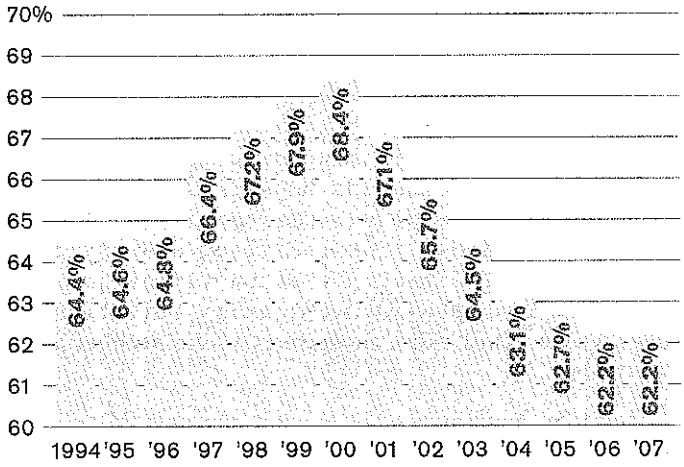
Medicare, but for those who are not eligible, the only option is to seek coverage in the non-group market – or join the ranks of the uninsured.

The decline of employer-based insurance

Historical data compiled by the Employee Benefit Research Institute highlight the decline in employer-based insurance (figure 1). Employee health care under employer-based plans peaked at 68.4 percent in 2000.

Figure 1

U.S. non-elderly population with employer-based insurance, 1994-2007



Source: EBRI Issue Brief No. 321, September 2008, p. 5.

Note to readers: *Information beyond data presented in the charts comes from a number of sources.The additional descriptions and explanations are intended to help the reader place the purchasing of health insurance in general and non-group insurance in particular in a broader context. The larger view allows for a more informed perspective in which to understand policy issues and potential policy solutions.*

Note on charts: *The data presented in this section's charts is derived from 2007 and 2008 Employee Benefit Research Institute (EBRI) issue briefs. These briefs provide historic data from 1994 to 2007 on the number and percentage of non-elderly individuals with and without health insurance using Current Population Survey (CPS) data. Since 1980, CPS has asked separate questions about employment-based health insurance, health insurance purchased directly from an insurer, insurance from a source outside of the household, Medicare, Medicaid, Tricare, CHAMPVA, Indian Health Service, or other state-specific health programs for low-income uninsured individuals. For more information regarding EBRI's methodology please visit www.ebri.org.*

Since then, employer-based coverage declined to 62.2 percent.[7]

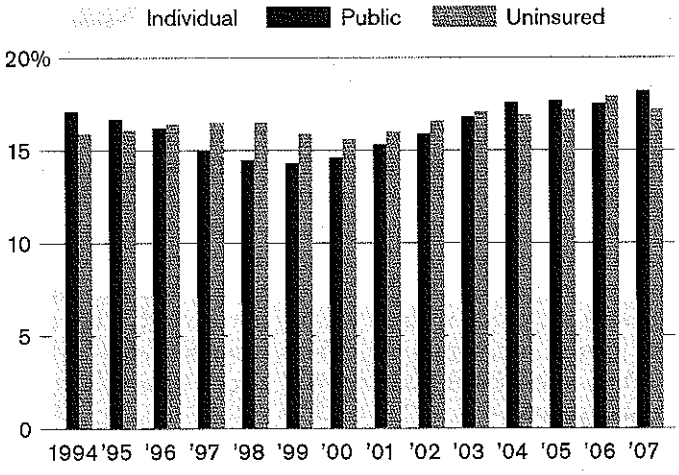
People working in small businesses have endured the sharpest decline in employer-based insurance. Very small businesses, those with three to nine workers, have been especially hard hit. Data from the annual *Kaiser/HRET Survey* found that 56 percent of these businesses offered health coverage in 1999. By 2007, only 45 percent offered coverage.[8]

Public insurance programs

Enrollment in public insurance programs has increased, but its growth has neither offset the drop in employer-based coverage nor decreased the number of uninsured (figure 2). The percentage of non-elderly Americans enrolled in public insurance programs increased from 14.3 percent in 1999 to 18.2 percent in 2007.

Figure 2

Health insurance coverage of U.S. non-elderly population, 1994-2007



Source: EBRI Issue Brief No. 321, September 2008, p. 5.

Research by the Agency for Healthcare Research and Quality (AHRQ) suggests that some of the increased enrollment in public insurance programs is indicative of a new trend. As employment-based coverage is lost or becomes unaffordable, a growing number of lower-income working families rely on a combination of private and public insurance, like the State Children's Health Insurance Program (SCHIP), to cover family members.[9]

For example, AHRQ found that from 1997 through 2005,[10] about two-thirds of single-parent families and more than half of two-parent families without access to

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employer-based coverage had at least one family member with public coverage. Even for families with access to employment-based coverage, the researchers found that nearly half of minority single-parent families had at least one member with public coverage.[11]

Through 2007, growth in the percentage of uninsured slowed slightly

The percentage of uninsured increased from a low of 15.6 percent in 2000 to a high of 17.9 percent in 2006. In 2007, the percentage dropped slightly to 17.2 percent (figure 2).

Numerous studies reveal that most uninsured, nearly 83 percent, live in families headed by a worker. In general, uninsured individuals and families have lower incomes, higher unemployment rates and work in the agriculture, forestry, fishing, mining, construction, the wholesale and retail trades or service industries.[12]

The uninsured also share ethnic, gender and age characteristics. For instance, individuals of Hispanic origin are more likely to be uninsured than other groups. Men are generally more likely than women to be uninsured, except for 55- to 64-year-olds, where women are more likely to be uninsured. Younger adults are more likely than older adults to be uninsured.[13]

The percentage of people with non-group health coverage has remained around 7 percent since 1994 (figure 2).

Note on data: *CPS data were used in this section for both Colorado and the nation. All estimates are derived using the U.S. Census Bureau, CPS Table Creator. Three years of data (covering calendar years 2005-07) are averaged to increase the sample size to a level that is sufficient to provide reliable estimates for Colorado.*

Data were not adjusted for Medicaid undercount or non-group overcount. Research examining household survey data suggests that a portion of survey respondents with public coverage (i.e., Medicaid and SCHIP) mistakenly report that they have private coverage, such as employer-sponsored or nongroup coverage. Consequently, these data underestimate public insurance enrollment[14] and overestimate the number of the non-group population.[15] Nevertheless, if these state and national data were adjusted, a similar pattern would be revealed though the proportion of non-group enrollees would be less. For example, using CPS data, the Colorado Health Institute found that six percent of nonelderly Coloradans were covered by non-group coverage for 2001-2002.[16] In comparison, the Lewin Group, also using CPS data and the Health Benefit Simulation Model (HBSM), estimated that 3.5 percent of Coloradans purchased coverage in the non-group market for 2004-2006.[17]

Summary

Though employer-based coverage continues to decline, it remains the primary source of health coverage for most people. While there has been a slight uptick in the number of people with public health insurance, this has neither fully offset the declines in employment-based coverage nor greatly reduced the number of uninsured, and the non-group market share has remained relatively stable regardless of changes.

