**Perspective**

The Nongroup Market As One Element Of A Broader Coverage-Expansion Strategy

With major modifications, the nongroup health insurance market could be used as part of a broader strategy to expand coverage.

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**ABSTRACT:** Effective health insurance provides financial protection and access to services that maintain and improve health. Such coverage is difficult to obtain in the nongroup market, however, because of a lack of sponsorship, the nature of coverage available, adverse selection, and high administrative costs. However, certain interventions could make this market an effective avenue for expanding coverage to moderate- to high-income persons who lack access to employer-based coverage. In “less regulated” markets, we suggest broader, deeper funding of high-risk pools and standardization of benefits, preexisting condition exclusions, and waiting periods. In “more regulated” markets, a broadly funded reinsurance mechanism could moderate premiums.

**WE BELIEVE THAT** health insurance should both provide financial protection and help to maintain and improve health. While expanding access to health insurance is a laudable goal, providing access to coverage that does not meet enrollees’ health needs is not necessarily “effective.”

In this commentary we outline the factors contributing to the ineffectiveness of the nongroup market as an avenue for major coverage expansion: lack of sponsorship; the nature of coverage available in the market; and the impacts of adverse selection and high administrative costs. Given these market deficiencies, we do not believe that the nongroup market can provide the basis for broad coverage expansion. However, with suggested interventions, this market may be an effective avenue for expanding coverage to a portion of the uninsured.

**Shortcomings Of Nongroup Coverage**

- **Lack of sponsorship.** In group markets, employers act as sponsors, helping consumers select and use health coverage. Sponsor functions include subsidizing premiums, which promotes take-up rates and viable risk pools; supplying information about plan and provider performance; structuring the number and type of benefit offerings; and, often, helping consumers resolve disputes with plans or providers. Sponsors also provide carriers with economies of scale in marketing and enrollment, which reduces administrative costs compared with the nongroup market.

  The nongroup coverage market lacks spon...
sorship resources, including tax subsidies and employer-paid premium contributions. Most of the broad-based tax-credit proposals being debated by policymakers are unlikely to make nongroup coverage affordable for any but the young and healthy. Several recent studies underscore and quantify this point.1

Consumers in the nongroup market face complex choices with inadequate information and assistance. These deficiencies can be remedied only by adoption of subsidies larger than the $1,000–$1,500 tax credits generally proposed (for single coverage) and establishment of new sponsors (either conventional or Internet-based) for this market.2 Another alternative would be to include individual enrollees in existing group-sponsor arrangements, such as the Federal Employees Health Benefits Program (FEHBP).

Nature of coverage in the nongroup market. People should not face undue financial barriers to necessary, effective care. However, much of the coverage available in the nongroup market creates these barriers, by including excessive cost sharing or by excluding preexisting conditions from coverage.

Effective coverage balances the competing goals of making premiums affordable and keeping cost sharing and benefit exclusions at an appropriate level to encourage responsible use of needed care. There is evidence, however, that for many people with mild to severe health conditions, this type of nongroup coverage is unavailable or unaffordable. It is difficult to quantify the extent of this phenomenon because the required data are generally proprietary to carriers. A recent study provides examples of the high premiums, benefit exclusions, and rejections that would be experienced by several hypothetical people purchasing nongroup coverage.3 An older study found that in surveyed states, rates of coverage rejection in the nongroup market averaged 18 percent.4

Adverse selection. One reason that nongroup coverage is not broadly available or affordable is that carriers medically underwrite. This practice is necessary to protect carriers from adverse selection caused by people who purchase coverage only when they know they will need care. This behavior, while understandable on the part of rational consumers, turns the concept of insurance on its head, creating instead a prepayment system for people who know they will use health care. As a result, carriers underwrite to preserve a risk mix that includes both likely users and nonusers of care. The unfortunate side effect is that underwriting makes coverage inaccessible to those who need it most. This type of adverse selection is particularly acute in nongroup markets, which can be entered at any time in most states. (In contrast, group markets permit enrollment only during defined periods.)

High administrative costs. There is no consensus about the extent of administrative costs in the nongroup market, but industry observers agree that marketing and other costs are higher in this market than in group markets.6 In particular, underwriting adds to carriers’ administrative burden. Policy interventions that reduce the need for underwriting may also reduce administrative costs and, therefore, premiums.

Addressing Deficiencies In The Nongroup Market

There is a trade-off in the nongroup market between policies that make the market more accessible to the sick and those that make it more attractive to the healthy.7 “Less regulated” markets (with few market rules and, usually, a high-risk pool) provide premium relief for the healthy but do less to address accessibility for the sick. “More regulated” markets (with guaranteed issue, rate bands, limits on preexisting condition exclusions, and so on) improve access to coverage for sicker people but may make coverage a poor value for the healthy. What policies would bring us closer to the goal of expanded access to appropriate coverage in each type of market?

Less-regulated markets. Twenty-two states have no significant nongroup rating regulations but do provide for a high-risk pool.8 In most cases, people are eligible for these pools after being rejected by a nongroup carrier or being offered coverage at a premium exceeding...
the pool's premium by a given percentage. Pools expand access by removing the highest risks from the market, which makes premiums more affordable for those who remain. However, pools are typically funded by a carrier tax or limited state revenues, and premiums, although subsidized, can be costly. There may also be sizable cost sharing at the point of service. Furthermore, some states have statutory authority to cap enrollment and establish a waiting list, although only a few have done so.

