Testimony for the Record

The United States House of Representatives Energy and Commerce Committee Subcommittee on Health

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"The Genetic Information Nondiscrimination Act of 2007"
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by

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The National Association of Health Underwriters is a 20,000-member association of insurance professionals involved in the sale and service of health insurance, long-term care insurance and related products. Our members serve the insurance needs of over 200 million Americans. We would like to take this opportunity to present information on the health insurance underwriting process and the effect well-intended genetic discrimination legislation could have on the cost of health insurance as well as the cost impact on employers that are providing benefits such as health insurance for their employees. NAHU believes health insurance affordability is the most important component of access to health care.

Advances in the field of genetics have increased so dramatically that we are now able to clone animals. These dramatic advances have also provided new ways to check for the probability of certain illnesses. The possibilities for treatment and prevention of illness based on the availability of this new information are truly exciting.

In light of these rapid advances in the field of genetic research, some people have expressed concern about whether their genetic information might be used improperly to prevent them from obtaining health insurance or by employers for hiring or firing purposes. NAHU believes that health insurance or employment discrimination based on the genetic information of an otherwise healthy individual should be prohibited, provided that the definition of the "prohibited information" is carefully, clearly and narrowly defined. Inappropriate disclosures of <u>all</u> health information, not just genetic information, should also be prohibited, and regulations on disclosure should apply consistently to all types of health information. But any action taken on these prohibitions should be carefully balanced with the medical promise offered by genetics. In our race to protect the rights of Americans against unlawful discrimination and disclosure, we must be careful not to legislate away our ability to use advances in genetic science to improve our health and eradicate illness.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislated many new protections for health insurance consumers; among those protections was a

provision stating that group health insurers cannot consider any employee's genetic information in the group health insurance underwriting process unless that genetic information has already resulted in a diagnosis. For example, if a generally healthy person had some genetic tests run to see if he had markers for any particular illnesses, that information would be prohibited from use. The law prohibits denial of benefits or increases in premium to individual members of a group health plan due to health status. HIPAA does not address the issue of genetic information in the individual health insurance underwriting process, nor does it address employment discrimination based on genetic information.

It is much more difficult to adequately spread insurance risk in the individual market than it is in employer-sponsored plans. This occurs for several reasons. First, in an employer-sponsored plan, employees are eligible to enroll for coverage when they are hired (following any probationary period) and, at most, once per year during an annual enrollment period. The employer also typically pays a significant portion of the cost of the coverage. For this reason, most people consider employer-sponsored coverage to be a good value and enroll for coverage when they are initially eligible, regardless of their health status. This results in employer-sponsored plans normally having a mix of insurable risks, particularly in larger plans.

In contrast, in the individual market, individuals are typically not eligible for health insurance coverage at a particular time and pay the cost of the coverage entirely on their own. As a result, they are much more likely to seek health insurance coverage when they think they need it, often called "adverse selection." These sicker individuals consume more health care and, because the cost of health insurance coverage is directly related to the cost of medical care by those who are insured, the cost of health insurance rises.

For this reason, it is important to determine the current health risk of those who apply for coverage by asking questions about health status. If legitimate health information is restricted from the underwriting process, the pool of people insured will gravitate toward those who are less healthy, and the cost of coverage will increase for everyone. This is

also the market most sensitive to those cost increases because, again, individual health insurance consumers do not have employers subsidizing the cost of their plans.

Many individuals and families will at some point in their lives purchase coverage in the individual health insurance market, and it is critical that the cost be affordable. If it is not, the ranks of the uninsured will rise, and costs in the small-group market will also increase as people attempt to game the system to somehow change their status from an individual market buyer to a "group."

The use of health status information in the underwriting process keeps costs down and offsets the impact of adverse selection. In states where individual health insurance policies must be issued without regard to health status ("guaranteed issue"), premiums are much higher, coverage choices are limited, and fewer insurance carriers operate in the individual health insurance market. A chart is attached that illustrates these cost differences.

To start out, it may be helpful to explain what underwriting is and why it is important.[1] Underwriting is a basic evaluation of risk. Applicants for all types of insurance go through a risk-evaluation process, or underwriting, as do applicants for credit cards, bank loans and mortgages. A bank would be very reluctant to issue a loan to someone who appears unlikely to be able to repay it, and an insurer would be unlikely to insure a house that was already on fire. If banks were unable to ask the information necessary to ensure the financial stability of applicants, they would either stop issuing loans or increase the interest rate to account for the increased likelihood of losses. Similarly, if an insurer couldn't ask whether a home was already on fire, the insurer would likely not insure homes or dramatically increase the cost to cover the cost of those who waited until their house was on fire to purchase coverage.

[1] A guide to understanding the health insurance underwriting process is included at the end of this testimony.

On the other hand, if the bank and insurer are able to ask the questions needed to accurately assess the risk of an applicant or homeowner, applicants may enjoy a "preferred" rate based on their good credit history, and homeowners may be able to receive discounts for certain safety and security features in their homes. Health insurance underwriting works the same way – the more information the underwriter has, the better the rates will be for most applicants.

Legislation under Consideration

The issue surrounding prohibition of discrimination by health insurance carriers due to genetic information has evolved over the past few years. Legislation to expand the prohibition on the use of genetic information in underwriting has resulted in a variety of opinions as to how genetic information should be defined. Using too broad a definition could disrupt and prevent normal underwriting procedures, resulting in unaffordable health insurance premiums for employers and individuals who purchase health insurance.

The first and primary issue regarding the definition of genetic information relates to **when** information should be considered genetic information. HIPAA prohibits discrimination by any individual within a group based on health status, including genetic information, in the absence of a diagnosis. During the 108th Congress, Representative Slaughter sponsored H.R. 1910. That bill excluded from the definition of "protected genetic information" information about physical exams of the individual, and other information that indicates the current health status of the individual. This exclusion is, unfortunately, not in H.R. 493. Genetic information about current health status may not only be very important to current diagnosis and treatment, but is also important to evaluation of risk for applicants in the individual health insurance market.

Because HIPAA did not adequately define **what** "genetic information" is, it is extremely important that any new legislation clearly specify what should be included in the term. NAHU believes the definition of genetic information should be limited to DNA and related gene testing done for the purpose of predicting risk of disease in asymptomatic or

undiagnosed individuals, and that it should clearly exclude such items as age, gender and information from physical exams and lab work, including items like cholesterol tests and blood pressure screening performed to detect symptoms, clinical signs or a diagnosis of disease.

As an example, a commonly performed lab test during a physical exam is cholesterol screening. Cholesterol screening is a metabolite test. Other legitimate genetic tests are also metabolite tests. Cholesterol screening is currently used as a diagnostic tool and, as such, a "high" result is considered a diagnosis. If physical exams and routine lab tests are not excluded as genetic tests, the status of an item such as cholesterol screening might have to be removed from the diagnostic category, along with the diagnostic code that allows millions of Americans to have their cholesterol-lowering medications covered by their health insurance.

Reduction in the ability to underwrite would have the same result it has had in the states that have tried it, including carrier withdrawal due to excessive losses, significantly reduced choice in benefits, few carriers from which to select coverage, and significantly higher cost for the coverage that is available.

Conclusion

Health insurance underwriting is a complicated process. It is a combination of art and science, and is highly dependent on not only the risk of the applicant but also on market conditions that may be beyond the applicant's control. The most important component of underwriting is complete information to allow for a thorough evaluation of risk.

Good underwriting at the inception of any health insurance policy won't prevent premium increases, but it does result in more stable rates over time. This stability allows families and businesses to plan and budget for their health care expenses, and helps keep coverage affordable and accessible.

There is no question that advances in genetics will increase exponentially in the coming decades. Changes in the accuracy and absolute predictability of the information that will be provided will also improve, and the use of this information to diagnose current illnesses may become as common as taking a blood pressure reading is today. It is extremely important that lawmakers recognize this changing dynamic and proceed thoughtfully on issues related to genetic discrimination, as well as privacy of all health information, to allow the medical field to advance treatments and find cures for those suffering with disease.

Additionally, lawmakers must realize the impact their actions will have on the cost of health insurance today and in the years ahead. Great care should be taken to craft legislation that is very specifically related to a prohibition of the use of genetic tests that are truly predictive in nature. Overly broad definitions will impede the normal underwriting process and increase the cost of coverage, resulting in reduced access to quality health care.

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Addendum A – Explanation of the Process of Health Insurance Underwriting

Underwriting of Health Plans

The Individual Health Insurance Market

Although most people who are insured are covered through employer-sponsored plans, some people do not have access to employer coverage and must buy in the individual health insurance market. The individual health insurance market offers a wide range of policy coverage options in many states, depending on the regulatory environment. Coverage is available in a wide range of deductibles and plan types, and most people can find a policy suitable for their needs, although coverage for maternity and mental health expenses is often limited and prescription drug benefits tend to be more restrictive than those found in the group market.

In most states, individual health insurance is rated based on the age and health status of the applicant and requires the completion of a health questionnaire. Occasionally, a paramedical examination and/or a blood and urine sample are required. Questions about genetic tests are not currently asked by any insurance carrier that we have been able to determine, although a small number of insurers ask questions about the medical history of the applicant's parents and siblings.

Applicants are asked a variety of questions about their current and past medical history, including height and weight, smoking status and details about recent physical exams, including the results of lab work. Complete information allows the underwriter to evaluate the risk of the applicant accurately and provides for greater rate stability. Any missing information can result in the applicant being turned down for coverage. At best, missing information will result in the underwriter assuming the worst, and the consumer will either pay more for coverage or have coverage excluded.

Depending on the state, an applicant for individual health insurance coverage will have coverage issued as applied for, have coverage issued with a rider for certain conditions or body parts, or have coverage "rated up" or issued at a premium higher than the standard rate. The majority of states don't have limits on rate-ups for individual coverage but, if an applicant's health history is such that a large rate-up is indicated, it is more likely that the person would be declined for coverage.

Applicants who are declined for coverage in many states are eligible for coverage through their state high-risk pool. In other states, there is an annual open-enrollment period for uninsurable individuals through one insurance carrier in the state. A few states guarantee coverage in the individual market, although the cost is high and choices significantly limited. Several states provide coverage through a "carrier of last resort," which means that the designated insurance carrier will accept an individual regardless of health status. Usually there is one month per year when this happens, although in some states applicants are accepted all year. A very small number of states have no option for medically uninsurable individuals.