Section 2

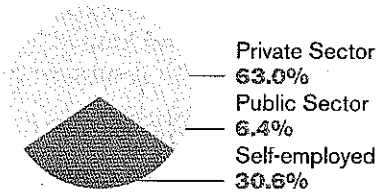
Non-group health coverage, trends and population characteristics

This section takes a closer look at trends and characteristics of the non-elderly (19 to 64 years of age) population with non-group health insurance.

Using CPS data and contextual factors such as work sector, occupation and firm size to identify employment patterns associated with non-group coverage. It also explores the similarities and differences between Colorado and national non-group enrollees.

Figure 3

U.S. workers 18 to 64 years with non-group coverage, 2007



Source: EBRI Issue Brief No. 321, September 2008, p. 12.

Non-group enrollment and occupation

Almost two-thirds of workers with non-group coverage work in the private sector (figure 3). This sector includes specialized trade and professional associations. Nearly one-third of people with non-group coverage are self-employed, while only 6 percent work in the public sector – areas such as education, public transportation, health services and corrections.

Most workers with non-group coverage work in service or sales occupations. In contrast, less than 1 percent of non-group enrollees work in farm, fish and forestry occupations (figure 4).

A higher percentage of small firms (fewer than 10

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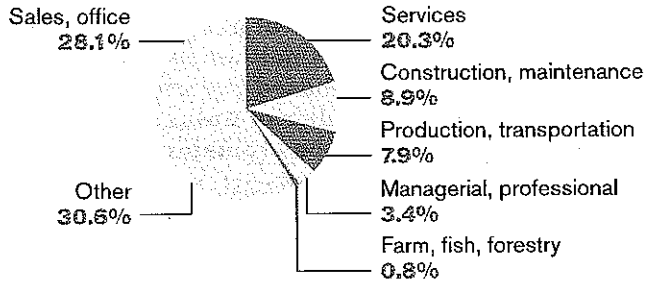
Figure 4
Non-elderly workers with individual coverage by occupation, 2007



Source: EBRI Issue Brief No. 321, September 2008, p 14.

workers) or very large firms (1,000 or more) have workers that are enrolled in the non-group market. It is not exactly clear why this pattern exists (figure 5).

A RAND Corporation study found that from 2000 through 2005, the median cost of providing health insurance for workers relative to payroll increased dramatically for small firms with fewer than 25 workers (43.5 percent) and large firms with more than 100 workers (39.5 percent). Costs were far less dramatic among midsize firms, 25 to 49 workers (10.3 percent).[18]

As the cost of providing health insurance to workers increases, employers tend to either drop benefits or push more health care costs onto workers in the form of higher deductibles, co-pays and limited benefits.[19] Higher employer-based health insurance costs may lead some healthier workers to seek lower-cost coverage in the non-group market.

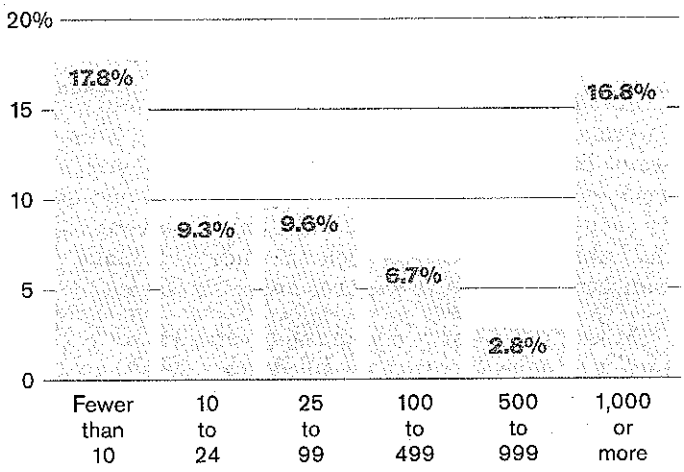
If this is true, there may be additional challenges in both the employer-based group market and the non-group market, such as "adverse retention," **19 (93)** meaning people with greater medical needs will remain in employer-based coverage.

Premiums in the non-group market, like premiums in the group market, increase annually. From 2002 to 2005, the average non-group premium policy increased 17.8 percents – a lower growth rate than employer-based premiums. But non-group *family policies* increased by 25.3 percent and older purchasers consistently paid higher premiums overall.[20]

With the current economic downturn, more people are losing coverage as they lose jobs. As a consequence, non-group market enrollment appears to be increasing dramatically – so too are non-group premiums.

According to a *USA Today* report, non-group enrollment has grown 18 to 24 percent since 2008 and early 2009. At the same time, non-group premium costs are increasing dramatically. For example, in 2009, Anthem Blue Cross in California has notified about 80 percent if its 800,000 individual policyholders of double-digit increases, many above 30 percent, and Blue Cross of Michigan requested a 56 percent increase in premiums for non-group policyholders.[21]

Figure 5
Firms providing non-group coverage, number of employees, 2007



Source: EBRI Issue Brief No. 321, September 2008, p. 12.

Non-group population characteristics

Enrollment in non-group insurance increases with age, especially for people above the age of 44 (figure 6). Interestingly, more than 20 percent of people aged 65 and older purchase non-group insurance, likely reflecting the purchase of Medicare supplemental plans (data not shown).

Almost half (49 percent) of young adults (19 to 26) were enrolled in an employer-based health plan in 2006. Ten percent were enrolled in a non-group health plan, and 10 percent were enrolled in Medicaid. About one in three young adults had no health insurance.[22] According to the Lewin Group, more than one-third (38.7 percent) young Colorado adults (19 to 24) were without insurance in 2004-06.[23]

Purchasing non-group health insurance is unaffordable for most young adults. Half of uninsured young adults live in households with incomes below the federal poverty level. Young adults are more likely to work in lower-paying, entry-level jobs that do not offer health coverage or offer coverage that is too costly.

