Chapter 2
Profile of Respondents

In 1991, OTA conducted a survey of commercial health insurers, Blue Cross and Blue Shield (BC/BS) plans, and health maintenance organizations (HMOS) as part of its report, *Cystic Fibrosis and DNA Tests: Implications of Carrier Screening (4). The survey* collected information on insurers underwriting practices and use of medical screening for individual and medically underwritten group policies. Additionally, it sought information about how insurers view and use genetic information and genetic tests, especially DNA-based tests for cystic fibrosis (CF) mutations. A 1986 OTA survey targeted a similar population, but the data collected for that survey focused on general medical testing (especially for the human immunodeficiency virus (HIV)), and did not examine genetic tests and genetic information (3).

RESPONDENT PROFILE

General industry profile questions asked by OTA included the number of people respondents insure in their plans, the number of applications received, and how those applications were rated. This chapter presents such data for each of the three populations OTA surveyed.1 Appendix A describes how the population samples were derived.

Commercial Health Insurers

In the United States, approximately 1,250 for-profit companies are in the business of writing major medical expense policies (2), but increasingly few health insurers write policies for individuals or medically underwritten groups (4). Of 225 commercial health insurers initially mailed a survey, 81 insurance companies responded that they offered neither individual nor medically underwritten group policies. Of the 51 responding companies that did offer such policies, 29 companies offered individual coverage, 37 respondents offered medically underwritten group policies, and 15 companies offered both (table 2-l). Thirty-eight companies also wrote disability insurance, and 42 wrote life insurance. None of the companies included Medigap policies or statistics in their responses. (Medigap policies are designed to supplement Medicare coverage for the elderly.)

As an aggregate population, responding companies reported receiving a total of 940,745 applications for individual health insurance in 1990. The annual volume of applications ranged from 50 to 368,350 applications per company (table 2-2). Four companies alone accounted for 564,475 applications, or more than half the annual volume of the entire survey population. Responding companies reported receiving 625,134 applications for medically underwritten group coverage, with a range of 100 to 100,000 applications. Responding companies reported insuring a total of 2 million people under individual policies, and 2.3 million under medically underwritten group policies (table 2-3).

Companies also were asked to indicate the distribution of persons they covered under self-funded administrative policies, individual policies, medically underwritten groups, and large groups. All respondents had business encompassing these practices, but the proportions among companies varied widely.

The client mix within any single responding commercial insurer varied. People covered under self-funded administrative policies comprised between 1 and 70 percent of clients covered by commercial respondents, with an average of 25 percent. Two to 1OO percent of persons were covered through individual policies, with an average of 50 percent. The percentage of persons who were covered under medically underwritten group policies of commercial insurers ranged from 1 to 100 percent and averaged 62 percent. Finally, commercial insurers responding to the OTA survey covered 6 to 96 percent of people under large group policies, with an average of 44 percent.

Blue Cross and Blue Shield Plans

Surveys were sent to both the medical director and the chief underwriter for 72 of the 73 BC/BS plans. (Puerto Rico's plan was excluded,) BC/BS plans often operate under considerably different condi-

[1] **For chapters 2 through 5, the numbers in the text might not total 100 percent or sum to the actual number of responses for a particular survey population because "no response" is not included in the discussion, but is presented in the table.**

Table 2-l—Respondent Profile: Companies That Offer Individual or Medically Underwritten Group Coverage

	Commercial insurers (n= 51)	BC/BS plans-underwriters/ medical directors (n= 29/18)	HMOS (n= 23)
Individual policies	29 companies	25/18 plans	11 HMOS
Medically underwritten group policies	37 commpanies	21/15 plans	20 HMOS
Nongroup/open enrollment	NA	8/7 plans	NA

NA - Not applicable.

SOURCE: Office of Technology Assessment, 1992.

Table 2-2—Number of Applications Received by OTA Survey Respondents

	Commercial insurers	BC/BS plans-underwriters/ medical directors	HMOS
Individual policies	940,745 (range: 50 to 368,350)	261,1 86/303,692 (range: 512 to 47,380)/ (range: 9 to 120,000)	69,554 (range: 24 to 43,000)
Medically underwritten group policies	625,134 (range: 100 to 100,000)	103,726/1 01,391 (range: 1,200 to 19,000)/ (range: O to 34,000)	414,977 (range: 150 to 350,000)
Nongroup/open enrollment	NA	29,360/1 3,768 (range: 60 to 25,000)/ (range: O to 6,168)	NA

NA = Not applicable.