Small Employer Groups of 2-50[1]

Although many people refer to employer self-funded health plans as ERISA plans, small-employer health insurance plans are also ERISA plans. Small employers can select from a variety of plans in most states, including HMOs, PPOs and indemnity plans. The selection depends largely on the regulatory environment in the state in both the small-employer **and** individual markets, and can vary dramatically from state to state.[2] Availability of coverage is also impacted by the location of the business. In general, rural businesses have less selection than businesses in metropolitan areas, largely due to the reluctance of rural providers to participate in managed care plans.

Even though HIPAA and state laws provide that small-employer health insurance coverage must be issued regardless of the health status of employees and dependents, many states allow rates to vary for the group based on overall health status. To determine the health status of the group, each employee is required to complete an individual questionnaire with detailed health information on the employee and all family members to be covered. The underwriter normally uses only information obtained from the application, but sometimes the underwriter will request additional information from an applicant's physician or may telephone the applicant to clarify an item on the application. If an underwriter is unable to obtain information necessary to accurately determine the risk of a particular applicant, he or she will underwrite more conservatively, meaning that the assumption relative to the missing information will be negative rather than positive.

For example, if an underwriter sees that a person has a history of high blood pressure that appears to be normal with medication and has a weight within normal limits, but is unable to determine whether or not the individual smokes and has a normal cholesterol level, the underwriter will assume that the missing information is negative.

[1] When we refer to group size, we are referring to the number of employees, not the total number of covered persons, which would include dependents.

[2] Availability in the individual market impacts the small-employer market dramatically. People who have difficulty qualifying for individual coverage in the individual market often try to find ways to make themselves eligible as a group, sometimes by enrolling family members as employees who may not be

Each employee application is considered individually, usually using a point system, and the overall negative points determine whether the group will be issued at the rates quoted or with a rate-up. On a very small group, one applicant with a health history that would have resulted in a "decline" prior to guaranteed-issue laws will result in a maximum rate-up for the group in most circumstances. It is very important, therefore, that each employee's application be as complete as possible in order to ensure that initial rates are accurate.

The most common type of state rating law allows groups to be rated 25% above or 25% below an "indexed" rate. The indexed rate is determined by averaging the lowest and highest possible rates. Most insurance carriers offer the lowest legal rate on their initial quotes, or 25% below the indexed rate, in states that employ this maximum. If a group's health status is such that it would be rated at the maximum level, this means that its final rate could be 67% higher than the rate initially quote. Most states that have this type of rating system also have a limit on rate increases due to the health status of the group, which is helpful in stabilizing rates over time. Even with these initial rate fluctuations for a new group, small-employer rates in these states tend to be lower than in states where health status rating is not allowed. A group that is rated correctly up front is much less likely to have a very large increase at renewal and, in order to rate the group correctly, the correct information on the initial application is essential. A chart showing the rating laws in each state is attached.

Midsize Employers of 50-300 Employees

This market is considered to be the "medium-size" market. Most employers in this category purchase fully insured health insurance or HMO policies that are regulated by state departments of insurance or another state regulatory body. Many employers of this size offer PPO plans, and a large number offer more than one plan choice for employees.

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actually eligible, for example. This gaming of the system is a type of adverse selection and causes rates to increase for small-employer plans.

It is quite common for an employer to "shop" its health insurance plan every year to be sure it is getting the best value for its dollar. This is normally done with the assistance of an insurance broker.

In order to obtain bids for coverage, employers that have a current health plan or plans are required to provide three years of claims experience to the carriers from which they are soliciting a bid for coverage. Claims experience is a listing of paid premiums vs. paid claims, and includes a calculation for anticipated claims that have not yet been received by the in-force carrier.[3] The claims experience will typically include a list of large claims by amount and the diagnosis associated with the claim. If this is not included with the claims experience, the bidding insurance carrier will request the large claim information. The bidding carrier will also ask about any known serious illnesses to the best of the employer's knowledge, such as cancer, heart problems, AIDS and the prognosis of each, to the best of the employer's knowledge. Names of the employees with these conditions are not requested, but gender and age for the employee or dependent with the condition may be requested, as it may better enable the underwriter to assess the risk.

Sometimes other questions are asked as well. For example, if a person has had recent heart surgery, questions about current blood pressure, weight, smoking status and cholesterol level might be asked. Supplying this information can have a very positive impact on the rates the employer pays for coverage. For example, if an employee who had a large claim is now deceased or is no longer employed, or if the large claim was due to an accident from which the employee has completely recovered, the amount of the large claim is adjusted out of the overall claims experience. If a person had bypass surgery early in the previous plan year, has recovered well and now has normal lab work and blood pressure readings, the chances of another large claim occurring soon are very low, and the underwriter will take that into consideration in setting the plan rates.

[3] Claims that have been incurred but not reported are referred to as IBNR claims.

If the employer is not able to supply large claim and serious illness information, the insurance carrier may either underwrite more conservatively[4] to be sure it covers its bases on the risk assessment or, in some instances, may decline to write coverage on the group. Groups over 50 lives are **not** guaranteed issue. Even though a larger group has more employees over which to spread risk, a group of 50-300 is not considered large enough to spread all possible risks it may contain, and it is necessary to identify particularly high risks in order to establish rates that are adequate to sustain the cost of claims and administration. If the employer is unaware of a serious condition, the health plan will not come back mid-year and penalize the employer for not reporting the condition during the bid process, but an adjustment based on the actual risk will be made at the plan's renewal.

In addition to the claims experience, a list of employees, including gender, date of birth and the type of family members to be covered,[5] is required to calculate an average age for the group and male and female content. Age has an obvious impact on the level of claims because older individuals statistically have higher medical expenses. Females tend to incur higher costs than males until about age 50, and that is the reason for the calculation on gender.

A group of 300 is considered to be 100% credible for its claims experience by most insurance companies. This means that if an employer has three years of available claims experience, an accurate rate can be calculated even without information on age or gender of the employees, just based on the group's past experience. Statistically, most groups follow a fairly predictable three-year pattern if they are large enough.

Of the three years of claims experience, the most weight is given to the most recent year. In addition, insurance carriers have a "book rate" based on their experience with other groups of employees of similar age, gender and industry. The book rate is used for newer groups that haven't had previous coverage and for groups that are a little smaller and not fully credible with their own claims experience. For example, a group of 200 might be

[4] When underwriters underwrite more conservatively, they put a "load" on the rates to account for an expected margin of error.
[5] Spouse only, children only or the entire family

considered 75% credible for its claims experience. Therefore, in calculating the rate, claims experience would be given 75% weight and the book rate would be given 25%. A group of 150 might be considered 50% credible and a group of 100 might be 25% credible. A group of 50 would receive a 100% book rate, modified by any known serious health conditions. This can vary slightly from carrier to carrier, but the general process is the same.

Rate Stability

A number of things can impact a group's rates from year to year. A group may have a large number of maternity cases in a single year, or one or more persons may have large claims that cause the group's claims experience to be abnormally high. New state or federal laws that require payment for specific items and services are not without cost. This cost adds to the total cost of claims paid under the plan, which in turn causes premiums to increase. The cost of prescription drugs is increasing for all employers, as is the cost of medical care in general. Even if nothing unusual happens in a group in a given year, these increasing costs may cause a group's claims experience to go up, and its rates to be increased at the plan's renewal. This is why it is so critical that the rates be as accurate as possible from the start. A plan with rates that are set too low initially will simply recoup its losses at renewal with a very large increase. These large fluctuations in premium are very unsettling for employers and employees, and can result in some employees dropping coverage as they become unable to pay their share of premiums.

Self-Insured Plans

Self-funded or self-insured plans are plans in which the employer takes the risk for the cost of health claims, rather than purchasing a plan from an insurance company. The employer often buys stop-loss coverage to protect against excessive losses, but retains financial responsibility for the plan.

Underwriting in self-funded plans works just like it does for fully insured plans in this market, primarily because of the stop-loss insurance. Although most employers in this

category are fully insured, a large number are partially self-funded and are subject to federal rather than state regulation. In a self-funded plan, an employer usually selects an insurance carrier or third-party administrator to administer claims, a PPO or HMO network of physicians, hospitals and other providers for preferred-provider benefits, a pharmacy benefit manager to manage prescription drug benefits, and a utilization review organization if this service is not performed by the preferred-provider network. Each of these services is normally purchased on a separate monthly-fee-per-employee basis, although the cost of some services may be combined if purchased from the same vendor.

The self-funded employer also normally purchases what is called specific stop-loss insurance to protect against large claims of any one individual covered by the plan, and aggregate stop-loss insurance to protect against excessive utilization by the group as a whole. Once an individual's or group's claims reaches the stop-loss level, the reinsurance carrier is responsible for the claims for the individual or the group, depending on the type of loss, for the balance of the contract year. In order for an employer to know how much stop-loss coverage is appropriate for its group, the same information asked of fully insured cases relating to overall claims experience, large claims and serious illnesses is required. Since stop-loss levels are established based on expected claims, it is very important to be as accurate as possible in anticipating future claims. Complete information during the underwriting process is extremely important or an employer may be forced to set stop-loss levels too high, resulting in inadequate protection in the event of a year of high claims.

Groups of 300 or More Employees

Larger-group underwriting works in a manner similar to that described for midsize employer groups. The differences are a matter of degree. Claims experience is required during the underwriting process but, for a larger group, a claim may not be considered large until it reaches $25,000, $30,000 or even larger.

For this reason, the number of claims that must be reported in the large claim listing may be fewer. Information on serious illnesses will be requested, but detailed information on prognosis is less important. The reason fewer questions are asked is that the larger the group becomes, the more credible its past claims experience is, even with some large claims thrown into the mix. Even large employers, however, have difficulty anticipating and budgeting for cost increases due to new technology and the cost of prescription drugs.

The other thing that changes is that the larger the group is, the more likely it is to be partially self-funded and, if really large, fully self-funded. Stop-loss coverage is usually purchased, but with a higher trigger point for claims as the group becomes larger and better able to handle cash flow fluctuations. Third-party administrators, brokers and consultants use formulas to help employers determine the level of stop-loss coverage that is appropriate based on expected claims, group size and the employer's level of risk tolerance.

Large employers also have greater ability, due to volume purchasing, to offer variety to employees, including multiple plan options. Large employers are also increasing their use of disease-management programs, wellness programs and options for alternative medicine.