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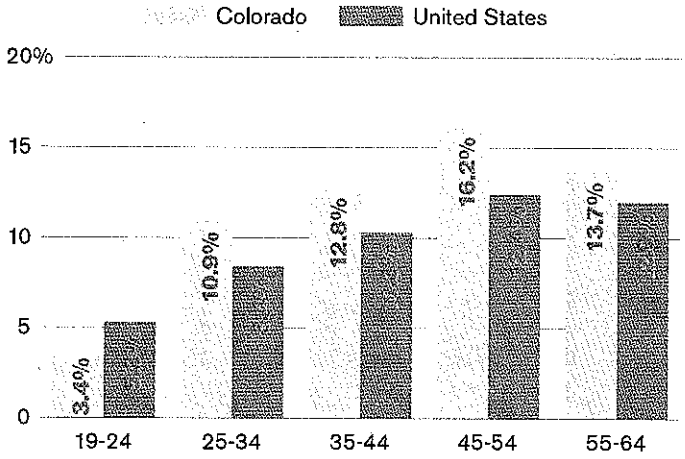
Figure 6

Percent of population with non-group coverage by age, 2005-2007

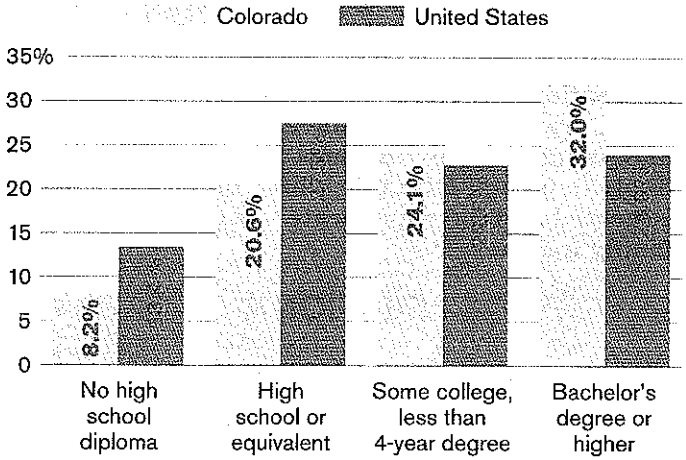


Source: All data from CPS table creator for 2005-2007 (not adjusted)

To address the growing concern of uninsured young adults, an increasing number of states are allowing young adults to be covered under a parent's plan until age 25 – and a few states allow coverage until age 30.[24] Since January 2006, Colorado has allowed adult children to be covered under a parent's group health plan until their 25th birthday as long as they are unmarried, financially dependent or share the same permanent address (HB 05-1101). However, this is not automatic; an employer must choose this option.

Figure 7

Non-elderly population with non-group coverage by educational attainment, 2005-2007



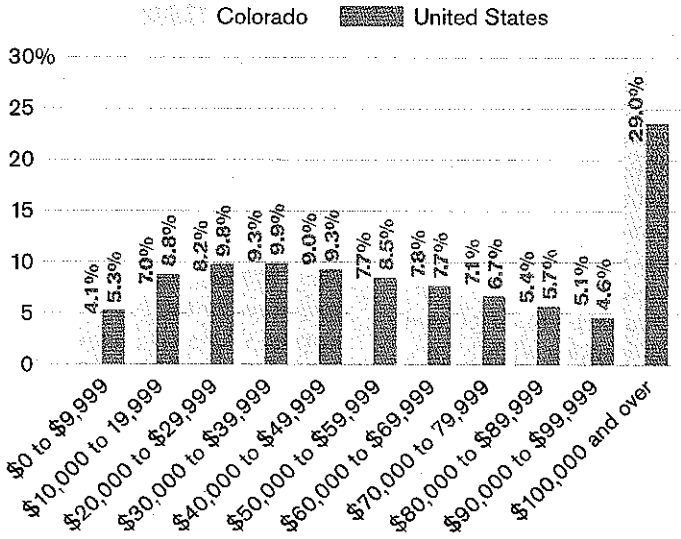
Source: All data from CPS Table Creator for 2005-2007 (not adjusted)

People with less than a high school education are much less likely to purchase non-group coverage than those with more education (figure 7).

People with higher incomes are much more likely to purchase non-group coverage – especially in Colorado. More than half (54 percent) of non-elderly buyers have median family incomes of $60,000 or more (figure 8). People with incomes at or below 100 percent of the federal poverty level ($10,210 for a single person, $17,170 for a family of three in 2007) are the least likely to purchase non-group coverage. Almost one-third of non-elderly buyers have median family incomes of $100,000 or more. This is consistent with other research showing that as income increases, non-group coverage rates also increase.[25]

Figure 8

Non-elderly population with non-group coverage by median family income, 2005-2007



Source: All data from CPS Table Creator for 2005-2007 (not adjusted)

Low non-group enrollment is often considered an affordability problem – especially for lower-income families. A recent study by the Kaiser Family Foundation found that even well-off individuals chose to remain uninsured rather than purchase non-group coverage when not offered coverage at work. According to the study,[26] only about a quarter of people at four times the federal poverty level ($38,292 for an individual and $74,640 for a family of four) purchased non-group coverage. Only about half of individuals earning 10 times the federal poverty level ($95,730 for an individual and $186,600 for a family of four) purchased non-group coverage between 2000 and 2003.

The Kaiser findings affirm that non-group

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enrollment increases with income, but the findings also suggest that non-group coverage is not easy to get, regardless of income.[27] Aggressive medical underwriting procedures and prohibitions on pre-existing conditions are believed to be contributing factors, although other resarch finds that age and gender are more influential.

For employer-based coverage, however, having a pre-existing condition is not associated with a lack of coverage. But having a low income is.[28] In 2004, for example,only about 20 percent of families with low incomes had employer-based coverage compared to 84 percent of families with high incomes.[29]

The importance of insurance in accessing health care is well-documented.[30] The research also shows that minorities are much less likely to have coverage than are non-Hispanic whites,[31, 32, 33] much less likely to have health insurance offered through their jobs[34] and significantly less likely to purchase non-group health insurance. More than 80 percent of enrollees in the non-group market are non-Hispanic white (figure 9). In Colorado in 2007, 71 percent of the population was non-Hispanic white. For the U.S., the figure is 66 percent.[35]