To make less-regulated nongroup markets more available to both the healthy and the sick, broader and deeper funding of high-risk pools is required. Considering financial capacity and equity concerns, we suggest federal funding to help support these pools to keep premiums and care affordable, particularly for low-income people.

In addition to enhanced funding for high-risk pools, we suggest development, through a public policy process, of a set of standardized benefit designs, analogous to the standardized Medigap policies. Each carrier in the market, directly or in partnership with another carrier, would be required to sell at least one of the standard benefit plans and could choose to sell other standard plans as well. Standard plan features could also include rules or limits on preexisting condition exclusions and waiting periods.

These rules would reduce the likelihood of risk segmentation and improve the viability of the risk pool. They would also prevent carriers from competing based on obscure features not easily understood by consumers or from offering plans whose benefits were so limited as to be illusory.

More-regulated markets. One study found that in the more heavily regulated nongroup markets, average premiums have increased since regulations were implemented, and there have been net losses of coverage (that is, fewer high-risk people have gained coverage than low-risk people have dropped it as a result of premium increases). In addition, insurance options for the healthy are more limited because carriers leave the market before they are forced into offering only high-premium products that affect their risk pools. At the same time, choices for sicker persons have increased.

To keep premiums affordable for the healthy and to keep carriers in highly regulated markets, a state- or federally funded reinsurance mechanism may be required. However, such a mechanism funded solely by carriers is unlikely to solve the problem, as it is simply a redistribution of money already in the market, not the additional subsidy required to moderate premiums.

Conclusions

In the near term, policymakers are unlikely to agree on a single approach to expanding access to insurance coverage for all Americans. Approaches using the voluntary nongroup market will, of necessity, leave some behind: the young and healthy who may develop a chronic illness or have a baby, despite their perception of invincibility; or those who are most vulnerable—the poor and chronically ill.

While we suggest interventions to address specific, persistent problems in the nongroup market, we also note the intractability of these problems in the absence of a mandate for universal coverage. Accordingly, policymakers should also consider coverage expansion strategies that do not rely on the nongroup market.

Given that almost 85 percent of nonelderly uninsured Americans are in households in which the head of the family works, coverage expansion in the employer-based market should be explored. This coverage has many advantages, such as natural risk pooling and the sponsorship provided by the employer. However, for some low-income people without ties to, or the ability to afford, employer coverage under any circumstances, expansion of public programs may be more viable.

Although it is unlikely in its current form to
be a means to universal coverage, with the reforms noted, the nongroup market may be an effective avenue to expand coverage to a portion of the uninsured (moderate- to high-income persons without access to employer coverage). Each of these approaches has advantages and disadvantages, and all should be considered together as part of a strategy to expand coverage to the greatest extent possible.

The views expressed in this paper are those of the authors and do not necessarily reflect the views of Kaiser Foundation Health Plan, Inc.

NOTES

1. See, for example, J. Gabel et al., “Individual Insurance: How Much Financial Protection Does It Provide?” 17 April 2002, www.healthaffairs.org/WebExclusives/Gabel_Web_Excl_041702.htm (20 August 2002); and J. Hadley and J. Reschovsky, Tax Credits and the Affordability of Individual Health Insurance, Issue Brief no. 53 (Washington: Center for Studying Health System Change, July 2002). Hadley and Reschovsky note that three-quarters of those now purchasing nongroup coverage pay 16 percent of their income or less for it. Using 16 percent of income as a measure of affordability, a $1,000 tax credit would leave nongroup coverage unaffordable for 26 percent of the uninsured. An additional 30 percent of the uninsured would pay 8–16 percent of their income for nongroup coverage—an amount that arguably borders on unaffordable.

2. More work is needed to determine how large a subsidy must be to promote affordability for people at various income levels.

3. K. Pollitz, R. Sorian, and K. Thomas, How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health? (Menlo Park, Calif.: Kaiser Family Foundation, June 2001). In this study, researchers applied for nongroup coverage on behalf of seven fictitious people with varying risk profiles. A hypothetical sixty-two-year-old retiree with high blood pressure was rejected for coverage 55 percent of the time and received substandard offers (that is, offers that were either rated up to account for his high blood pressure or did not cover that condition at all) 42 percent of the time. In one instance, he was offered “coverage” that excluded any ailment related to his circulatory system—clearly not a good value for him. The rates of rejection and substandard offerings across all hypothetical applicants were 37 percent and 41 percent, respectively.


5. Medical underwriting is “a process by which insurers determine how much an individual or group is likely to incur in the way of medical bills and thus, how much that person or group should pay in premiums. Medical underwriting looks at demographic factors...as well as individual medical histories...and...in some cases...results in an insurer’s declining to offer coverage at all, or offering coverage that excludes certain conditions.” J. Rovner, Health Care Policy and Politics A to Z (Washington: CQ Press, 2000), 120.

6. M. Pauly, A. Percy, and B. Herring, “Individual versus Job-Based Health Insurance: Weighing the Pros and Cons,” Health Affairs (Nov/Dec 1999): 28–44. The authors estimate that administrative costs are about 5 percent of premium for the largest groups, 20–25 percent for the smallest groups (fewer than twenty-five employees), and 30 percent in the nongroup market.


10. Ibid.

11. Nichols, “State Regulation.” The markets included in this analysis were Vermont, Massachusetts, New York, New Jersey, Kentucky, and Washington, each of which has passed more nongroup market reforms than most other states.

12. Ibid.