One thing that should be noted is that not all employers that self-fund use administrators and insurance carriers. Although it is not very common, there are employers who self-administer their benefits plans. Not all of these employers are "jumbo" employers, and some are in the 50-300 size category. Self-administration is done to save money, and many of the employers that employ this method would not be able to afford to offer a plan if they didn't administer it themselves. The smaller employers that self-administer usually offer decent coverage without complicated provisions. These employers take great care to pay claims accurately, and actually understand the stop-loss provisions of their reinsurance contracts very well. The reinsurance coverage they purchase requires all of the same information gathering required under other arrangements, although it is

sometimes more difficult for them to obtain reinsurance without the "official" prior claims documentation provided by a third-party claims administrator or insurance carrier.

Additional Information about Rates on Health Plans

Rates are also obviously impacted by plan design and type. Rates for PPO plans are usually, but not always, higher than HMOs, partly because the way providers are paid impacts the ultimate claims cost. PPO plans pay preferred providers based on a discounted fee for service or, in some cases, on a previously agreed to per-diem rate for things like hospital stays. Sometimes "case" rates are paid for maternity or similar types of common expenses. A case rate is a lump sum paid for a certain types of expenses. For example, an uncomplicated vaginal delivery might have a case rate of $1,000. Out-of-network providers are paid based on a percentile of the usual and customary (UCR) cost of a service in the ZIP code of the provider. Some plans pay out-of-network providers based on the 80th percentile of UCR, some on the 70th percentile, and some on the 90th percentile. The percentile used is important because on out-of-network claims, the insured is responsible for all charges the insurance plan doesn't pay for, and because it impacts the dollar amount of total claims paid.

Example: Employee is covered by a plan that pays for services at 90% in network and 70% out of network. Out-of-network charges are paid on the 90th percentile. Employee has surgery by an out-of-network physician who charges $1,000. Ninety percent of physicians in the area charge $900 or less for the procedure, so the physician the employee selected is above the 90% percentile of usual and customary charges by $100. Here is how the claim is paid at both the 80th and 90th percentiles:

	At 90th Percentile	At 80th Percentile
Surgery	$1,000	$1,000
Minus amount over Usual & Customary Charges	$ 100	$ 150
Covered fee	$ 900	$ 850

Insurance pays 70%	$ 630	$ 595
Employee pays 30% plus amount over UCR	$ 370	$ 405

If the insured uses an in-network PPO provider, then the insured would not be responsible for charges in excess of the contract rate. Example:

	Charges
Regular rate for the surgery	$1,000
Contract rate for the surgery	$ 650
Insurance pays 90%	$ 585
Employee pays 10% of contract rate	$ 65

As you can see, because of the PPO discount, both the plan and the employee pay less with the PPO provider, even though the plan is paying at 90%. This means claims payments will be less and premiums lower if most employees use preferred providers. It also is an incentive for plans to develop full networks of providers. In this instance, if the plan did not have an adequate network and had to pay the full undiscounted rate to the surgeon at 90%, the plan would have paid $900 for a service that should have cost it $585.[6]

Premiums on PPO plans are also impacted by the ability of the plan to negotiate discounted fees with preferred providers. In rural areas, it is often difficult to negotiate a discounted fee with a physician who may be the only specialist of that type in town, and many physicians in rural areas don't negotiate at all. In those situations, there may be

[6] One of the reasons rural areas have fewer PPO and other managed care plan options is that PPOs and HMOs frequently experience difficulty in getting physicians in rural areas to participate. This results in the problem described above, where the plan is forced to pay for a service at the full undiscounted rate at the highest applicable percentage, while the employee's cost-sharing is not allowed to be more than it would have been with an in-network provider, because of rules on network adequacy. Network-adequacy rules require plans to include providers in each specialty that might be required by people insured under the plan, as well as provide for adequate facilities for lab, x-ray and hospital care. In this case, a plan may decide it's not economically feasible to offer coverage in the area, or may attempt to control costs with a "hospital

few PPOs available and, for those that are available, it is much more likely that out-of-network claims will be paid at a lower percentile of UCR and that the percentage payable will be less. If you go back to the example above, you will note that the out-of-network claim paid at the 80th percentile resulted in a payment by the plan similar to the payment made to the PPO provider. The difference in this situation is that for out-of-network claims, the insured takes on all of the responsibility for the amount not paid by the carrier while, with preferred providers, the provider absorbs the cost.

In addition, even though the flexibility of a PPO is attractive, there are few barriers to utilization and, as a result, costs may be higher than they would be under an HMO. All rates are based on claims, whether it is the group's own claims experience or a book rate. Therefore, anything that increases the ultimate cost of claims paid out will impact the rate paid. This includes the cost of prescription drugs; for this reason, many employers that want to retain as high a level of benefits as possible for non-pharmaceutical benefits are requiring increasingly larger copays for drugs, especially those not on the formulary.

HMOs pay providers in a variety of ways. Some actually pay physicians the same way PPOs do, based on a discounted fee for service. This is especially common when an HMO enters a new area and doesn't yet have a significant market share. But, more commonly, the HMO pays a primary care physician a fixed rate, called a capitated rate, per member per month, regardless of the number of times a person may or may not have seen the physician that month. Some specialists are capitated the same way, and others are paid a discounted fee for service. Certain specialties are very likely to be capitated, such as anesthesia, pathology and radiology. Hospitals are usually paid on a per-diem basis, although they may be capitated or paid a case rate for some types of admissions.

HMOs usually require a referral from the primary care physician for a patient to see a specialist, and only cover care from network providers. The idea of referrals is to ensure that only patients who actually require specialty care are seen by plan specialists.

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only" PPO or an indemnity plan where it can have some control over reimbursements by lowering the percentile it uses for usual and customary charges.

Because primary care physicians are capitated, the cost of non-hospital care is more predictable and is usually lower than under a PPO where costs are more impacted by the rate of utilization. Most services require authorization from the primary care physician, and this more tightly managed care results in greater cost efficiencies.

In spite of this management of care, a sick person will result in high costs regardless of the type of plan. How high the costs are will vary by degree with the plan type. HMO rates are typically based on the "community" of members in their pool; however, they are permitted to make adjustments based on the demographics of the actual group to be insured. Again, it is essential that the bidding HMO have accurate information on the actual group to be insured in order to establish adequate initial rates.

One other type of common option is a point of service (POS) plan. This type of plan option is often confused with a PPO because they look similar on the surface. In reality, a POS plan is simply an HMO with an option to use out-of-network providers. Usually the out-of-network option is significantly less attractive than an out-of-network option on a PPO plan, and the in-network portion of the plan is an HMO. This means that in the network, all HMO rules must be followed, including rules on referrals for in-network specialty care. While not quite as flexible as a PPO plan, a POS plan offers a good value for the dollar, especially if HMO providers will be used most of the time, while still allowing a safety net for people who want to retain the option of using non-network providers.

Addendum B

A Comparison of Individual Market Health Insurance Costs and Individual Health Insurance Market Regulatory Factors for Low-Income Families Across the United States (Rates as of June 2005)

In this analysis, the National Association of Health Underwriters (NAHU) compares how much a health insurance policy purchased by a low-income American family through the individual health insurance market in each state would cost, as well as what type of plan benefits would be available to them. We assumed this was a family made up of a single mother, age 35, and two healthy daughters, ages seven and nine. When obtaining these rates, we assumed that each of these fictional individuals were healthy, non-smokers with creditable coverage who live in the same ZIP codes and counties as the capitals in each of these states. We also assumed that coverage would begin on June 1, 2005.