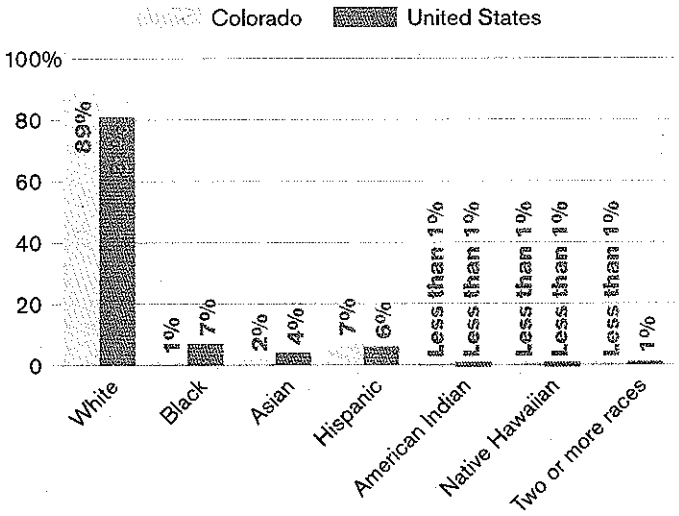
Colorado is primarily a rural state. Of the state's 64 counties, 47 are designated rural, and only two counties, Denver and Broomfield, have no rural areas at all. Rural county residents not only suffer from a shortage of health professionals, they also are more likely to have health coverage problems.[36]

Nationally, rural residents tend to have lower incomes, be older and report their health as being less than very good or excellent, compared to urban residents.[37] *A 2007 Health Insurance Survey of Farmers and Ranchers*[38] *found that most family farm and ranch operators had health insurance. But those rural residents paying the highest premiums were much more likely to have purchased insurance in the non-group market. Moreover, one in four of privately insured residents reported that health care expenses contributed to financial problems.*

In Colorado, the high cost of health insurance leaves rural residents more vulnerable to being uninsured or being dependent on public insurance. In Colorado, rural residents have higher rates of being uninsured than the overall population (18 percent vs. 15 percent).[39]

Figure 9

Non-elderly population with non-group coverage by race/ethnicity, 2005-2007



Source: All data from CPS Table Creator for 2005-2007 (not adjusted)

The ethnic-racial gap in insurance coverage is not well understood, although income appears to be an important factor. Looking specifically at non-group coverage, because of low eligibility levels within public health programs like Medicaid, many low-income minorities make too much money to be eligible but not enough money to afford private market health insurance.[40] Other research suggests that when income is held constant, education plays a significant role in the likelihood of purchasing non-group health coverage among minority populations.[41]

Summary

Taking contextual and population characteristics of non-group enrollees together, a profile of typical enrollees emerges. Enrollees are more likely to work in service and sales occupations, in either very large or very small firms, are older, better educated with moderate to high median family incomes. Enrollees are also likely to be non-Hispanic white, older and better educated and have moderate to high median family incomes.

SECTION 3

Federal and state regulations, state high-risk insurance pools

Unless eligible for public programs, once employer-sponsored insurance and COBRA are exhausted, the

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alternative for individuals under age 65 is non-group coverage.[42] Survey of Income and Program Participation (SIPP)[43] data, however, show that most people, 58 percent, return to employer-based insurance as soon as they are able. The median length of time for individual coverage is eight months, with only about one-sixth of enrollees retaining coverage for more than two years.[44]

Federal and State Regulations

Federal regulations have attempted to address the coverage gap between employer-sponsored insurance and non-group coverage. The most well-known is the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, individuals working at firms with 20 or more employees have the right to continue in the group health plan offered by their employer, but they must pay the full premium. COBRA coverage generally lasts 18 months.[45]

Many states offer COBRA-like continuation programs to employees who leave a business with fewer than 20 workers. Like the federal COBRA, individuals participating in a state's continuation coverage program pay the entire premium and may continue coverage up to 18 months.[46] Colorado is one of 40 states with this type of continuation coverage; Colorado Continuation is the name of the program.

A recent analysis from the Commonwealth Fund found that two out of three working adults are eligible to buy into COBRA, but workers pay four to six times more for premiums than when under an employer-based plan. Because of the high premiums, only 9 percent of eligible unemployed workers used COBRA coverage in 2007. The Commonwealth Fund estimates that newly unemployed workers would need subsidies of 75 to 85 percent of premium costs to maintain COBRA coverage.[47]

With a deep recession and growing job losses, President Obama signed into law the American Recovery and Reinvestment Act. Part of the stimulus provides money to subsidize payments for COBRA. The subsidies allow people who have lost their jobs between September 2008 and December 2009 to pay 35 percent of their premiums to continue health coverage for nine months. The federal government will reimburse employers for the other 65 percent. The subsidies are available to eligible individuals whose annual income did not exceed $145,000 and for families whose incomes did not exceed $290,000. For more information go to the U.S. Department of Labor or the Colorado Division of Insurance.

Another policy that helps maintain coverage is the 1996 the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows workers and their families to transfer and continue health coverage when they lose or change jobs. One of the most important protections under HIPAA is that it helps those with pre-existing conditions maintain health care coverage (i.e., guarantee issue).[48, 49, 50]

Once COBRA continuation coverage is exhausted, HIPAA-eligible people are guranteed the right to purchase nongroup health insurance without a pre-exisitng condition clause. Under HIPAA, all coverage sold in the individual market must be made available to eligible individuals, or insurers may designate two policies specifically for federally eligible people. There are no restrictions on premiums that may be charged.

Many states, including Colorado, have adopted an alternative mechanism to ensure HIPAA-eligible people have guarantee access to non-group coverage through a high risk pool rather than through the private marketplace.

High-risk pools

CoverColorado is a non-profit organization organization that provides individual, major-medical health insurance for non-Medicaid, non-Medicare, non-HIPAA-eligible individuals and for those with pre-existing medical conditions. As of April 2009, the program has 9,000 enrollees.[51]

CoverColorado is state-subsidized high-risk program that offers insurance to residents who are considered uninsurable in the non-group market. As of July 2008,[52] 33 states, including Colorado, had high-risk pools covering 190,361 people.[53]

Because high-risk pools enroll people with high medical costs, monthly premiums are expensive. CoverColorado premiums are capped at 150 percent of the standard market rate. but monthly premiums for enrollees are currently set at 140 percent of the standard market rate.[54] CoverColorado offers sliding-scale premium discounts to low-income households. In 2008-2009, about 30 percent of low-income enrollees pay a reduced rate that is between 100 and 120 percent of the standard market rate.[55]

The majority of CoverColorado enrollees are between 40 and 59 years of age. The length of enrollment varies, but most remain enrolled for more than one year. About one-third (36 percent) remain in the program for one to three years and just under one-third (29 percent)

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remain enrolled for more than three years. The chart at right shows the demographic characteristics of program enrollees in 2008.

For non-HIPAA eligible-individuals with pre-existing conditions, CoverColorado is the only insurer available in the state – an important safety net for those that could not otherwise get health insurance. In CoverColorado, if a non-HIPAA-eligible individual has not been insured for the 90 days prior to coverage by Cover-Colorado, expenses related to pre-existing medical conditions will not be covered for the first six months of enrollment.

