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Individual Health Insurance

3rd Edition

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Acknowledgments

In the first edition of this text, Bill Bluhm wrote "A textbook such as this cannot really be written by one person." That sentiment seems even more true today. It has become even more difficult for any one person to keep up with all aspects of the health insurance markets as they continue to evolve and grow in complexity.

We are fortunate to have a large network of friends and colleagues who are experts in various types and aspects of individual insurance. These folks were incredibly generous in donating their time and effort to help us as we wrote this textbook, in exchange for nothing more than our gratitude.

We want to extend a special thanks to Pat Ryan, whose decades of experience working with insurers brought an important viewpoint to the writing and editing of this text. Pat sadly did not live to see the publishing of this edition. We are grateful that we were able to work with him and benefit from his expertise before his passing.

Many other subject matter experts also shared the benefit of their experience in areas where our experience was lacking. Our thanks to Jeff Anderson, Mike Bergerson, Ashlee Borcan, Ken Clark, Paul Correia, Jackie Daniels, Annie Hallum, Jason Karcher, Lindsy Kotecki, Michael Niemerg, Doug Norris, Nick Ortner, Jason Petroske, and Dan Skwire.

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Finally, our thanks to Bill Bluhm, who paved the way for us on this journey.

Preface to the Third Edition

The first edition of this textbook was published in 2007, and the second in 2015. It is nearly the end of 2025, as we are putting the final touches on this third edition. That means—assuming a geometric trend in time per edition based on available data points—you may have to make this edition last you until 2037.

In 2007, the national healthcare reform debate that ultimately resulted in the passage of the Affordable Care Act in 2010 was just starting. Massachusetts had passed its own version of reform in 2006, but it was too soon to tell how things would play out. Underwriting was a core activity for insurers in the individual major medical market, and more powerful computing and analytical techniques were just beginning to show their potential to turn data into better decisions and competitive advantages.

In 2015, the major provisions of the ACA had just been launched the year before. It was a time of incredible change, with federal and state regulators barely able to get guidance out in time for insurers to try to comply with it, as they priced and administered the new products created by the law. The work we were doing as healthcare actuaries was suddenly newsworthy (and also garnered a lot more questions from relatives at Thanksgiving dinner than it had before). However, it was far from clear whether the new markets would settle down into a stable equilibrium or not.

Now, in late 2025, we have seen that the ACA markets have proven remarkably resilient, surviving even as several key supports included in the law were removed (most notably the individual mandate penalty for not having insurance). This is in large part due to the significant subsidization of coverage provided by the government for certain categories of people. Still, these markets continue to be in flux as political winds change direction or other events impact the population seeking coverage in these markets.

Since the last edition, we have all weathered a global pandemic, which had profound impacts on individual health insurance, as well as personal impacts on all of us who lived through it. We have also seen incredible continuing advances in technology as the amount of data and the sophistication of tools available to make use of it keep increasing. According to some, generative artificial intelligence is poised to solve all our problems (possibly by rising up and exterminating us all in a singularity event).

More seriously: the products described in this book matter. The success or failure of health insurance markets has real consequences for people's lives. Insurance has a reputation for being boring[1], and ideally maybe it should be so: boring would mean you can buy coverage for the important risks you face at a price that you can afford, and then go on to live your life with more security and less anxiety.

Unfortunately, in the United States, health insurance has not been boring and seems to be in little danger of becoming so anytime soon. Thus, there is plenty of work to do to help ensure that individuals continue to have meaningful options available to protect themselves and their loved ones. It is our hope that the methods and principles described in this book may help actuaries and other professionals meet and overcome the challenges of today, along with whatever comes next.

Hans Leida & Erica Baird, November 2025

[1] If, on the other hand, you want to get inspired and read an argument that insurance is anything but boring—here's Peter L. Bernstein from his book Against the Gods: The remarkable story of risk:

> *This book tells the story of a group of thinkers whose remarkable vision revealed how to put the future at the service of the present. By showing the world how to understand risk, measure it, and weigh its consequences, they converted risk-taking into one of the prime catalysts that drives modern Western society. Like Prometheus, they defied the gods and probed the darkness in search of the light that converted the future from an enemy into an opportunity.*

About the Authors

Hans K. Leida is a Principal and Consulting Actuary with Milliman. He joined the firm in 2006 after completing a PhD in mathematics at the University of Wisconsin-Madison. Hans is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Hans has a great deal of experience with group and individual commercial major medical coverage, as well as Medicare Supplement and Medicare Advantage plans. Hans is a frequent speaker and prolific writer on healthcare topics, and he has been quoted in publications such as *The Wall Street Journal*, *Reuters*, *Bloomberg Businessweek*, and *Modern Healthcare*.

Hans co-authored a paper in 2007 (updated in 2012) on the impact of guaranteed issue and community rating laws adopted by certain states in the 1990s. That paper has been widely cited by multiple stakeholders in the ongoing conversation on healthcare reform in the U.S., most notably by the Chief Justice of the U.S. Supreme Court in his opinion on the case regarding availability of premium subsidies in federal exchange states (*King v. Burwell*).