For each state, NAHU sought out PPO family coverage that cost approximately $250 per month, or approximately $3000 per year. In most states there was coverage in this price range, and less expensive policies were also available; however, in some cases similar coverage could not be obtained in that price range so the least expensive equivalent policy information is listed. In addition to the rates and policy benefits listed, we also provide a summary of the individual health insurance market regulatory climate in each state, which can have a substantial impact on health insurance rates and the availability of coverage.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Alabama 36130	PPO	$245.34	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual $1500/$3000 out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool to serve HIPAA-eligible population. Allows for elimination riders. 60-month look-back and 24-month exclusionary period limit for preexisting conditions. State regulation of managed care entities makes it extremely difficult for carriers to offer individual market PPO products.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Alaska 9 9 8 1 1	Managed Indemnity	$289.30	$5000/$15000	100% coverage after the deductible.	Non-preventive office visits and hospitalization are subject to deductible and coinsurance. Additional $50 ER deductible (waived if admitted). Mental health up to $1,000 per insured per calendar year, limited to 25 visits per year, charges paid at 50% including prescriptions, $40 maximum benefit per day, $10,000 lifetime maximum inpatient and out patient combined. RX discount card, average 15% discount. Annual $5000/$15000 out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool to serve the state's medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Geographical considerations may impact competition and prices.
Arizona 85007	PPO	$236.12	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. $1500/$3000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. No mechanism to serve the state's medically uninsurable population. Individual market serves as the GI option for HIPAA-eligible population. Elimination riders allowed, except for HIPAA-eligible individuals. Credit for prior coverage not required, except for HIPAA-eligibles. Preexisting conditions may not be considered for HIPAA-eligibles. No look-back or exclusionary period limit for preexisting conditions for other individual policies. The Healthcare Group of Arizona Purchasing Pool must GI coverage to groups-of-one.
Arkansas 72201	PPO	$225.72	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. $1500/$3000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool to serve the state's medically uninsurable and HIPAA-eligible populations. 60-month look-back period limit on preexisting conditions. Elimination riders allowed.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
California 95814	PPO	$239.00	$2500/$5000	70% coverage after the deductible.	$30 office visit co-pay. Separate $100 deductible for RX with $15/35/50 30-day pharmacy co-pay and $30/70/100 90-day mail-order co-pay. ER visits, mental health and hospitalization are subject to additional co-pays following the deductible. $4500/$9000 annual family out-pf-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool to serve the state's medically uninsurable population. All carriers must GI their two most popular products to the HIPAA-eligible population and to people who have exceeded two years in the risk-pool. Elimination riders not allowed. Credit for prior coverage required. 12-month look-back and exclusionary period limit for preexisting conditions for 1-2 lives covered by an individual policy. 6-month look-back and exclusionary period limit for 3 or more lives covered by an individual policy.
Colorado 80203	PPO	$262.10	$2000 (individual only)	80% in-network coverage after the deductible.	$30 office visit co-pay. $15/40/60 RX co-pay. 50% mental health coinsurance rate. $3000 annual per-member out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool to serve the state's medically uninsurable and HIPAA-eligible populations. Elimination riders allowed for medical conditions. Credit for prior coverage required. 12-month look-back and exclusionary period limit for preexisting conditions. Carriers must GI basic and standard small-group coverage during an annual open enrollment window to groups-of-one with involuntary loss of coverage only.
Connecticut 06106	PPO	$238.57	$1500/$3000	80% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. $1000 individual annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool to serve the state's medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage required. 12-month look-back and exclusionary period limit for preexisting conditions. Carriers must GI standardized small-group coverage to groups-of-one.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Delaware 19901	PPO	$254.16	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. $1500/$3000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. No mechanism to serve the state's medically uninsurable population. Individual market serves as the GI option for the HIPAA-eligible population. Elimination riders allowed except for the HIPAA-eligible population. Credit for prior coverage only required of the HIPAA-eligible population. Carriers must GI small-group coverage to groups-of-one.
District of Columbia 20004	PPO	$251.00	$2500/$5000	80% coverage after the deductible.	$30 primary care office visit co-pay . $40 specialist office visit co-pay. $15/25/40 RX co-pay with $5000 annual maximum and $500 calendar year deductible for non-generic drugs. ER visits subject to $100 co-pay if not admitted. Mental health office visits subject to 75% coinsurance for the first 40 visits and 60% thereafter. $5000/$10000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. Limited GI coverage during an annual open enrollment with a 2-month waiting period available through Carefirst BCBS for the medically uninsurable population. Individual market serves as the GI option for the HIPAA-eligible population. Elimination riders allowed except for the HIPAA-eligible population and the BCBS GI product. 12-month exclusionary period limit for preexisting conditions for HMOs. 10-month exclusionary period limit for preexisting conditions for BCBS GI product. Credit for prior coverage only required of the HIPAA-eligible population.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Florida 32399	PPO	$239.16	$1500/$3000	80% coverage after the deductible.	Office visits, RX, hospitalization and ER subject to the deductible. $500 outpatient/$2500 inpatient annual maximum for mental health and 50% coinsurance. $2000/$4000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. Legislation passed in 2004 to create a new risk pool for the medically uninsurable population, however at this time it is not funded. The current risk-pool for medically uninsurable population is currently closed to new applicants. Individual market serves as the GI option for the HIPAA-eligible population. Elimination riders permitted, except for HIPAA-eligible population. 24-month look-back and exclusionary period limit for preexisting conditions. Preexisting conditions may not be considered for HIPAA-eligible population. Credit for prior coverage required. Carriers must GI certain small-group coverage to groups-of-one during annual open enrollment period.
Georgia 30303	PPO	$237.80	$2500/$5000	80% coverage after the deductible.	Office visits, hospitalization and ER subject to the deductible. $500 RX deductible and then $10/30/50/25% co-pay. $500 outpatient/$2500 inpatient annual maximum for mental health and 50% coinsurance. $2000 individual annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. 24-month exclusionary period limit for preexisting conditions. No mechanism to serve the state's medically uninsurable population. Carriers must provide GI coverage to the HIPAA-eligible population on an assignment basis. Elimination riders permitted except for the HIPAA-eligible population under certain circumstances. Credit for prior coverage not required except for the HIPAA-eligible population under certain circumstances.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Hawaii 96813	HMO	$294.50	None	70% coverage.	$15 office visit co-pay, $50 ER co-pay and $35 ER physician co-pay, hospitalization subject to coinsurance, and maternity subject to 90% coinsurance. $7500/$22000 annual out of-pocket maximum.	No rate caps and medical underwriting allowed. No mechanism to serve the state's medically uninsurable population that does not have access to the group market. Individual market serves as the GI option for the HIPAA-eligible population. 36-month exclusionary period limit for preexisting conditions. Preexisting conditions may not be considered for HIPAA-eligible population. Elimination riders permitted, except for the HIPAA eligible population. Credit for prior coverage not required, except for the HIPAA-eligible population. State's group coverage mandate for employees that work 20 or more hours per week Geographical considerations may impact competition and prices.
Idaho 83720	PPO	$245.02	$3000 Individual (deductibles waived for all other insureds after three family members meet their deductible)	80% coverage after the deductible.	Hospitalization, ER, RX and office visits subject to the deductible and coinsurance. Separate $5000 maternity deductible. Separate coinsurance and benefit limits for mental health services. $5500 annual out-of-pocket maximum.	Rates are subject to bands of plus or minus 50 percent of the base individual market rate for experience, health status and duration, with variances also allowed for age and gender. Carriers must GI at least three products (basic, standard and catastrophic) to all individual market consumers with 12 months of creditable coverage. State individual market high-risk reinsurance pool to provide the medically uninsurable population with lower cost GI coverage. 6-month look-back and 12-month exclusionary period limit for preexisting conditions. Preexisting conditions may not be considered for standardized policies. Credit for prior coverage required. Elimination riders not permitted.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Illinois 62706	PPO	$209.96	$1000/$3000	80% coverage after the deductible.	Office visits and hospitalization are subject to deductible and coinsurance. Additional $75 ER co-pay (waived if admitted), and separate $500 RX deductible with $10/30/50/25% co-pays. $2500 annual maximum for mental health services with 50% coinsurance. Annual out-of-pocket maximum per individual is $2000 in addition to deductibles.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed except for HIPAA population. Credit for prior coverage not required except for HIPAA population. 12-month look back period during first two years of coverage, and if the condition is determined to be preexisting a 24-month exclusionary period is allowed, as is a 12-month exclusionary period for symptoms.
Indiana 46204	PPO	$244.01	$2500/$5000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $2500/$5000.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. 12-month look-back and 24-month exclusionary period limit for preexisting conditions. Elimination riders not permitted. Credit for prior coverage required only in the small group market.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Iowa 50319	PPO	$204.06	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $1500/$3000.	Carriers are subject to rating restrictions based on the pricing for of their different blocks of business. The rate differential between the two policy forms must be no more than 2.028 to 1 at each age, i.e., the composite effect of 30%, and 20%. Subsequent rate changes must be within 15% of each other. Carriers must GI standardized policies for residents with 12 months of creditable coverage that meet other specified criteria. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders permitted. Credit for prior coverage required for HIPAA-eligibles and standardized policies. Preexisting conditions may not be considered for HIPAA-eligibles. 12-month look-back and exclusionary period limit on preexisting health conditions for standardized GI policies. 60-month look-back and 12-month exclusionary period limit on preexisting health conditions for all other individual market policies.
Kansas 66612	PPO	$238.08	$2500/$5000	80% coverage after the deductible.	Office visits, mental health and hospitalization are subject to deductible and coinsurance. Additional $75 ER co-pay (waived if admitted), and separate $500 RX deductible with $10/30/50/25% co-pays. Varying coinsurance rates for mental health outpatient visits and 30-day limit for mental health/chemical dependency inpatient care. Annual out-of-pocket maximum per individual is $2000 in addition to deductibles.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage not required. 12-month look-back and 24-month exclusionary period limit for preexisting conditions.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Kentucky 40601 (Franklin County)	PPO	$220.90	$1000/$2000	80% coverage after the deductible.	Office visits, hospitalization, mental health and ER visits are subject to the deductible and coinsurance. $15 co-pay for generic/formulary RX, non-generic/formulary not covered. $3000/$6000 annual out-of-pocket limit.	Rates are subject to bands of plus or minus 35 percent of the base individual market rate. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders not permitted. Credit for prior coverage required. 6-month look-back and 12-month exclusionary period limit for preexisting conditions.
Louisiana 70804	PPO	$238.10	$5000/$15000	100% coverage after the deductible.	$10 office visit co-pay for non-preventive care. RX discount card. Hospitalization subject to deductible, and ER subject to $50 additional deductible (waived if admitted). Annual mental health benefit limits of $1000/25 visits out-patient/$2500 inpatient, and coverage is subject to coinsurance. $5000/$15000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. (Statutory rate bands are not enforced in Louisiana's individual health insurance market.) High-risk pool serves the state medically uninsurable and a separate pool serves the HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage required. 12-month look-back and exclusionary period limit for preexisting conditions.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Maine 04333	PPO	$267.98	$5000/$10000	100% coverage after the deductible.	Office visits, RX coverage, ER visits and hospitalization all subject to the deductible. Preventive care and well-baby care covered outside of the deductible, with benefit maximums	All major medical products must be offered on a GI basis. Modified community rating with adjustments of plus or minus 20 percent of the community rate only allowed for age, occupation, and geography. A separate adjustment can be made for smoker status. Individual market serves as the GI option for HIPAA-eligible population. Elimination riders not permitted. Credit for prior coverage required.
Maryland 21401	PPO	$237.90	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $1500/$3000.	No rate caps and medical underwriting allowed, except for a 200% of the base rate cap for HIPAA eligibles. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed except for HIPAA-eligibles. Credit for prior coverage required for HIPAA eligibles. 4-month look-back and 24-month exclusionary period limit for preexisting conditions. Preexisting conditions may not be considered for HIPAA-eligibles and HMO plans. Carriers must GI coverage standardized plan to self-employed individuals during annual open enrollment period.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Massachusetts	PPO	$377.49	$5000/$10000	100% coverage after deductible.	Office visits, ER visits, hospitalization, maternity and mental health services subject to the deductible. RX discount card available. $5000/$10000 annual out-of-pocket maximum.	Carriers must GI at least three individual market products to all consumers. Modified community rated basis, with adjustments limited to age, geography and benefit level on a 2:1 basis. Individual market serves as the GI option for HIPAA-eligible population. Elimination riders not permitted. Credit for prior coverage required. 6-month look-back and exclusionary period limit for preexisting conditions. Carriers must GI coverage to groups-of-one.
Michigan 48909	PPO	$221.55	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $1500/$3000.	No rate caps and medical underwriting allowed, except for BCBS of Michigan and HMOs. BCBS of Michigan must GI products to all residents and groups-of-one. BCBS of Michigan serves as the GI option for HIPAA-eligibles. HMOs must GI all products during an annual open-enrollment period. Elimination riders not permitted. Credit for prior coverage not required. 6-month look-back and a 12-month exclusionary period limit on preexisting health conditions. 6-month look-back and exclusionary period limit preexisting health conditions for BCBS and HMOs.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Minnesota 55155	PPO	$234.83	$1500 (individual only with limit of three deductibles per family per year)	80% coverage after the deductible.	Office visits, hospitalization, mental health, maternity and ER are subject to the deductible, with an 18-month initial exclusion for maternity. No deductible for pre-natal care. Separate $500 RX deductible. $2500 individual annual out-of-pocket maximum.	Rates are subject to bands of plus or minus 25 percent of the base individual market rate for health status, plus or minus 50 percent for age and plus or minus 20 percent for geography. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. High-risk pool has a 3-month look-back and a 6-month exclusionary period limit on preexisting health conditions for people without creditable coverage. Elimination riders not permitted for policies issued after 1993. Credit for prior coverage required. No exclusionary period allowed for preexisting health conditions for people with creditable coverage.