Since high-risk enrollees have higher medical costs and higher premiums, keeping premiums affordable for purchasers is an ongoing challenge. To help with affordability, most states subsidize a portion of costs by imposing fees on insurance carriers and allocating some state monies. Even so, most states with high-risk pools operate at a loss.[56]

Colorado is no exception. According to an actuarial analysis, CoverColorado's funding will increase significantly as membership and claims grow over the next decade. In an effort to address long-term funding needs, the General Assembly passed HB 08-1390 which implemented a new funding structure and established the CoverColorado Long Term Funding Task Force to investigate options and develop a ten-year funding plan. Under HB 08-1390, approximately half of funds come from a combination of member premiums, CoverColorado cash funds, contributions from state insurance premium tax credit allocations and other gifts, grants and donations. One-quarter of program funding is from a special fee assessment on health insurance carriers and the remaining one-quarter of funding is from the state's Unclaimed Property Fund.[57]

CoverColorado

Demographic profile (Dec. 31, 2008)

Age distribution	
Under 20	8%
20 to 39	23%
40 to 59	46%
60 to 64	23%
65 or older	0%
Geographic distribution	
Urban areas	77%
Rural	23%
Gender distribution	
Male	47%
Female	53%
Smoker vs. non-smoker	
Smoker	11%
Non-smoker	89%
Deductible level	
$1,000	22%
$1,500	4%
$2,000	19%
$2,000 HSA	16%
$3,000	10%
$5,000	19%
$7,500	3%
$10,000	6%
Time in program*	
Less than six months	18%
Less than one year	18%
1-3 years	36%
More than three years	29%
* Current enrolees	
Claims experience*	
More than $50,000	197
More than $75,000	113
More than $100,000	66
More than $150,000	34
More than $200,000	18
* Individuals	

Summary

Once employer-based coverage is lost, workers can retain coverage through COBRA if they sign up within 60 days of employer notification.They must pay the full cost of the health premium, and HIPAA regulations ensure that workers with pre-existing conditions are not denied coverage. A majority of people find COBRA premiums too costly. The recently signed American Recovery and Reinvestment Act provides a 65 percent subsidy to the recently unemployed who are eligible for COBRA.

For those not eligible for Medicaid, the non-group market is the only other option for retaining health benefits.Individuals with pre-existing conditions are often discouraged from applying or denied non-group coverage and have few options other than enrolling in a state high-risk insurance pool. While high-risk pools provide health benefits to people who cannot otherwise get insurance, premiums, even though subsidized are expensive and claim costs are high. Consequently, high-risk pools operate at a loss and struggle to maintain adequate funding.

SECTION 4

Medical underwriting, coverage and affordability

Insurance carriers weigh the cost of providing health coverage against the likelihood that sickness will occur or treatment will be needed (i.e., medical underwriting). Those calculations are used to determine financial risk, which will set insurance premium levels and potentially deny coverage if the financial risk is too great. From an insurer's point of view, medical underwriting deters "adverse selection" – the purchase of health insurance coverage only when sick, pregnant or in need of medical care.

Research consistently shows most health care spending is concentrated among a very small portion of

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the population; this pattern is true for all insurance. (See appendix for comparison of rating factors by market.) The 5 percent of the U.S. population with high health care expenses (costs that are $14,601 or higher annually) is responsible for nearly half, 47.7 percent, of total health care spending. It is important to note however, that this is not a static group of individuals. Rather, people move in and out of this high-cost category as health circumstances change.

In contrast, 50 percent of the population has low annual expenses ($776 or lower) and accounts for 96.8 percent of total spending (figure 10). In theory, then, if most costly individuals were placed in a state-subsidized high-risk pool, the remaining pool would carry standard risk for carriers. Insurance premiums, in turn, would be more affordable for 50 percent of the population seeking private health insurance coverage.[58]

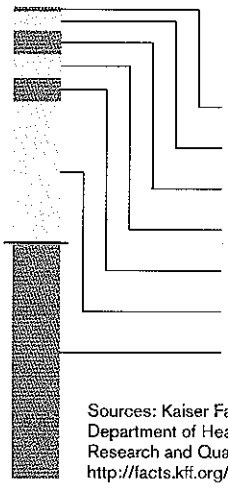
In practice, however, premiums continue to increase for everyone regardless of the risk pool, mainly due to the underlying cost of care. Aggressive and narrow underwriting practices may contribute to risk segmentation in which high and low risks are both sold coverage but segmented into different groups by plan or price.[59]

Many insurers are screening applicants by using **person-specific databases** such as the one maintained by the Medical Insurance Bureau (MIB). The bureau is a membership organization that shares information on applicants among 500 life, health and disability insurance companies. MIB information is limited to people who have applied for some form of individual insurance and have agreed to have their information released. Information is held for about seven years.[60]

While most people use an insurance agent or broker to help find non-group coverage, a growing number of policies are being sold via the Internet. The largest vendor is eHealthInsurance. With this trend, some insurers are now reducing the role of agents by using teleunderwriting to replace written applications. Teleunderwriting vendors follow a computer-assisted script, and many claim that people reveal information more readily over the phone.[61]

Figure 10

Concentration of health care spending in the United States, 2006



Population sector	Average health care spending	% of total health care spending
Top 1%	≥$41,580	21.2%
Top 5%	≥$14,601	47.7%
Top 10%	≥$8,078	63.3%
Top 15%	≥$5,558	73.0%
Top 20%	≥$4,029	79.8%
Top 50%	≥$776	96.8%
Bottom 50%	<$776	3.2%

Sources: Kaiser Family Foundation calculations using data from U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS), 2006. http://facts.kff.org/chart.aspx?ch=822

Critics of underwriting point out that this process gives insurers an unfair advantage. Once medical information is gathered, carriers can offer coverage that is not affordable or they can deny coverage for people with relatively minor and treatable pre-existing conditions. For example, many of the conditions that make an individual uninsurable are common ailments such acne, old sports injuries or being pregnant.[62, 63]

Medical underwriting rating practices are regulated by state. Very few states – 15 in 2007 – have any type of rating restrictions in the individual market.[64]

Collecting individual health information for medical underwriting purposes begins with an application form. Applications include questions on one's medical history including medication use, history of pregnancy and use of alcohol, drugs and tobacco. Insurers may also ask about high-risk activities or if the applicant has ever been denied coverage from another health insurer.

For potential enrollees, more health risks mean higher premiums or even denial of coverage. If an insurer discovers that an applicant did not respond fully or truthfully to questions, the insurer has the right to rescind or deny payment of a claim.