SOURCE: Office of Technology Assessment, 1992.

tions from commercial carriers. Some plans hold open enrollment periods, all are regionally based, and many enjoy significant shares of their local health insurance market. These factors play a pivotal role in underwriting policies. Twenty-nine chief underwriters completed a survey and 18 medical directors returned surveys. Some overlap exists between the two populations, so the reported data are not additive, but are treated as two populations.[2] In addition to inquiring about medically underwritten groups and individuals, the BC/BS survey instrument asked how the questions applied to a third category: nongroup open enrollment policies.[3]

Of the 29 BC/BS plans represented by the underwriter survey, 25 of 29 write individual policies and 21 of 29 offer medically underwritten group policies. Eight of 29 BC/BS surveys returned by chief underwriters represented plans that offer open enrollment; each of these eight offers continuous, year-round open enrollment (table 2-l).

All 18 BC/BS plans represented by the medical director survey write individual policies, and 15 plans also offer medically underwritten group policies. Seven represented plans that offer continuous, year-round open enrollment. Twelve States require BC/BS plans to offer an open enrollment period—i.e., all applicants must be accepted for coverage regardless of their health status and with no medical underwriting. Three BC/BS plans represented by the underwriter survey also provide disability insurance and six wrote life insurance; 1 plan represented by the medical director survey also provides disability insurance and 1 wrote life insurance.

The responding BC/BS plans represented by the underwriter survey received 261,186 applications for individual health insurance in 1990, with a range of512 to 47,380 applications. The medical director sample revealed that 303,692 individual insurance applications were received by these respondents, with a range of 9 to 120,000. BC/BS underwriters

[2] Because anonymity and confidentiality were guaranteed, OTA does not report the actual number of policies that overlapped, nor did OTA perform a comparative analysis between the underwriter and medical director responses from the same BC/BS plan.

[3] When BC/BS plans were first offered in the 1930s, all applicants were accepted for coverage regardless of their health status—i.e., open enrollment. Today, plans in 12 States have an open enrollment period, although most contracts have waiting periods for preexisting conditions.

Table 2-3-Number of People Insured by OTA Survey Respondents

	Commercial insurers	BC/BS plans-underwriters/ medical directors	HMOS
Individual policies	2.0 million (range: 171 to 240,000)	1.7 million/1.4 million (range: 1,500 to 690,559)/ (range: O to 324,800)	306,861 (range: 350 to 258,945)
Medically underwritten group policies	2.3 million (range: 1,000 to 382,000)	2.4 million/671 ,385 (range: l,039 to 1,592,000)/ (range: O to 205,144)	4.2 million (range: 1,501 to 2 million)
Nongroup/open enrollment	NA	645,164/1 34,878 (range: 550 to 51 2,477)/ (range: 675 to 43,589)	NA

NA - Not applicable.

SOURCE: Office of Technology Assessment, 1992.

reported their plans received a total of 103,726 individual applications, with a range of 1,200 to 19,000 applications; medical directors reported receiving 101,391 medically underwritten group applications, with a range of O to 34,000. Finally, a total of 29,360 applications were received by underwriters during open enrollment, with a range of 60 to 25,000 applications received. Medical directors reported they received 13,768 applications during open enrollment, with a range of O to 6,168.

Underwriters for BC/BS plans responding to the OTA survey reported that their plans insure 1,736,270 people through individual policies, 2,394,703 in medically underwritten groups, and 645,164 under open enrollment contracts. Medical directors at BC/BS plans responding to the OTA survey said their plans insure 1,383,166 through individual policies, 671,385 in medically underwritten groups, and 134,878 under open enrollment contracts.

Based on the survey responses of chief underwriters, the fraction of persons covered through self-funded policies ranged from 1 to 62 percent, with an average of 23 percent. One to 49 percent of BC/BS clients were covered by individual policies, with an average of 14 percent. The percentage of persons covered under medically underwritten group policies ranged from 4 to 73 percent, and averaged 20 percent. Finally, underwriters from BC/BS plans responding to the OTA survey covered 19 to 82 percent of people under large group policies, with an average of 44 percent.