Mississippi 39201	PPO	$217.14	$2500/$5000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $2500/$5000.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage not required. 12-month look-back and exclusionary period limit for preexisting conditions.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Missouri 65101	PPO	$250.88	$2500/$5000	80% coverage after the deductible.	$25 primary care/$40 specialty care office visit co-pays up to 4 visits per year. After 4 visits are met, then 20% coinsurance after deductible. Mental Office visits, mental health and hospitalization are subject to deductible and coinsurance. Additional $75 ER co-pay (waived if admitted), and separate $500 RX deductible with $10/30/50/25% co-pays. Varying coinsurance rates for mental health outpatient visits and 30-day limit for mental health/chemical dependency inpatient care. Annual out-of-pocket maximum per individual is $2000 in addition to deductibles.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable population. All Carriers must GI basic and standard products to HIPAA-eligibles. (Missouri never enacted HIPAA enabling legislation, so there is federal enforcement of HIPAA through CMS. Elimination riders allowed except for HIPAA-eligibles.) Credit for prior coverage not required except for HIPAA-eligibles. Unlimited look-back and 24-month exclusionary period limit for preexisting conditions. Preexisting conditions may not be considered for HIPAA-eligibles.
Montana 59620	PPO	$223.68	$2000/$6000	50% coverage after the deductible.	Office visits, hospitalization and maternity are subject to deductible and coinsurance. Additional $75 ER access fee (waived if admitted), and additional $500 hospital access fee. Separate $500 RX deductible. Generic: $10 co-pay. Brand when generic not available: $25 co-pay plus 50% of remaining cost. Brand when generic available: The difference between the cost of brand vs. generic plus $25 co-pay plus 50% of remaining cost. Annual out-of-pocket maximum is $2500/$5000 plus the deductible.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage required. 36-month look-back and 12-month exclusionary period limit for preexisting conditions. Geographical considerations may impact competition and prices.
Nebraska 68509	PPO	$242.77	$1500 individual	100% coverage after the deductible.	Office visits, hospitalization and ER are subject to the deductible and coinsurance. Additional $100 ER co-pay. Mental health benefits as mandated by the state. RX discount card.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. No look-back or exclusionary period limit for preexisting conditions. No look-back or exclusionary period limit for preexisting conditions.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Nevada 89101	PPO	$229.00	$2000/$4000	70% coverage after the deductible.	$30 office visit co-pay up to 4 visits a year. ER, hospitalization and mental health/chemical dependency subject to deductible and coinsurance. RX coverage with separate $100 deductible and $20/30 co-pay and $100 annual limit. Mental health coverage for severe illnesses only, subject to limits and chemical dependency subject to limits. $4000/$8000 annual out-of-pocket maximum.	Rates are subject to bands of plus or minus 50 percent of the base individual market rate. Carriers must GI basic and standard plans to HIPAA-eligibles. Credit for prior coverage required. Elimination riders permitted except for HIPAA-eligibles and the basic and standard plans. Preexisting conditions may not be considered for HIPAA-eligibles. No look-back or exclusionary period limit for preexisting conditions for other individual policies.
New Hampshire 03301	PPO	$325.49	$5000	80% coverage after the deductible.	Non-preventive office visits, hospitalization and ER visits subject to deductible and coinsurance, as well as a $100 ER co-pay. $10 generic RX co-pay with $1000 annual maximum. $15000 annual out-of-pocket maximum per family.	Rates are subject to rate bands. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders are permitted. Credit for prior coverage is required. 3-month look-back and a 9-month exclusionary period limit on preexisting health conditions. Carriers must GI coverage to groups-of-one during bi-annual open enrollment periods.
New Jersey 08625	EPO	$420.08	None	70%	100% coverage of office visits up to $700 per year. $50 deductible for periodic health exams and OB/GYM visits, then 20% coinsurance up to $600 annual limit. $500 hospitalization co-payment and $100 ER co-payment.	Pure community rating for all products, except for the basic and essential plans which allow 3.5:1 variations for age, gender and geography. All carriers must GI five standardized products to all consumers. Elimination riders not permitted. Credit for prior coverage required. 6-month look-back and 12-month exclusionary period limit for preexisting conditions.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
New Mexico 87501	PPO	$228.96	$1000/$3000	80% coverage after the deductible.	Non-preventive office visits, ER and hospitalization subject to deductible. 100% coverage of preventive care up to a $400 per member annual maximum, then subject to deductible and coinsurance. RX discount card for generics. $2000/$5000 annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage required. 6-month look-back and exclusionary period limit on preexisting health conditions. The NM Health Insurance Alliance must GI coverage to HIPAA-eligibles and self-employed individuals under certain conditions.
New York 12224	PPO	$734.13	$250/$500 (out-of-network only)	100% coverage of the GHI Schedule of Allowance	Office visits not covered except for well-child visits. Separate RX deductible of $50 and $10 co-pay for generics and brand name without generic equivalent. $10 plus difference between brand and generic for brand name with generic equivalent. No RX deductible for mail order and $8/$15 co-pay for 90-day supply. Coverage of hospitalization, maternity and ER visits ($50 co-pay). Thirty days annual inpatient psychiatric care and5 days per calendar for substance abuse and detoxification. $10,000 annual out-of-pocket limit.	Coverage must be community-rated with adjustments limited to family composition and geographic regions. All carriers must GI all individual market products to all consumers. Elimination riders not permitted. Credit for prior coverage required. 6-month look-back and 12-month exclusionary period limit for preexisting conditions.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
North Carolina 27699-	PPO	$239.77	$5000/$15000	100% in-network coverage after the deductible.	$25 non-preventive office visit co-pay. ER and hospitalization are subject to deductible and coinsurance. Additional $50 ER deductible (waived if admitted). Mental health up to $1,000 per insured per calendar year, limited to 25 visits per year, charges paid at 50% including prescriptions, $40 maximum benefit per day, $10,000 lifetime maximum inpatient and out patient combined. RX discount card, average 15% discount. Annual $5000/$15000 out-of-pocket maximum.	No rate caps and medical underwriting allowed. No mechanism to serve the state's medically uninsurable population. Individual market serves as the GI option for HIPAA-eligible population. BCBS of NC GIs some products to all consumers. Elimination riders allowed, except for HIPAA-eligible individuals. Credit for prior coverage required. Preexisting conditions may not be considered for HIPAA-eligibles. 12-month look-back and exclusionary period limit for preexisting conditions for other individual policies. Carriers must GI basic and standard plans to groups-of-one.
North Dakota 58505	PPO	$197.76	$1600/$3200 The deductible for family coverage is integrated.	80% coverage after the deductible.	Office visits, RX, ER and hospitalization subject to deductible and coinsurance, with an additional $75 ER access fee (waived if admitted). $500 per year benefit for all wellness services. Mental health services $500 calendar year maximum $2,500 combined inpatient and outpatient, including inpatient chemical dependency with 50% coinsurance after deductible. Annual out-of-pocket maximum of $2000/$4000 plus deductible.	Rates are subject to rate bands. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders permitted Credit for prior coverage required. 6-month look-back and 12-month exclusionary period limit on preexisting health conditions. Geographical considerations may impact competition and prices.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Ohio 43215	PPO	$233.56	$1000/$3000	80% coverage after the deductible.	Office visits, hospitalization and ER are subject to deductible and coinsurance. Additional $75 ER access fee (waived if admitted). Separate $500 RX deductible. Generic: $10 co-pay. Brand when generic not available: $25 co-pay plus 52% of remaining cost. Brand when generic available: The difference between the cost of brand vs. generic plus $25 co-pay plus 20% of remaining cost. Annual out-of-pocket maximum is $2000/$4000 plus the deductible.	No rate caps except on standardized products, and medical underwriting allowed. Traditional carriers must GI two standardized products until they meet enrollment caps, and HMOs must GI coverage one month each year. Elimination riders permitted. Credit for prior coverage required. 6-month look-back and 12-month exclusionary period limit on preexisting health conditions. Preexisting conditions may not be considered for HMO basic health service plans.
Oklahoma 73105	PPO	$238.25	$3500/$7000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual $3500/$7000 out-of-pocket maximum.	No rate caps and medical underwriting allowed, except for HMOs. (HMOs must community rate individual market coverage in Oklahoma and cannot look-back at preexisting conditions or impose exclusionary periods in this market; however, no HMOs offer individual market coverage in the state at this time.) High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage not required. Preexisting conditions may not be considered for HMO products. No look-back or exclusionary period limit for preexisting conditions for all other individual products.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Oregon 97301	PPO	$249.00	$500 individual	80% coverage after the deductible.	Hospitalization, ER and maternity are subject to the deductible and coinsurance, with $100 ER co-pay (waived if admitted). Inpatient mental health subject to deductible and coinsurance and 30-day benefit limit, and chemical dependency subject to deductible and coinsurance, as well as a $4500 per consecutive 24-month period benefit limit. RX covered at 50% with a $10,000 benefit limit. Annual $4,000 out-of-pocket maximum.	Community rating with variances allowed based on geography and benefit design. Carriers must GI portability products to residents with 6 months of prior coverage. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders not permitted. Credit for prior coverage required. Preexisting conditions may not be considered for portability products. No look-back or exclusionary period limit for preexisting conditions for all other individual products.
Pennsylvania 17120	PPO	$251.77	$2500/$5000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $2500/$5000.	No rate caps and medical underwriting allowed. Various BCBS plans GIs some products to all consumers and serve as the GI option for HIPAA-eligible population. Elimination riders allowed, except for HIPAA-eligible individuals. Credit for prior coverage not required. Preexisting conditions may not be considered for HIPAA-eligibles. 60-month look-back and 36-month exclusionary period limit for preexisting conditions for other individual policies.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Rhode Island 02903	PPO	$392.62	None	80% coverage after the deductible	Hospitalization, ER visits, and inpatient maternity and mental health subject to coinsurance. $500 per hospital admission co-payment.	No rate caps and medical underwriting allowed. All carriers must GI coverage to HIPAA-eligibles and individuals with 12-months of prior coverage. Elimination riders permitted except for GI plans. Credit for prior coverage not required except for GI plans. Preexisting conditions may not be considered for HIPAA-eligibles and those with 12 months of prior coverage. 36-month look-back and 12-month exclusionary period limit for preexisting conditions for other individual policies. State regulation of managed care entities makes it extremely difficult for carriers to offer individual market PPO products.
South Carolina 29201	PPO	$212.41	$2000/$4000	80% coverage after the deductible.	$35 office visit co-pay (maximum 2 visits per person, per year, then not covered). Well baby covered as per state mandates. Hospitalization and ER are subject to deductible and coinsurance. Additional $500 ER co-pay (waived if admitted). RX discount card. Annual out-of-pocket maximum is $3000 per person plus two deductibles per family per year.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage not required, except for HIPAA eligibles. 12-month look-back and exclusionary period limit for preexisting conditions for HMOs. Unlimited look-back and 24-month exclusionary period limit for preexisting conditions for other individual policies.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
South Dakota 57501	Managed Indemnity	$335.70	$2500/$7500	100% coverage after the deductible.	Non-preventive office visits, hospitalization and ER visits subject to deductible and coinsurance, with a separate $50 ER deductible (waived if admitted). RX discount card. Annual mental health benefit limits of $1000 outpatient/$2500 inpatient, and coverage is subject to coinsurance and limitations. $2500/$7500 annual out-of-pocket maximum.	Rates are subject to bands of plus or minus 30 percent of the base individual market rate. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. (Individuals must have at least 12-months of creditable coverage for risk-pool participation only if group coverage was lost through cancellation.) Elimination riders allowed. Credit for prior coverage required. 12-month look-back and exclusionary period limit on preexisting health conditions Geographical considerations may impact competition and prices.
Tennessee 37243	PPO	$210.43	$2500/$5000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $2500/$5000.	No rate caps and medical underwriting allowed. Tenncare serves the state's medically uninsurable population, but is closed at this time. Individual market serves as the GI option for HIPAA-eligible population. Elimination riders allowed, except for HIPAA-eligible individuals. Credit for prior coverage not required, except for HIPAA-eligibles. Preexisting conditions may not be considered for HIPAA-eligibles. No look-back or exclusionary period limit for preexisting conditions for other individual policies.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Texas 78701	PPO	$253.00	$1500 individual (two member per family maximum)	75% coverage after the deductible.	$30 office visit co-pay for the first 4 visits per member per year with deductible waived; after 4 visits, 25% of negotiated fee. Hospitalization and ER subject to deductible and coinsurance. Mental health charges over $100 per day covered up to $3,000 per year maximum. Separate $150 RX deductible then $15/$25 co-pay. $3000/$6000 plus deductible annual out-of-pocket maximum.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for 1-month or more prior coverage required. Preexisting conditions may not be considered for HMO products. 60-month look-back and 24-month exclusionary period limit for preexisting conditions for other individual policies.
Utah 84114	PPO	$240.00	$1000 individual	80% coverage after the deductible.	$20 office visit co-pay and $5/25%/50% RX co-pay. Separate $5000 maternity coverage deductible (not applied to out-of-pocket maximum), then 100% coverage. Hospitalization and ER visits subject to deductible and coinsurance, with $75 ER in-network co-pay. Mental health services subject to 50% coinsurance after the deductible plus benefit limits. $3500 annual out-of-pocket maximum, including deductible.	Rates are subject to rate bands of plus or minus 30 percent of the indexed individual market rate. Carriers must guarantee issue products to people that meet certain health criteria. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage required. 6-month look-back and 12-month exclusionary period limit on preexisting health conditions. Carriers must GI coverage to certain HIPAA-eligibles who meet specified health criteria.
Vermont 05609	PPO	$578.94	$10000/$20000	100% coverage after the deductible	$30 office visit co-pay. All other benefits subject to deductible and coinsurance. $17000/$34000 out-of-pocket annual maximum.	All individual market coverage must be offered on a guarantee issue basis. 9-month look-back and a 12-month exclusionary period limit on preexisting health conditions. Carriers may only offer coverage on a community rated basis with adjustments limited to those approved by the state Insurance Commissioner. Currently variances of plus or minus 20 percent of the average group rate based on age and gender are allowed.