Coverage: age, gender and chronic conditions

By using underwriting, insurers calculate costs based on immediate risk, but they also use the information to anticipate and exclude conditions likely to have high costs. As a result, people with chronic conditions are almost always denied individual coverage.

More than half of all non-group enrollees are in excellent or very good health, while 5 percent or less are

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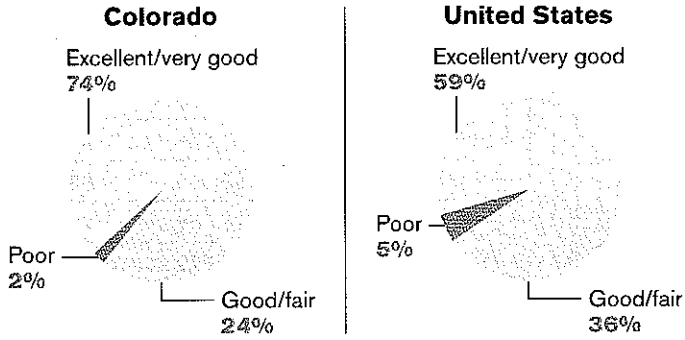
Figure 11

Health status of non-elderly population with non-group coverage, 2005-2007



Note: In the employer-based (both small- and large-group) market in Colorado, 77 percent are in excellent/very good health; 22 percent are good/fair; and 1 percent are poor. In the U.S., the percentages are 73, 26 and 2.

Source: All data from CPS table creator for 2005-2007 (not adjusted)

in poor health (figure 11). The disparity is even more marked in Colorado.

While it is difficult to know exactly how many people are impacted by the medical underwriting process, numerous empirical studies show that the problem is substantial. For example, in a joint study conducted by the Georgetown University and American Diabetes Association, researchers found that only 15 out of 396 people with diabetes seeking non-group coverage were successful in finding coverage.[65]

The Commonwealth Fund's 2005 Biennial Health Insurance Survey found that most non-elderly adults (89 percent) who had sought coverage in the individual market in the past three years never purchased a plan. When asked why, more than half, 58 percent, said that they could not find affordable coverage and 21 percent said they were either denied coverage, charged a higher price because of a pre-existing condition, or had a health problem excluded from coverage.[66]

Research suggests however, that chronic conditions may be less of a predictor of high premium costs. One possibility is that people may first purchase coverage when they are relatively healthy. If a chronic condition develops overtime, insurers are less likely to increase rates when a policy is renewed.[67]

Age and gender are significant risk factors in the non-group market

Studies show that age, gender and location consistently predict higher premiums – a finding that holds true regardless of HIPAA or state regulations.[68, 69]

Figure 12

U.S. non-group health insurance premiums by age, 2002 and 2005

Age category	2002	2005
Single policy		
Less than 40	$1,661	$1,580
40-54	$2,767	$3,325
55-64	$3,703	$4,288
Family policy		
Less than 45	$4,125	$3,863
45-64	$4,707	$6,835

Source: AHRQ Statistical Brief #202 (p. 4).

Age

Studies show that older individuals pay higher premiums than younger non-group enrollees (figure 12). Higher premiums are due to the relatively higher health care costs people incur as they get older.[70] Even with much higher premiums, people in their 50s are much more likely than younger people to buy non-group coverage.[71]

In 2005, premiums for single coverage average $1,580 for enrollees under age 40. In contrast, single coverage premiums for people 40 and older averaged around $3,800. Early retirees, aged 55 to 64, had the highest premiums.

Gender

Research by the National Women's Law Center (NWLC) found that in every state, women pay higher premiums than men for identical non-group health plans.[72] NWLC gathered and analyzed information on individual health insurance plans offered through eHealthInsurance. Information was submitted for three hypothetical female applicants and three hypothetical male applicants, all non-smokers, at ages 25, 40 and 55. Results showed that at age 25, women were charged between 6 and 45 percent more; at age 40, between 4 and 48 percent more; and at age 55, women were charged 22 percent less to 37 percent more than men for the same policy. After age 60, men pay more than women.[73]

The NWLC further refined the data by region, comparing premium costs for the same individual insurance plans (excluding maternity coverage) sold in select state capitals of Rocky Mountain states (figure 13). For Colorado, a 40-year-old woman living in Denver is charged 15 to 38 percent more than a 40-year-old man for the same plan. In Idaho, a 55-year-old woman

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Figure 13

Difference in premiums charged to women versus men for health plans

(Two coverage plans used in survey, two similar sets of plans called Plan A and Plan B)

State	Plan	25-year-olds	40-year-olds	55-year-olds
Colorado	A	12%	15%	-9%
	B	23%	38%	5%
Idaho	A	38%	40%	8%
	B	18%	42%	5%
Montana		Gender rating prohibited		
Nevada	A	12%	15%	-9%
	B	29%	38%	-8%
New Mexico	A	0%	5%	-9%
	B	6%	20%	0%
Utah	A	22%	37%	4%
	B	17%	8%	37%
Wyoming	A	12%	15%	-9%
	B	42%	13%	-16%

Source: Table adapted from No Where to Turn (2008, p. 26) by the National Women's Law Center: http://action.nwlc.org/site/DocServer/NowhereToTurn.pdf?docID=601

living in Boise is charged between 5 and 8 percent more than a 55-year-old man for the same plan.

Insurance carriers note that women are charged more because they utilize health services at much higher rates. However, once women reach age 55, their medical costs, relative to those for men, start to decline substantially, according to insurers in many states and NWLC data. In Colorado, for example, a 55-year-old woman is charged 5 percent more for Plan B and 9 percent less for Plan A than a 55-year-old man. NWLC researchers note, however, that the size and prevalence of the disparities are not easily explained away.[74]

According to CPS data, during 2005-2007, of all non-elderly people enrolled in a non-group plan in the U.S., 54 percent are female. In Colorado the figure was 55 percent.

Affordability

With employer-based coverage, there is guarantee issue, which minimizes medical underwriting, and cost drivers are spread out over a large number of people. In contrast, with non-group coverage, medical underwriting is allowed, meaning that such factors as pre-existing conditions, age and gender can be used to determine person-specific premium costs.

Despite evidence that age and gender drive premium costs, carriers insist that, on average, non-group premiums are less costly than group premiums.

America's Health Insurance Plans (AHIP), for example, found that in 2004, the average annual premium for non-group single coverage was $2,268 and $4,424 for family coverage. By comparison, the average annual premium for employer-based single coverage was $3,696 and $9,948 for family coverage.[75] What is not made clear is that under the employer-based plan, the employer generally pays for more than half of the total premium and covered benefits tend to be more comprehensive.

AHIP also points out that people with non-group coverage have a much wider selection of benefits from which to choose, whereas group plans generally offer relatively few choices.