For BC/BS medical directors who responded to the OTA survey, a range of O to 66 percent of clients were covered under self-funded policies, with an average of 24 percent. One to 49 percent of persons were covered under individual policies, with an average of 15 percent. Coverage under medically underwritten group policies for this survey population ranged from 4 to 60 percent, with an average of 14 percent. Clients covered under large group policies also varied widely, ranging from 10 to 73 percent, with an average of 46 percent.

Health Maintenance Organizations

As of December 1990, there were 569 HMOS in the United States. OTA sent surveys to the 50 largest HMOS, as well as a sample of 28 plans that were the largest HMOS within a State or the largest by HMO model type. (Four HMO types exist: the staff plan, group plan, network plan, and the individual practice association plan.) Forty-three surveys were returned, of which 20 neither offered individual policies nor medically underwrite groups. Of the 23 HMOS responding that do offer such coverage, 11 HMOS accept individuals and 20 medically underwrite groups (table 2-l). Eighteen of the 23 HMOS responding are federally qualified plans. Of the 23 respondents, 1 wrote disability policies, and 4 wrote life insurance.

As a group, responding HMOS received 69,554 applications for individual coverage in 1990, with a range of 24 to 43,000; 414,977 applications were received for medically underwritten group coverage, with a range of 150 to 350,000. Survey respondents covered a total of 306,861 individual members, with membership ranging from 350 to 258,945. Those HMOS that offer medically underwritten group policies cover about 4.2 million people under such policies, with a range of 1,501 to 2 million people.

The percentage of persons within each HMO covered under self-funded policies ranged from O to 61 percent, with an average of about 4 percent (20 of the responding 43 HMOS had no self-funded policies). Zero to 34 percent of persons were covered through individual policies, with an average of 3 percent (11 HMOS had no individual policies). The percentage of persons covered under medically underwritten group policies ranged from O to 100 percent, and averaged 68 percent. Finally, HMOS responding to the OTA survey covered O to 99 percent of their clients under large group policies, with an average of 25 percent.

TREATMENT OF APPLICATIONS

The outcome of underwriting is risk classification, the final evaluation of whether the applicant for insurance will be covered on a standard or substandard basis, or not at all. Not all insurers view specific conditions the same. A medical condition or impairment that makes an applicant uninsurable to one insurer could be excluded from coverage by another, be included in a policy at a rated (higher-priced) premium, or be ignored altogether. This section describes data related to the treatment of applications for existing clientele. Chapter 3 describes data on how respondents *would* **treat** applications under specific scenarios.

Commercial Health Insurers

Most applicants for individual health insurance are classified as standard and can purchase coverage without additional premiums or limitations (i.e., exclusions). Over half (18 of 29) of commercial insurers responding to the OTA survey provided standard coverage to at least 60 percent of their individual applicants. Three-quarters of the respondents (30 of 38) underwriting small groups also cover 60 to 100 percent of group members on a standard basis.

Substandard policies can include an exclusion waiver, a rated premium, or both. Exclusion waivers temporarily or permanently exclude a medical condition from coverage. The exclusion may be for a specific condition, such as gallstones, or for an entire organ system, such as reproductive disorders. More than half (18 of 29) of responding commercial insurers reported that O to 19 percent of their individual policies carried an exclusion waiver. (Information on the duration of the waiver was not gathered in this survey.) Four companies imposed exclusions for 20 to 34 percent of their individual coverage applicants. Thirty-three of 38 commercial respondents that offer medically underwritten group coverage required exclusion waivers for O to 20 percent of applicants.

Sixteen of 29 commercial insurers that offer individual coverage reported that the increased risk associated with 1 to 20 percent of their applicants required a rated premium. The cost of additional premiums usually ranges from 25 to 100 percent of the standard premium, although some insurers use higher ratings (l). In this survey, OTA found that 18 commercial companies that offer medically underwritten group coverage never charge applicants a rated (higher priced) premium.