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
Virginia 23219	PPO	$233.21	$1500/$3000	100% coverage after the deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $1500/$3000.	Various BCBS plans GIs some products to all consumers. Individual market serves as the GI option for HIPAA-eligible population. Elimination riders allowed, except for HIPAA-eligible individuals. Credit for prior coverage not required, except for HIPAA-eligibles. Preexisting conditions may not be considered for HIPAA-eligibles. 12-month look-back and exclusionary period limit for preexisting conditions for other individual policies.
Washington 98504	PPO	$253.00	$1500/$4500	80% coverage after the deductible.	Office visits, hospitalization and ER visits are subject to deductible and coinsurance, $100 ER co-pay for in-network hospitals and a $150 co-pay for out-of-network. $4000/$12000 annual out-of-pocket limit.	Limited medical underwriting allowed. Carriers may only offer coverage on a modified community rated basis with adjustments limited to age, geography, wellness, family size and tenure in plan. Carriers must guarantee issue products to people that meet certain health criteria. In Elimination riders not permitted. Individual market serves as the GI option for HIPAA-eligible population. Credit for prior coverage is required. 6 month look-back and a 12-month exclusionary period limit on preexisting health conditions

State	Individual Market Health Insurance Options for Subject Family					Regulatory and Market Factors That May Impact Individual Market Health Insurance Pricing and Availability
	Plan Type	Monthly Premium	Annual In-Network Deductible (Individual /Family)	Coinsurance Rate	Additional Policy Benefits	
West Virginia 25305	PPO	$357.18	$5000/$10000	80% coverage after the deductible.	Office visits, hospitalization, and ER subject to the deductible and coinsurance. 50% coverage of RX, which is not subject to the deductible. Well-baby and well child visits covered at 100%. $6000/$12,000 annual out-of-pocket maximum.	Individual health insurance rates are subject to rate bands of plus or minus 30 percent of the base individual market rate. Individual market currently serves as the GI option for HIPAA-eligible population, but the state high-risk pool will assume that function during the summer of 2005. Elimination riders allowed, except for HIPAA-eligible individuals. Credit for prior coverage is not required except for HIPAA-eligibles. 12-month look-back and a 24-month exclusionary period limit on preexisting health conditions, except for HIPAA-eligibles.
Wisconsin 53707	PPO	$246.38	$1500/$3000	100% coverage the after deductible.	Office visits, hospitalization and RX are subject to deductible and coinsurance. Additional $100 ER co-pay, and $50 outpatient co-pay and $3000 lifetime maximum for mental health services. Annual out-of-pocket maximum is $1500/$3000.	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage not required. 24-month exclusionary period limit for preexisting conditions.
Wyoming 82002	PPO	$239.65	$2100/$4200	100% after deductible	Office visits, RX, ER and hospitalization subject to deductible and coinsurance, with an additional $75 ER access fee (waived if admitted). $500 per year benefit for all wellness services. Mental health services $500 calendar year maximum $2,500 combined inpatient and outpatient, including inpatient chemical dependency with 50% coinsurance after deductible. Annual out-of-pocket maximum of $2000/$4000 plus deductible	No rate caps and medical underwriting allowed. High-risk pool serves the state medically uninsurable and HIPAA-eligible populations. Elimination riders allowed. Credit for prior coverage required. 6-month look-back and a 12-month exclusionary period limit on preexisting health conditions. Geographical considerations may impact competition and prices.

Addendum C

National Association of Health Underwriters

State Level Individual and Small Group Market Health Insurance Reforms

February 2006

State	Individual Market Reforms						Small-Group Market Reforms[i]		
	Guarantee Issue	**Rating Structure**	**Elimination Riders**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Credit for Prior Coverage**	**Medically Uninsurable Individuals**	**Size[ii]**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Rating Structure**
Alabama	No	NRS	Yes	60/12	No	HRP[iii]	2-50	6/12	+/- 20%
Alaska	No	NRS	Yes	None	No	HRP	2-50	6/12	+/- 35%
Arizona	HIPAA[iv]	NRS	Yes[v]	None[vi]	No[vii]	None	2-50	6/12	+/- 60%
Arkansas	No	NRS	Yes	60-month Look-Back	No	HRP	2-50	6/12	+/- 25%
California	HIPAA[viii]	NRS	No	6/6 or 12/12[ix]	Yes	HRP/GI[x]	2-50	6/6	+/- 10%
Colorado	No	NRS	Yes	12/12	Yes	HRP	1-50[xi]	6/12	+/10% -25%
Connecticut	No	NRS	Yes	12/12	No	HRP	1-50[xii]	6/12	MCR[xiii]
Delaware	HIPAA[xiv]	NRS	Yes[xv]	None[xvi]	No[xvii]	None	1-50[xviii]	6/12	+/- 35%
Florida	HIPAA[xix]	NRS	Yes[xx]	24/24[xxi]	Yes	HRP[xxii]	1-50[xxiii]	6/12	MCR +/- 15%[xxiv]
Georgia	HIPAA[xxv]	NRS	Yes[xxvi]	24-month Exclusionary Period[xxvii]	No[xxviii]	None	2-50	6/12	+/- 25%
Hawaii	HIPAA[xxix]	NRS	Yes[xxx]	36-month Exclusionary	No[xxxii]	None	1-50[xxxiii]	None	NRS[xxxiv]