Research by the Kaiser Family Foundation concurs. However, Kaiser notes that lower premiums may be due to population characteristics. For example, most non-group enrollees report that their physical and mental health statuses are excellent, which translates into low risk and less costly premiums. In addition, Kaiser found non-group benefits are not always as comprehensive as group coverage and cost-sharing and out-of-pocket expenses tend to be much higher in the non-group market – all of which contribute to lower premiums.[76]

Tax deductions have limited ability to help make non-group coverage affordable

There is substantial premium subsidization with employer-based coverage that does not exist in the non-group market. On average, employers nationwide contribute 84 percent of premium costs for single coverage and 73 percent of premium costs for family coverage. Employees pay the remaining portion.[77, 78]

For tax purposes, workers receive a tax benefit because an employer's contribution is not counted as part of a workers taxable income. For example, the average cost of a family premium in 2008 was $12,680. Of that amount, the worker contributed $3,354 and the employer contributed $9,325. The portion the employer contributed was not counted as income, and the worker has no tax liability even though they received more than $9,000 in benefits.[79]

Some workers pay their portion of a health insurance premium from their take-home pay after wages have already been taxed. Federal regulations, however, permit employers to sponsor arrangements in which workers pay their share of the health premium with money deducted from their wages before they are taxed (Section 125 of the Internal Revenue Code). In this case, deducted wages do not count as taxable income.

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Employers also receive tax advantages. Employer health insurance premium contributions are excluded from federal income and payroll taxes that go to support Social Security and Medicare.[80] The U.S. Treasury estimates that employer taxes not collected totaled more than $200 billion in 2007.[81]

In contrast to employer-based insurance, there are few tax advantages for non-group health insurance plans. Most often families that itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums that exceed 7.5 percent of adjusted gross income.[82]

Itemizing deductions, however, has little value for lower-income individuals and families that do not owe federal income tax unless they are eligible for the Earned Income Tax Credit (EITC). The EITC is a refundable tax credit, and itemizing deductions could increase the amount of credit they receive. Thus, to benefit from a deduction for health insurance premiums, lower-income individuals and families would need (1) to have federal income tax liability, (2) be eligible for the EITC, (3) have itemized deductions in excess of the standard deduction amounts and (4) have medical expenses exceeding 7.5 percent of their adjusted gross income. Those eligible for the EITC would benefit the most.[83]

A special tax provision allows self-employed people to take a deduction for the amount paid for health insurance for themselves, their spouse or dependents when calculating their income tax. There are several limitations. First, to qualify for the deduction, the insurance plan must be established under the self-employed person's business; neither the self-employed individual nor his or her spouse can be eligible for employer-based coverage. In addition, the amount deducted cannot exceed the net profit and other earned income from the business. The deduction cannot be included when calculating net earnings subject to the self-employment tax.[84]

Another tax advantage exists only for workers displaced by foreign competition. In 2002, Congress passed the Health Coverage Tax Credit (HCTC) allowing Trade Adjustment Assistance (TAA) or Alternative Trade Adjustment Assistance (ATAA) recipients and Pension Benefit Guaranty Corporation (PBGC) benefit recipients to receive a refundable tax credit to help cover nongroup premium costs. The HCTC tax credit pays 65 percent of health insurance premiums for eligible individuals and their family members.[85]

Studies consistently show that modest subsidies for non-group health insurance coverage, including the HCTC,[86] do not result in greater numbers of people enrolling in insurance plans, and they have only a small effect on decreasing uninsurance rates.[87]

Health Savings Accounts (HSAs) are tax-advantaged accounts that are coupled with high-deductible health insurance plans. HSAs were authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 as a way of reducing health costs by placing more financial responsibility on the individual for health care.

HSAs allow account-holders to deposit and accumulate tax-free money to be used for medical expenses. Anyone under age 65 with no other insurance coverage (dental, vision, disability and long-term care insurance excluded) can contribute to an HSA if they buy a high-deductible health insurance policy. HSAs tend to have lower premiums than conventional plans. An HSA's deductible must be at least $1,000 for individuals or $2,000 for families.

Research suggests that HSAs are more popular for higher-income, relatively healthy individuals. A 2008 General Accountability Office study found that tax filers between 19 and 64 with HSAs had an average adjusted gross income of about $139,000, compared to about $57,000 for all other filers. Further, individual contributions to HSAs were about twice that of withdrawals.The average contribution in 2005 was $2,100, whereas the average withdrawal was $1,000. Small- and large-employer contributions varied, with average contributions for single coverage ranging from $625 to $806 in 2007.

The same study found that while the number of people participating in HSA plans increased significantly between 2005 and 2007, those with HSAs represented only about 2 percent of individuals with private health insurance.[88]

Finally, since individuals or families must pay the entire premium, potential purchasers are very price sensitive.[89] This sensitivity may lead people to purchase coverage plans that are less comprehensive thereby contributing to the growing number of underinsured individuals. The recently implemented Cover Florida plan provides a case in point.

In 2008, the Florida legislature passed a new non-group plan to provide health care options for Floridians who have been without insurance for a least six months. Under this legislation, carriers are required to offer two plans. One plan provides coverage for preventive services, screenings, office visits, outpatient and

inpatient surgery, prescriptions and so on. The other plan offers only catastrophic and hospital coverage. According to the *February 2009 enrollment summary*, fewer than a thousand people (952) have enrolled in Cover Florida. Most (784) enrolled only in the catastrophic plan.

Summary

The non-group market allows insurance carriers to use health status, claims experience, age, gender, geography and other factors to determine if a potential enrollee will be too great a financial risk. Medical underwriting, in brief, enables insurers to set premium rates according to potential health risk costs or to deny coverage all together.

While carriers note that premiums in the non-group market are comparatively less than employer-based premiums, they do not account for the portion of premium employers cover. Research suggests that non-group benefits are less comprehensive, and cost-sharing is much greater than with employer-based coverage. Moreover, workers and employers receive substantial tax advantages when employers provide health benefits. These advantages do not exist for non-group coverage.

Section 5

Individual Health Insurance Carriers

In Colorado, there are many insurance companies selling non-group health coverage products to relatively few people (figure 14).