All 39 companies that offer individual policies declined some portion of applicants; responses ranged from 2 to 22 percent of applicants. Similarly, all 27 companies offering medically underwritten group coverage declined between 1 and 30 percent of applicants for these policies.

Blue Cross and Blue Shield Plans

Although BC/BS plans generally do not screen for high-risk applicants as exhaustively as do commercial carriers, the risk classification that is used once a high-risk applicant is identified varies little from the approach used by commercial carriers (3). A majority of BC/BS plans represented by the underwriter survey (17 of 25) do not offer standard coverage for their individual applicants; 7 BC/BS plans reported offering standard rates for 25 to 85 percent of individual applicants. About half (11 of 21) of BC/BS plans offering medically underwritten group coverage do not offer standard rates to any applicants. Seven respondents offer standard rates to 10 to 25 percent of applicants for medically underwritten group coverage.

For BC/BS plans represented by a medical director survey, 10 of 18 plans that offer individual coverage do not offer standard coverage to any applicants. Five of the 18 plans that offer individual coverage did so at standard rates to 60 percent or more of all applicants. For medically underwritten groups, one-third (5 of 15) of plans do not offer standard coverage to any applicants. Four of 15 BC/BS plans represented by a medical director survey that offer medically underwritten group coverage offered standard rates to less than 30 percent of applicants. Another four BC/BS plans

offered standard rates to more than 75 percent of applicants.

BC/BS plans generally do not offer coverage at standard rates to open enrollment applicants; seven of eight BC/BS underwriters that work for plans with open enrollment reported that applicants for this type of coverage are not offered standard rates. Three of seven BC/BS medical directors that work for plans with open enrollment said they do not offer individual coverage to any applicants at standard rates. Most plans attempt to hold down premium rates for open enrollment subscribers by providing less comprehensive benefits relative to medically underwritten applicants. Others require open enrollment subscribers to pay higher premiums than underwritten applicants for identical coverage. Open enrollment coverage of high-risk applicants usually entails waiting periods before initial benefits may be paid and may impose limitations on coverage of preexisting conditions (3).

The majority of BC/BS plans represented by underwriter surveys (23 of 25) offering individual coverage do so with standard rates, but with exclusion waivers for O to 50 percent of applicants. However, of the 21 plans offering medically underwritten group coverage, over half (14 plans) do not offer coverage at standard rates with an exclusion waiver to any applicants. The remaining five responding plans offered this coverage to less than 10 percent of applicants. None of the eight BC/BS underwriters plans offered open enrollment coverage at standard rates with an exclusion waiver,

Eight of 18 BC/BS plan medical directors said their plans do not offer standard coverage with an exclusion waiver to anyone applying for individual coverage; the remaining eight BC/BS plans offer standard coverage with an exclusion waiver to less than 27 percent of applicants for individual coverage. Eight of 15 medical directors of BC/BS plans that offer medically underwritten group policies said they do not offer standard coverage with an exclusion waiver to any applicants; the remaining seven BC/BS plans offer this type of coverage to less than 11 percent of all medically underwritten group applicants. For open enrollment, a majority (5 of 7) of medical directors from BC/BS plans that offer such coverage said they offer standard rates with an exclusion waiver to any open enrollment applicant.

Underwriters from 15 of the 25 BC/BS plans offering individual policies responded that more than 50 percent of their applicants are offered coverage at a standard premium but with a waiting period, as do 13 of 21 BC/BS plans offering medically underwritten group coverage. Underwriters at four of eight BC/BS plans offering open enrollment said their plans offer applicants standard rates, but require waiting periods.

Medical directors from 11 of the 18 BC/BS plans that write individual coverage said more than 58 percent of their plans' applicants are offered policies at a standard premium but with awaiting period. Six of 18 BC/BS plans do not offer standard rates with a waiting period to any medically underwritten group applicants, but medical directors from six other BC/BS plans reported their plans offer such coverage to more than 65 percent of their applicants. Three of 7 BC/BS plans offering open enrollment do not give standard rates with a waiting period to any applicants, while two of seven give this coverage to all applicants.