State	Individual Market Reforms						Small-Group Market Reforms[i]		
	Guarantee Issue	**Rating Structure**	**Elimination Riders**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Credit for Prior Coverage**	**Medically Uninsurable Individuals**	**Size[ii]**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Rating Structure**
				Period[xxxi]					
Idaho	GI[xxxv]	+/- 50%	No	6/12[xxxvi]	Yes	HRRP	2-50	6/12	+/- 50%
Illinois	No	NRS	Yes	12/24[xxxvii]	No	HRP	2-50	6/12	+/- 25%
Indiana	No	NRS	No	12/24	No	HRP	2-50	6/9	+/- 35%
Iowa	No	RB[xxxviii]	Yes	12/12 and 60/12[xxxix]	No[xl]	HRP	2-50	6/12	+/- 25%
Kansas	No	NRS	Yes	12/24	No	HRP	2-50	6/3	+/- 25%
Kentucky	No	+/- 35%	No	6/12	Yes	HRP	2-50	6/12	+/- 35%
Louisiana	No	NRS[xli]	Yes	12/12	Yes	HRP	3-35	6/12	+/- 35%
Maine	GI[xlii]	MCR[xliii]	No	12/6	Yes	GI	2-50	6/12	MCR[xliv]
Maryland	No	NRS	Yes	4/24	No	HRP	1-50[xlv]	0/0	MCR[xlvi]
Massachusetts	GI[xlvii]	MCR[xlviii]	No	6/6	Yes	GI	1-50[xlix]	6/6	MCR[l]
Michigan	GI[li]	CR/NRS[lii]	No	6/6 and 6/12[liii]	No	CLR[liv]	2-50[lv]	6/12	+/- 45%[lvi]
Minnesota	No	RB[lvii]	No	0[lviii]	Yes	HRP	2-50	6/12	+/- 25%
Mississippi	No	NRS	Yes	12/12	No	HRP	1-50[lix]	6/12	+/- 25%
Missouri	No	NRS	Yes[lx]	Unlimited/24[lxi]	No[lxii]	HRP	3-25	6/12	+/- 25%
Montana	No	NRS	Yes	36/12	Yes	HRP	2-50	6/12	+/- 25%
Nebraska	No	NRS	Yes	None	No	HRP	2-50	6/12	+/- 25%
Nevada	HIPAA[lxiii]	+/- 50%	Yes[lxiv]	None[lxv]	Yes	None	2-50	6/12	+/- 25%
New Hampshire	No	RB	Yes	3/9	Yes	HRP	2-50	6/12	MCR[lxvi]
New Jersey	GI[lxvii]	CR[lxviii]	No	6/12	Yes	GI	2-50	0/0 or 6/6[lxix]	MCR[lxx]
New Mexico	No	NRS	Yes	6/6	Yes	HRP	2-50	6/6	+/- 25%
New York	GI[lxxi]	MCR[lxxii]	No	6/12	Yes	GI	2-50	6/12	CR[lxxiii]
North Carolina	HIPAA[lxxiv]	NRS	Yes[lxxv]	12/12[lxxvi]	Yes	CLR[lxxvii]	1-50[lxxviii]	6/12	+/- 20%
North Dakota	No	RB	No	6/12	Yes	HRP	2-25	6/12	+/- 35%
Ohio	HIPAA[lxxix]	NRS[lxxx]	Yes	6/12	Yes	OE[lxxxi]	2-50	6/12	+/- 35%
Oklahoma	No	NRS[lxxxii]	Yes	None[lxxxiii]	No	HRP	2-50	6/12[lxxxiv]	+/- 25%

State	Individual Market Reforms						Small-Group Market Reforms[i]		
	Guarantee Issue	**Rating Structure**	**Elimination Riders**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Credit for Prior Coverage**	**Medically Uninsurable Individuals**	**Size[ii]**	**Preexisting Conditions** (Look-Back/ Exclusionary Period in Months)	**Rating Structure**
Oregon	GI[lxxxv]	MCR[lxxxvi]	Yes	None[lxxxvii]	Yes	HRP	2-25	6/12	MCR[lxxxviii]
Pennsylvania	HIPAA[lxxxix]	NRS	Yes[xc]	60/36[xci]	No[xcii]	CLR[xciii]	2-50[xciv]	6/12	NRS[xcv]
Rhode Island	GI[xcvi]	NRS	Yes[xcvii]	36/12[xcviii]	No[xcix]	CLR[c]	1-50[ci]	6/12	+/- 10%
South Carolina	No	NRS	Yes	12/12 and unlimited/24[cii]	No	HRP	2-50	6/12	+/- 25%
South Dakota	No	+/- 30%	Yes	12/12	Yes	HRP	2-50	6/12	+/- 25%
Tennessee	HIPAA[ciii]	NRS	Yes[civ]	None[cv]	No[cvi]	None[cvii]	2-50	6/12	+/- 35%
Texas	No	NRS	Yes	60/24[cviii]	Yes[cix]	HRP	2-50	6/12	+/- 25%
Utah	GI[cx]	+/- 30%	Yes	6/12	No	HRP	2-50	6/12	+/- 30%
Vermont	GI[cxi]	MCR[cxii]	No	9/12	Yes	GI	2-50	6/12	MCR[cxiii]
Virginia	HIPAA[cxiv]	NRS	Yes[cxv]	12/12[cxvi]	No[cxvii]	CLR[cxviii]	2-50	6/12	NRS[cxix]
Washington	GI[cxx]	MCR[cxxi]	No	6/12	Yes	HRP	2-50	6/12	MCR[cxxii]
West Virginia	No	+/- 30%	Yes	12/24	No	HRP	2-50	6/12	+/- 30%
Wisconsin	No	NRS	Yes	24-month Exclusionary Period	No	HRP	2-50	6/12	+/- 30%
Wyoming	No	NRS	Yes	6/12	Yes	HRP	2-50	6/12	+/- 35%

Explanation of Abbreviations

Individual Market Reforms

Guarantee Issue—GI=Guarantee issue required; and HIPAA=People exercising their group-to-individual portability rights under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) must be guarantee-issued products in the traditional individual market.
Rating Structure—NRS=No rating structure. Medical underwriting allowed without restriction; RB=Rate bands; CR=Community rated; MCR=Modified community rated; and +/- X%=Rate bands of plus or minus the specified percentage of the indexed rate.
Medically Uninsurable Individuals—HRP=High-risk health insurance pool; HRRP=High-risk reinsurance pool; None=No mechanism for providing individual market access to medically uninsurable people; CLR=Carrier of last resort; OE=Open enrollment; and GI=Guarantee-issue.

Small-Group Market Reforms

Rating Structure—+/- X%=Rate bands of plus or minus the specified percentage of the indexed rate; NRS=No rating structure; CR=Community rated; and MCR=Modified community rated.

[i] In addition to the reforms noted, as per the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), all health insurance contracts for employer-groups of 2-50 employees must be issued on a guarantee-issue basis. All group insurance contracts must also 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. In addition, according to HIPAA, credit for prior coverage is required as long as there is no more than a 63-day break in coverage.
[ii] Despite the group-size definition imposed by the state, as per federal law, all HIPAA protections apply to groups of 2-50.
[iii] Alabama's high-risk health insurance pool only serves the state's HIPAA-eligible population.
[iv] In Arizona, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[v] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[vi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[vii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[viii] In California, all individual market carriers must guarantee issue their two most popular individual products to people who are exercising their group-to-individual portability rights provided by HIPAA. Carriers must also guarantee issue coverage to people who have spent two years in the state's high-risk health insurance pool.
[ix] In the California traditional individual health insurance market, there is a 12-month look-back and exclusionary period limit for pre-existing conditions for policies that cover one or two people. There is a 6-month look-back and exclusionary period limit for individual policies that cover three or more people.
[x] Carriers must guarantee issue coverage to people who have spent two years in the state's high-risk health insurance pool.
[xi] For employer groups-of-one employee, Colorado carriers must guarantee issue basic and standard small-group coverage during an annual open enrollment window to groups-of-one with involuntary loss of coverage only.
[xii] Connecticut regulations allow groups of one to apply for any plan however, following medical history review they may be offered the small group regulation guarantee issue product.
[xiii] Connecticut requires that small-group rates be based on a community rate with adjustments allowed for age, gender, geography, group size, family, and industry.
[xiv] In Delaware, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market carrier offering coverage in the state.
[xv] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[xvi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[xvii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[xviii] In Delaware, carriers must guarantee-issue coverage to employer groups-of-one.
[xix] Currently in Florida, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through either a conversion product, or through individual market carriers.
[xx] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[xxi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[xxii] Florida's current high-risk pool, the Florida Comprehensive Health Association has been closed to new enrollees since 1991. As such, there is no mechanism currently in place to serve new medically uninsurable individuals who do not either have access to group coverage or guarantee issue rights provided under HIPAA. However, legislation was enacted in Florida in 2004 to create the Florida Health Insurance Plan, a new high-risk pool, which would combine the

existing pool with new enrollees. The development of the pool is contingent upon the creation of a funding mechanism. A legislative effort is currently underway to create a funding mechanism for the pool, so that it can become operational and accept new enrollees.

[xxiii] In Florida, carriers must guarantee issue certain small-group products to groups-of-one during annual open enrollment periods.

[xxiv] In the small group market in Florida there are rate bands of +/-15% of the indexed rate depending on the health of the group. Groups over 10 employees may use a group medical questionnaire. Groups of fewer than 10 employees must answer individual medical questionnaires. Small employer health insurance carriers may only use the following rating factors: geographic area and number of employees, as well as health of the group. Renewals are capped at 15% plus trend.

[xxv] In Georgia, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through either a conversion product, or through individual market carriers on an assignment basis.

[xxvi] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.

[xxvii] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.

[xxviii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.

[xxix] In Hawaii, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.

[xxx] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.

[xxxi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.

[xxxii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.

[xxxiii] Hawaii does not have a statute that defines the size of their small group market. Most carriers define it as 1-50; however, some use the definition of 1-100. Individuals who attempt to obtain guarantee-issue coverage as a business group-of-one must satisfy criteria set by the carrier.

[xxxiv] Coverage in the Hawaii small group market may be medically underwritten. The state does not have specified rate requirements, except that all rates must be reasonable for the coverage provided, and effective 1/1/2003, all rates must have prior approval by the state Department of Insurance.

[xxxv] Idaho individual health insurance carriers must guarantee issue at least three products (basic, standard and catastrophic) to all individual market consumers with 12 months of creditable coverage, including all HIPAA-eligible individuals.

[xxxvi] Preexisting conditions may not be considered for standardized policies.

[xxxvii] For traditional individual health insurance policies in Illinois, there is a 12-month look back period during first two years of coverage. If the condition is determined to be preexisting a 24-month exclusionary period is allowed.

[xxxviii] Carriers are subject to rating restrictions based on the pricing for their different blocks of business. The rate differential between the two policy forms must be no more than 2.028 to 1 at each age, (i.e., the composite effect of 30%, and 20%). Subsequent rate changes must be within 15% of each other.

[xxxix] Carriers are subject to rating restrictions based on the pricing for their different blocks of business. The rate differential between the two policy forms must be no more than 2.028 to 1 at each age, i.e., the composite effect of 30%, and 20%. Subsequent rate changes must be within 15% of each other.

[xl] Credit for prior coverage is required for HIPAA-eligibles and standardized policies.

[xli] There are no rate caps in the individual health insurance market in Louisiana, as statutory rate bands are not enforced.

[xlii] In Maine, all major medical individual health insurance products must be sold on a guarantee issue basis to all consumers, including all HIPAA-eligible individuals.

[xliii] In Maine, the individual market is rated on a modified community basis. Adjustments of plus or minus 20 percent of the community rate are only allowed for age, occupation, and geography. A separate adjustment can be made for smoker status.

