Rating and Underwriting: Individual Health Insurance

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Individual (Non-Group) Health Insurance

• Status Quo (“SQ”):
  – 17 million covered individuals in 2007
  – Most states:
    • Do not require Guaranteed Issue (GI)
    • Do not restrict pre-existing condition exclusions
    • Do not limit premium variation to any significant degree
SQ: Categories of Non-Group Insurance

- Individually underwritten policies
- Federally guaranteed issue policies (If you lose your job)
  - COBRA continuation policies
    - Most with ESI qualify for either 18 or 36 months
    - Premium is 102% of average total premium for employer’s plans
  - HIPAA continuation policies
    - Available within 63 days after COBRA period ends
    - Benefit/plan types are highly limited, but no health restrictions
    - Wide variation in premiums
    - High risk pools only in some states (rather than these policies)
Individual Health Insurance Issues

- “Mixed bag” of premiums and coverage
  - Initial underwriting effective in eliminating likely high cost applicants
    - Lower premiums for best risks
    - High variance in premiums
      » Age/gender factors may be in a 6:1 range or more
      » Rate-ups for those with certain conditions can increase premiums to 250% of “standard premiums” for persons of same age
      » Total may vary by factor of 10x (or more)

- Most individuals choose higher deductible plans to further reduce premiums

- Other actions may result in high premium increases for renewing policy holders
Individual Health Insurance Issues

- Pre-existing condition exclusions and “post-claims” underwriting may limit coverage
- Rescission of policies
  - If an insurer finds the policyholder lied or withheld medical history, it may cancel the policy
  - Some insurers under fire for canceling policies over “minor” mistakes by applicants
- Administrative costs are high (30-35% of premium) relative to other coverage types
  - Sales and commission expense are large portion
SQ: Underwriting

• In most states, each person is tightly underwritten at issue for health conditions:
  – Generally an “expandable” set of +/-10 basic health questions; more questions asked about specific conditions, if any
    • “Have you seen a doctor?”
    • “Do you have a heart condition?”
  – Four possible outcomes:
    • Accept at standard (low) premiums
    • Add a “rate-up” to premiums for existing conditions
    • Exclude specified pre-existing conditions from coverage for some period
    • Decline coverage
SQ: Underwriting

- Premiums at issue of policy:
  - “Standard” premiums typically based on age, gender, geographic area, tobacco use (known as case characteristics)
  - 20% to 30% of applications getting a modified offer---Percentage depends on:
    - How much agent pre-screening occurs
    - Whether insurer uses only rate-ups or exclusions
  - Premiums can reflect either:
    - Rate-ups only
    - Exclusion of pre-existing conditions, or
    - Both
SQ: Underwriting

- Healthy individuals (e.g., recent college grads) have low, age-rated standard premiums
- Rate-up individuals might pay as little as 10% more or up to 250% of “standard” premiums
  - Rate-ups generally less than 150% as insurers more likely to deny coverage
- Pre-existing condition individuals might pay lower rates, but not have coverage for specified conditions
  - Insurers have differing standards
  - Some might allow a minor condition, while others would exclude coverage
- In comparison, COBRA premiums might be higher at most typical employers for employees younger than age 50
Rating Rules in Some States
Rating Bands

• Some states (mostly in the Northeast) restrict the ability to rate for health risk and case characteristics (age, gender, geographic area or tobacco use)

• A few states restrict rates for only case characteristics, but not necessarily for health rate-ups

• A few states have restrictions on maximum rate-ups
Survey of State Rate Restrictions

– Only half of surveyed states have restrictions on ranges of rates or rate increases
  • Range by age -- from 1:1 to 5:1
  • Range by rating area -- from 0.8:1 to 5:1
  • Health status, including smoking -- some +/-35%, some 1.5:1, one at 15% variance
  • Rate increase limits -- “trend + 20%,” “trend+15%+age change,” “No more than 25% from all sources”

– Some states do not have jurisdiction on premium rates for out-of-state master policies
  • Little rate regulation of these policies

Source: American Academy of Actuaries Rate Filing Task Force, Appendix F, May 12, 2004
Renewal Premiums

- Policies are Guaranteed Renewable, so can’t be canceled
- Generally, all policies in the same block are rated together
  - A “block” of policies is usually a group of enrollees of various ages in the same product, same issue period (e.g., 3-5 year span) and perhaps the same region
  - All policies will increase for block’s trend, plus additional increase for “deductible leveraging” as paid claims increase faster than trend due to effect of big deductible on remaining claims
  - Premiums are usually age-rated and increase every year for this factor also
  - “Wearing off” of underwriting (regression to the mean) may also add to increase over 3-5 years, if block is not replenished with new policies
- Most states prohibit “re-underwriting,” giving higher rate increases to some with lower increases to the healthiest
Glossary of Insurance Terms

• Active Life Reserves -- funds held by an insurer that recognize lifetime total costs of a policy. In early years after policy issue, paid claims are low but Active Life Reserves are set up to assure premium stability in later years with high paid claims.

• “Block of Policies” -- a group of enrollees of various ages in the same product, same issue period (e.g., 3-5 years) and perhaps the same region.

• “Deductible Leveraging” -- because cost increases apply to all claim costs, the amount of paid claims minus a “frozen” deductible will increase at a faster rate than just the rate of growth of all services only.
Glossary of Insurance Terms

• Incurred Claims
  – For group policies, generally paid claims plus claims “in the pipeline” for payment
  – For non-group policies, paid claims + “in the pipeline” claims + Active Life Reserves

• Medical Loss Ratios -- the ratio of health claims (without admin) to premium paid

• Paid Claims -- only actual health claims for services paid in the reporting period