Hans also has significant experience with risk adjustment and the use of predictive modeling and artificial intelligence to measure, forecast, and manage healthcare risks. He has played a key role in the Milliman Advanced Risk Adjusters (MARA) software product since its inception.

Hans lives in Minnesota with his wife Sunshine, five children (not counting one more that's out of the house), two cats, one dog, one snake, one turtle, and one chicken…but who's counting?

Erica S. Baird is a Principal and Consulting Actuary with Milliman. She joined the firm in 2013 after completing a PhD in mathematics at Oregon State University. Erica is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

Erica has experience working with payers and healthcare providers in the individual health insurance space, including Medicare Advantage, Medicaid, and commercial markets. Erica is a frequent speaker at actuarial industry meetings, focusing on risk adjustment and predictive modeling of healthcare costs.

Erica has served on two American Academy of Actuaries task forces to revise Actuarial Standards of Practice and was appointed to the Actuarial Standards Board in 2026.

Erica also has significant experience with designing and evaluating value-based care arrangements and leads research and development efforts for the Milliman Advanced Risk Adjusters (MARA) software product. After living in Oregon, Minnesota, and Texas, Erica is now taking on the job of part-time forester on a family tree farm in Indiana with her husband Kyle.

William F. Bluhm, is a retired Principal and Consulting Actuary of Milliman in Minneapolis. Bill joined that firm in 1983, when he opened the Albany office, and was in Minneapolis from 1987 until his retirement in 2013.

Bill spent his career in the health insurance field, working with insurers, health benefit providers, and governments. In that time, he was a frequent speaker and award-winning author. He was Principal Editor of the first six editions of the well-known and highly regarded textbook, *Group Insurance*. Many of his works have been required reading on the Society of Actuaries' exam syllabus.

Bill is a past Board Member for the Society of Actuaries, the Conference of Consulting Actuaries, and the American Academy of Actuaries, as well as Past President of the latter two. Bill was also awarded a Lifetime Achievement Award by his colleagues at the Conference of Consulting Actuaries. Currently, Bill runs the winery he founded with his wife Christine, Dancing Dragonfly Winery in St. Croix Falls, WI.

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The Products

There is a wide array of products being sold in the individual health insurance market. Each of them has its own characteristics, varying from other products in many different ways. This chapter describes those characteristics and is organized by product type. Sections 2.1 through 2.6 describe medical-type coverages, 2.7 and 2.8 describe income protection coverages, 2.9 describes long term care coverage, and 2.10 describes dental coverages.

2.1 Major Medical Coverage

The precursor of **major medical** coverage was available in the early 20th century, when disability coverage added a provision to increase payments while someone was hospitalized. The most major changes to liberalize medical care insurance occurred in the 1930s (initially accident-only) and 1940s. Major medical coverage was introduced about 1950,[1] as medical care costs became much more significant than they were previously, and it became obvious that simple coverage of only hospital costs, or only physician costs, did not adequately protect the policyholder. Major medical is distinguished from earlier coverages in that it was the first time the disparate sources of health care costs (hospital, physician, and ancillary) were combined into a common policy.

The list of health care expenditures a policy covers is commonly called **covered services**, or **covered expenses**, and this term is typically well defined in the policy form itself. Regulators felt the need to require that a certain minimum combination of covered services should be provided if a policy was to be called "major medical," presumably under public policy aimed at either (1) preventing insurers from misleading consumers by using the name for a policy with lesser benefits, or (2) prohibiting policies which have unexpected (at least for the policyholder) holes in the benefit plan.

[1] *Health Insurance Provided Through Individual Policies*, Edwin L. Bartleson. Published by the Society of Actuaries, 1968.

New York's Regulation 62, for example, requires a specific set of minimum benefit parameters that a policy must meet to be called major medical insurance.[2] (The exact wording of this part of the regulation, section 52.7, is contained in Appendix A to this text.)

Once the covered services are defined for a policy, it is necessary to define how benefits are calculated from those services. These calculations reflect various ways in which the covered expenses are allocated between the insurer, the insured, and the provider.

Allocating a portion of the covered expense to the insured is often deemed to be good design because it still provides some (albeit watered-down) financial incentive to the insured to control costs. The portion of costs allocated to the insured is called **cost sharing**.

2.1.1 Deductibles

A **deductible** is a dollar amount, specified in the policy, for which the insured is responsible before any benefits are payable. A plan with a 100% benefit after a $100 major medical deductible means that if, for example, $1,000 of covered services occurs, the first $100 of covered expense would automatically be the responsibility of the insured, and the $900 in excess would then go into the benefit calculation.

Deductibles can apply to all services under the contract, to major categories of services (like hospital inpatient charges), or to smaller categorizations. The categories might depend on where the service occurs (such as inpatient vs. outpatient vs. physician's office), whether the provider is part of the insurer's network (such as a separate deductible for inpatient stays in non-network hospitals), what kind of service it is (such as inpatient stays, ancillary services, or prescription drugs), or other factors.