Requiring a rated premium with no waiting period or exclusion waiver was uncommon for plans offering individual coverage-only one plan covered applicants this way among surveys returned by chief underwriters. Although a majority of chief underwriters at BC/BS plans that medically underwrite groups (12 of 21) reported they never offered applicants a rated premium with no waiting period or exclusion waiver, a few plans did: 6 did less than 50 percent of the time and 2 did for more than 80 percent of their applicants. However, no plans offering open enrollment covered applicants this way.

No medical directors from the 18 BC/BS plans that write individual policies offered such coverage at a rated premium without a waiting period or exclusion waiver. Similarly, medical directors from 11 of 15 BC/BS plans said they never offered medically underwritten group coverage with a rated premium and no waiting period or exclusion waiver. A majority (5 of 7) of medical directors from BC/BS plans offering open enrollment said they did not offer this type of coverage to any applicant.

Only 1 of the 25 underwriters from BC/BS plans offering individual coverage responded he or she did so with a rated premium and an exclusion waiver—to 1 percent of applicants. Underwriters from 22 of 25 BC/BS plans offering individual coverage said their plans did not cover any applicants with a waiting period and a rated premium. Six BC/BS

plans offering medically underwritten group policies covered less than 25 percent of applicants with a waiting period and a rated premium, but 13 plans represented by underwriters never offered this coverage. No open enrollment plans offered coverage with a waiting period or an exclusion waiver and a rated premium.

None of the medical directors from BC/BS plans that offer individual policies said their plan covered any applicants with a rated premium and an exclusion waiver. Medical directors from 12 of 15 BC/BS plans that offer medically underwritten group policies said their plans do not cover any applicants with a rated premium and an exclusion waiver. Fifteen of 18 medical directors from BC/BS plans that offer individual coverage said their plans do not cover any applicants with a waiting period and a rated premium. Medical directors from 10 of the 15 BC/BS plans that offer medically underwritten group coverage said their plans do not cover any applicants with a waiting period and a rated premium.

For BC/BS plans represented by the underwriter population, 19 of 21 plans that offer individual coverage declined applicants between O and 25 percent of the time. Nearly all responding underwriters from BC/BS plans (20 of 21) said they declined applicants less than 35 percent of the time. Medical directors from 15 of the 18 BC/BS plans that offer individual coverage reported their plans declined applicants between O and 25 percent of the time. Thirteen of the 15 BC/BS plans returned by a medical director declined applicants for medically underwritten group coverage less than 3 percent of the time.

Health Maintenance Organizations

All 11 HMOS offering individual coverage accept more than 50 percent of their applicants at standard rates. Three-quarters (16 of 20 respondents) of those HMOS offering medically underwritten group coverage offer standard rates to more than 50 percent of their applicants. The majority of HMOS offering individual coverage (9 of 11) do not use exclusion waivers, and a similar proportion of HMOS offering medically underwritten group coverage (15 of 20) also do not use exclusion waivers. Similar proportions were found for HMOS covering applicants with rated premiums: 10 of the 11 HMOs offering individual coverage and 13 of the 20 offering medically underwritten coverage never provide coverage with a rated premium.

Clearly, HMO practices are either to accept applicants or to decline them. Rarely did HMO survey respondents report accepting an applicant with a restriction on the policy. More than half of responding HMOS that offer individual coverage (6 of 11) declined applicants less than 25 percent of the time. The remaining 5 respondents declined applicants for coverage less than 45 percent of the time. For HMOS offering medically underwritten group coverage, the proportion of declined applicants was similar: 15 of the 20 offering medically underwritten group coverage declined coverage less than 25 percent of the time.

CHAPTER 2 REFERENCES

1. Health Insurance Association of America, *A Course in Individual Health Insurance: Parts A and B* (Chicago, IL: Health Insurance Association of America, 1983).
2. Iglehart, J. K., "The American Health Care System—Private Insurance,' New *England Journal of Medicine 326:1715-1720,* 1992.
3. U.S. Congress, Office of Technology Assessment, *Medical Testing and Health Insurance, OTA-H-384* (Washington, DC: U.S. Government Printing Office, August 1988).
4. U.S. Congress, Office of Technology Assessment, *Cystic Fibrosis and DNA Tests: Implications of Carrier Screening, OTA-BA-532* (Washington, DC: U.S. Government Printing Office, August 1992)