[xliv] In Maine, small group health plan rates are determined on a modified community basis. Rates can only be adjusted by plus or minus 20% from the standard community rate for the following factors: age, geography, occupation, and smoking status. The use of medical underwriting is prohibited.
[xlv] In Maryland, carriers must guarantee issue a standardized coverage plan to self-employed individuals during an annual open enrollment period.
[xlvi] In Maryland, small group health insurance coverage premiums must be community rated with up to 40 percent plus or minus variations allowed for age and geography.
[xlvii] All Massachusetts individual market health insurance carriers must sell at least three products to all consumers on a guarantee issue basis, including all HIPAA-eligible individuals.
[xlviii] Carries may adjust rates on a modified community rated basis. Adjustments are limited to age, geography and benefit level on a 2:1 basis.
[xlix] In Massachusetts, carriers must guarantee-issue coverage to business groups-of-one.
[l] In Massachusetts, small group health insurance premiums must be based on a community rate, with adjustments allowed for age, industry, group size, geography, family composition, participation rate, wellness program participation, and participation in the small employer reinsurance plan.
[li] Blue Cross Blue Shield of Michigan must offer all products to all residents on a guarantee issue basis, and HMOs in the state must offer guarantee issue coverage to residents during annual open enrollment periods.
[lii] Blue Cross Blue Shield of Michigan must community rate products in the individual market, but other carriers have no rate restrictions.
[liii] There is a 6-month look-back and exclusionary period limit on preexisting health conditions for Blue Cross Blue Shield of Michigan and HMOs. All other individual market carriers are subject to a 6-month look-back and a 12-month exclusionary period limit on preexisting health conditions.
[liv] Blue Cross Blue Shield of Michigan is required by statute to serve as the carrier of last resort for people seeking coverage in the individual market through a year-round open enrollment for specified products. Also, HMOs in Michigan are required to offer individual coverage with a 30-day open enrollment period for all individuals annually.
[lv] In Michigan, commercial carriers and Blue Cross Blue Shield of Michigan may impose an open enrollment period for sole proprietors and impose a 6 month look-back and exclusionary exclusion period for preexisting conditions.
[lvi] Blue Cross Blue Shield of Michigan is allowed to impose a 35 percent variation from the geographic rate for small groups.
[lvii] Minnesota individual health insurance market rates are subject to bands of plus or minus 25 percent of the base individual market rate for health status, plus or minus 50 percent for age and plus or minus 20 percent for geography.
[lviii] There is no exclusionary period allowed for preexisting health conditions for people with creditable coverage in Minnesota.
[lix] In Mississippi, carriers must guarantee-issue coverage to business groups-of-one.
[lx] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[lxi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[lxii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[lxiii] In Nevada, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage in the form of a basic or standardized plan through any individual market carrier.
[lxiv] Elimination riders permitted except for HIPAA-eligibles and in the Nevada basic and standard plans.
[lxv] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[lxvi] In New Hampshire, small group health insurance premiums must be based on a community rate, with adjustments allowed for age, family composition, group size and industry classification when determining rates, and the use of health status, claims experience, duration of coverage, geographic location and other characteristics is prohibited.

[lxvii] All New Jersey individual market health insurance carriers must guarantee issue five standardized products to all consumers, including HIPAA-eligible individuals.
[lxviii] Traditional individual coverage must be purely community-rated. Carriers may also offer a basic and essential plan, which may have 3.5:1 variations for age, gender and geography.
[lxix] In New Jersey, new groups sized 2-5 are subject to a 6-month look-back/6-month preexisting condition exclusion period, but other small groups are not subject to an exclusion period. Late enrollees in groups of 2-50 may also be subject to a 6-month preexisting condition waiting period.
[lxx] In New Jersey, small-group premiums are based on a modified community rate, and carriers may consider only the age, gender and family status of eligible employees, and the location of the employer in determining the premium for the group. Carriers may not consider any other factor, including health status or prior claims history of eligible employees or the type of business. Carriers are required to limit the range of premiums from the highest risk group and the lowest risk group to a 2:1 basis.
[lxxi] In New York, all carriers must guarantee issue all individual health insurance products to all consumers, including HIPAA-eligible individuals.
[lxxii] Coverage must be community-rated with adjustments limited to family composition and geographic regions.
[lxxiii] In New York, small group health insurance premiums are subject to pure community rating.
[lxxiv] In North Carolina, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market carrier. In addition, Blue Cross/Blue Shield of North Carolina voluntarily sells certain products on a guarantee-issue basis to all consumers.
[lxxv] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[lxxvi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[lxxvii] Blue Cross Blue Shield of North Carolina voluntarily serves as the carrier of last resort for people seeking coverage in the individual market through a year-round open enrollment for specified products.
[lxxviii] In North Carolina, carriers must guarantee issue basic and standard plans to business groups-of-one.
[lxxix] Traditional Ohio individual market carriers must guarantee issue two standardized products to individuals exercising their group-to-individual portability rights provided by HIPAA until they meet enrollment caps, and HMOs must guarantee issue coverage one month each year to HIPAA eligible individuals.
[lxxx] Standardized plans are subject to rate caps.
[lxxxi] In Ohio, HMOs and insurers must hold annual open enrollment periods during which they must offer two specified products to all individuals until they meet specified statutory enrollment caps.
[lxxxii] Individual market HMOs are subject to rate caps; however, no HMOs offer individual market coverage in the state at this time.
[lxxxiii] Preexisting conditions may not be considered for HMO products in the Oklahoma individual health insurance market, however, no HMOs offer individual market coverage in the state at this time.
[lxxxiv] In Oklahoma, HMOs cannot consider, look-back at or issue exclusions for preexisting conditions. All other group health insurance carriers can impose a 6-month look-back/12-month exclusionary period for preexisting conditions on enrollees that do not have prior creditable coverage.
[lxxxv] In Oregon, all individual market carriers must guarantee issue portability products to residents with six months of prior coverage.
[lxxxvi] Oregon individual carriers must use community rating with variances allowed based on geography and benefit design.
[lxxxvii] Preexisting conditions may not be considered for portability products in Oregon's individual health insurance market.
[lxxxviii] Small group health insurance premiums in Oregon must be based on a modified community rate. For groups of 2-25 employees, rating is based on family mix, member age, and geographic location of the employer. All carrier rates must have no more than a .43 difference in rates between the highest age and lowest

age band. For groups of 26-50 employees, rates also must be based on family mix, member age, gender and geographic location of the employer, but there are no age band requirements.

[lxxxix] In Pennsylvania, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee issue private individual health insurance coverage through the various Blue Cross/Blue Shield plans serving as the state's carriers-of-last resort. The various Blue Cross/Blue Shield plans also offer a medical-only product to all consumers on a guarantee-issue basis.

[xc] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.

[xci] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.

[xcii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.

[xciii] The various Blue Cross/Blue Shield plans operating in the state voluntarily serve as the carriers-of-last-resort for people seeking coverage in the individual market through a year-round open enrollment for specified products.

[xciv] Pennsylvania does not have a specific statute or regulation that defines the size of a small employer for the purposes of providing health insurance coverage. Most Pennsylvania insurance carriers define a small group as 2-50 employees.

[xcv] In the small group health insurance market in Pennsylvania, medical underwriting is allowed without restriction with rate variations allowed up to 300 percent of the base rate. Some Blue Cross/Blue Shield carriers community rate or use a modified community rate voluntarily.

[xcvi] All carriers must guarantee issue coverage to all individuals with at least 12 months of prior coverage. Blue Cross Blue Shield of Rhode Island voluntarily offers an individual health insurance product to all consumers on a guarantee issue basis. HIPAA-eligible individuals can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.

[xcvii] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA or for the guarantee issue products.

[xcviii] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA or those with 12 months of prior coverage.

[xcix] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA and in the guarantee issue plans.

[c] Blue Cross Blue Shield of Rhode Island voluntarily serves as the carrier of last resort for people seeking coverage in the individual market through a limited annual open enrollment period.

[ci] In Rhode Island, carriers must guarantee issue coverage to business groups-of-one.

[cii] There is a 12-month look-back and exclusionary period limit for preexisting conditions for HMOs in South Carolina's individual health insurance market. There is an unlimited look-back and 24-month exclusionary period limit for preexisting conditions for other individual policies.

[ciii] In Tennessee, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.

[civ] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.

[cv] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.

[cvi] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.

[cvii] Some medically uninsurable individuals in Tennessee are still eligible for the state's scaled-back TennCare program.

[cviii] Preexisting conditions may not be considered for HMO products in the Texas individual market.

[cix] Credit for one month or more prior coverage is required.

[cx] In Utah, individual market carriers must guarantee issue products to people that meet certain health criteria. Individuals who do not meet these criteria can obtain guarantee-issue private individual health insurance coverage through the state's high risk pool.

[cxi] All individual health insurance products in Vermont must be sold on a guarantee issue basis, including to HIPAA-eligible individuals.
[cxii] Vermont individual health insurance carriers may only offer coverage on a community rated basis with adjustments limited to those approved by the state Insurance Commissioner. Currently variances of plus or minus 20 percent of the average group rate based on age and gender are allowed.
[cxiii] In Vermont, small group health insurance premiums must be based on a community rate with variations allowed only for age and gender.
[cxiv] In Virginia, individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[cxv] Elimination riders aren't allowed for people exercising their group-to-individual portability rights under HIPAA.
[cxvi] Preexisting conditions cannot be considered for people exercising their group-to-individual portability rights under HIPAA.
[cxvii] Credit for prior coverage is required for people exercising their group-to-individual portability rights under HIPAA.
[cxviii] The various Blue Cross Blue Shield plans operating in the state are required by statute to serve as the carrier of last resort for people seeking coverage in the individual market through an open enrollment period for specified products.
[cxix] In the small group market in Virginia, private health insurance carriers can medically underwrite rates without restriction, except for standardized plans. For the standardized plans, rates may vary by plus or minus 25 percent of the indexed rate based on age, gender, geography, health status, claims experience and duration of coverage for similar groups.
[cxx] In Washington, individual market carriers must guarantee issue products to people that meet certain health criteria. Individuals who do not meet these criteria can obtain guarantee-issue private individual health insurance coverage through the state's high-risk pool. Individuals exercising their federal group-to-individual health insurance rights provided by HIPAA can obtain guarantee-issue private individual health insurance coverage through any individual market health insurance carrier.
[cxxi] Washington individual health insurance carriers may only offer coverage on a modified community rated basis with adjustments limited to age, geography, wellness, family size and tenure in the plan.
[cxxii] In Washington, small group premium rates must be based on a community rate with adjustments allowed for age, geography and family composition. The rating between the highest rate and lowest rate for the community cannot exceed 375 percent.