According to the Colorado Division of Insurance, approximately 300 insurance companies wrote some individual coverage in 2006, with 45 companies writing 90 percent of the policies.[90] In contrast, three insurance carriers, Kaiser Foundation Health Plan of Colorado, United Healthcare Insurance Company and Anthem Blue Cross Blue Shield, provide coverage for nearly 70 percent of all covered lives in the small-group market.[91]

The fact that no carrier dominates the non-group market in Colorado would suggest that there is a fair amount of competition among carriers. However, relying solely on market shares to assess market strength masks the instability of the non-group market.[92]

From a carrier's perspective, the non-group market represents only a very small part of overall business. Because products are purchased individually,

Figure 14

Market Shares of carriers offering non-group coverage in Colorado, 2001-2007

	Market shares by year				
Carrier	2001	2004	2005	2006	2007
Aetna Health Ins.	1.70%	2.48%	1.62%	1.54%	2.29%
Anthem Blue Cross and Blue Shield	16.00%	15.94%	8.61%	8.90%	9.87%
Fortis/Assurant/ Time Insurance Co.	1.80%	2.62%	1.33%	1.32%	1.09%
Humana Insurance Co.	8.80%	4.29%	1.96%	3.54%	4.26%
Kaiser Permanente Insurance Co.	23.86%	0.29%	0.27%	0.44%	0.48%
PacifiCare Life Assurance Co.*	14.82%	4.71%	14.70%	5.98%	1.65%
Rocky Mountain Healthcare Options, Inc.	7.35%	2.34%	1.69%	1.89%	1.69%
United American Insurance Co.	0.40%	0.27%	0.13%	0.18%	0.18%

**PacifiCare no longer offers individual insurance*

Source: Colorado Insurance Insider report using edited information from the Colorado Division of Insurance; information contains only health insurance companies offering individual/family health insurance plans in Colorado. http://www.healthinsurancecolorado.net/complaint-ratio.html

administrative costs are higher, marketing and sales channels differ, risk pooling is limited, coverage duration is short and adverse selection is a bigger concern compared to employer-based coverage.

From a purchaser's perspective, not only are there substantial barriers to obtaining coverage – especially in states that allow aggressive medical underwriting – there are few if any tax advantages or subsidies of any kind to help defray premiums costs leaving many price-sensitive individuals uninsured. For those that do purchase non-group coverage, benefits may not be comprehensive. (See appendix for comparison of rating factors by market.)

Summary

The individual market does not function like the group market. People generally use individual coverage for very brief periods as a bridge between periods of employer-based insurance. The lack of subsidies in the non-group market keep premiums costs out of reach for many. For carriers, benefit packages, sales channels, administrative costs, adverse selection concerns differ markedly from the group market.

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Section 6

Conclusion

This paper uses Current Population Survey data to examine demographic characteristics and available literature to describe contextual patterns of use in the individual, or non-group, market. Though the individual market is viewed as a mechanism for addressing problems of the uninsured as well as a mechanism for providing portable, continuous health coverage, there is little evidence to suggest that the individual market would effectively accomplish either goal.

Overall, the individual market is not a popular option for people losing employer-based coverage. Since 1994, the percentage of people enrolled in non-group coverage has remained around 7 percent. This trend has occurred despite changes in employer-based coverage, expansion of public health insurance or growing numbers of uninsured.

Affordability remains problematic in the non-group market. Tax advantages are limited, and data show that young adults and the unemployed are extremely sensitive to premium cost, regardless of tax incentives. Though premium costs may be lower in the individual market, research shows that benefits are often less comprehensive and out-of-pocket expenses are greater. Moreover, aggressive medical underwriting practices allow carriers to force those with pre-existing or chronic conditions out of the market.

Overall, the individual market functions as the insurer of last resort. Most non-group purchasers use this coverage as a stop-gap measure until they can enroll in employer-based coverage. Further, non-group insurance tends to attract only a small subset of the population in need of health coverage – mostly those who are healthy, higher-income and non-Hispanic white.

The fact that so few minorities participate in the non-group market is not well understood, but their absence suggests that gaps in coverage can't be easily addressed with expansions in the non-group market. Rural residents, too, are not likely to benefit from expansions when geographic access to providers is a larger concern.

There are many carriers going after a small amount of business. With low overall enrollment and customers that are not only extremely price sensitive but who tend to stay enrolled for less than a year, carriers are continually faced with high administrative and product sales costs. High costs combinedwith the ability to limit enrollment to healthier individuals leaves carriers with little incentive to expand coverage to a larger population.

As the economic recession deepens and more people lose their jobs and their health insurance, affordable health care becomes a bigger issue – one that the individual market is not likely to help solve.

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Bell Policy Center

Non-group insurance: not a quick fix for health care

Appendix

Colorado's ratings and regulations by insurance market

Private insurance	Non-group	Small group *One to 50 workers*	Large group *51 or more workers*
Coloradans covered, private insurance[2]	7%	7%	16% *Large-group* 34% *ERISA self-funded*[1]
Companies writing coverage (2007)	292	21	230
Companies writing 90% or more of total (2007)	47 (90%)	10 (97%)	26 (90%)
Regulation of health coverage	No rate caps; elimination riders allowed for medical conditions; credit for prior coverage required; 12-month lookback and exclusionary period limit for pre-existing conditions, some mandated benefits; wide variety of benefit design and structure; prior approval of rate increases by DOI.	Mandated benefits; benefit design; guarantee issue; may impose a 6-month look-back/6-month exclusionary period for preexisting conditions on enrollees that do not have prior creditable coverage; prior approval of rate increases by DOI.	Mandated benefits; can negotiate benefit package within boundaries; prior approval of rate increases on policies under DOI jurisdiction. Firms that self-insure are regulated by federal law through the Employer Retirement Insurance Security Act and do not fall under the state's regulatory framework.
Guarantee issue[3]	No	Yes	Not required to offer
Medical underwriting	Yes	No	Yes (of entire group)
Rating factors			
Age bands *(5 years)*	No	Yes	Many don't vary by age
Age *no bands*	No	Yes	Many don't vary by age
Gender	Yes	No	No
Family composition	Yes	Yes	As specified by group
Geography	Usually by ZIP code	Based on county	Limited, carrier area factors
Smoking/tobacco use	Rate-up or discount	15% up, 10% discount	No prohibition under state law
Health status	By indiv., med. underwrite	No (as of 12/31/08)	Yes, aggregated for group
Claims experience	Not as separate factor	No (as of 12/31/08)	Yes, aggregated for group
Industrial code	No	Yes, to adjust rate	Yes, aggregated for group
Plan design	Yes	Yes	Yes

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[2] Technically, it is possible for plans with fewer than 50 workers to be self-funded. Self-insured plans are offered by employers who directly assume the major cost of health insurance for their employees.

[3] As per the federal Health Insurance Portability and Accountability Act of 1996, all group insurance contracts, including large group contracts, must be guarantee-renewable, unless there is non-payment of premium, the employer has committed fraud or intentional misrepresentation or the employer has not complied with the terms of the health insurance contract.