It is important to address how the deductible interacts with other aspects of the contract - in particular, provider discounts. Suppose, for example, that the $1,000 claim in the previous example was for physician services, and is the retail, undiscounted charge the physician puts on the bill (commonly called **billed charges**). If the physician is participating in the insurer's network, it is likely that the physician has agreed to abide by a payment schedule (or other discount mechanism) which might reduce that $1,000 to, for example, $700. (This figure of $700 would be called the **allowed charges** for that benefit, and is what the insurer will recognize in the benefit calculation.)

The benefit for this imaginary plan pays 100% above the deductible, so the benefit calculation subtracts the $100 deductible from the *discounted* $700 benefit and pays the physician $600. In this case, the insurer gets the full value of the discount, and the insured must pay the undiscounted $100 (and the provider typically bears the burden and risk of collecting it from them). This is the most common interpretation of deductibles.

[2] 11 NYCRR 52.7

Family deductibles commonly take one of two forms: (1) an **aggregate family deductible**, in which the plan doesn't begin paying expenses for any member until the aggregate deductible has been met, or; (2) an **embedded deductible**, in which the plan begins paying for an individual once the individual deductible has been met, but also pays for all individuals once the family deductible has been met. The family deductible is often expressed as a multiple of the individual deductible. Aggregate deductibles are common in high-deductible health plans (HDHPs), while embedded deductibles are common in other types of major medical plans. A plan with an embedded deductible will generally result in higher costs to the insurer than an aggregate family deductible at a given family deductible level, since it will pay more benefits in the case where a member has met the individual deductible, but the family has not yet met the family deductible.

The following example illustrates this by calculating the cost to the insurer under an embedded deductible and an aggregate deductible, where both plans have the same family deductible.

Example 2.1. Make the following assumptions:

- Coverage is for a family of three with the following claims:
  - Member One incurs $2,000 in claims early in the year; and
  - Member Two incurs $3,000 in claims later in the year.
- The embedded deductible is $1,500 per individual;
- Both plans have a family deductible of $3,750 (2.5 times the individual deductible for the embedded deductible plan);
- The plan pays 100% of costs above the deductible.

Under the embedded deductible plan, the following payments would be made:

- Member One reaches the individual deductible, and the plan pays $(\$2{,}000 - \$1{,}500) = \$500$.
- Member Two also reaches the individual deductible, and the plan pays $(\$3{,}000 - \$1{,}500) = \$1{,}500$. Since Member One only paid $1,500 and Member Two paid $1,500, the family deductible was not met.

With an embedded deductible, the plan pays a total of $2,000 and the family pays a total of $3,000.

Under an aggregate deductible plan, the following payments would be made:

- Member One does not reach the aggregate deductible, so the plan does not make any payments.
- Member Two causes the family to reach the aggregate deductible, so the play pays $(\$2{,}000 + \$3{,}000 - \$3{,}750) = \$1{,}250$.

With an aggregate deductible, the plan pays a total of $1,250 and the family pays a total of $3,750.

The impact of family deductibles will vary depending on family size and composition. For instance, in the example plan above with an embedded individual deductible, a family of size two would never reach the family deductible, since the embedded deductible is less than half of the aggregate deductible.

2.1.2 Coinsurance

It is common in major medical plans that, once the deductible is satisfied, benefits above that amount are payable at a percentage (typically 75%-90%, the most common being 80%) of covered expenses. Perhaps counter-intuitively, the percentage payable by the insurer (80%) is called the **coinsurance**; the remaining portion (20%) is part of the insured's cost-sharing. (This terminology is not used consistently. Some people call the 20% the coinsurance.)

In the example with $1,000 of billed charges, $700 of allowed charges, and a $100 deductible, if the policy pays 80%, then the $600 of allowed charges in excess of the deductible would be payable at 80%, or $480, with the insured responsible for the remaining $120.

Most provider contracts require that the provider accept the allowed charge amount as payment in full and not seek the difference between billed and allowed charges from the insured. The practice of seeking payment from the insured for the excess of billed charges over allowed charges is known as **balance billing**. The federal No Surprises Act[3] protects the policyholder in certain out-of-network situations, and many states have passed legislation to implement their own protections.[4]

[3] https://www.cms.gov/nosurprises
[4] https://www.commonwealthfund.org/node/27021

2.1.3 Copays

Cost sharing that occurs each time a service is provided is called a **copay**. Commonly, when they are used, copays apply to physician office visits (perhaps $20 per visit, for example), prescription drugs (often **tiered**, with copays varying depending on the drug prescribed), emergency room (such as $50 per visit), or other specific benefits. Copays may be used in conjunction with coinsurances and/or deductibles, or without either.

Copays came into vogue in the '70s and '80s, when HMOs first became popular.[5] At that time, HMOs tended to use copays with no deductibles for cost-sharing purposes. Historically, there have been a number of motivations for using copays rather than other types of cost sharing.

- Copays are sometimes used on services which might be subject to over-utilization or for which less expensive alternatives exist, particularly where the insureds themselves have significant control over the usage. Examples of this include physician office visits, emergency room visits, and prescription drugs. For example, copays might be used to provide a disincentive to use the more costly services (such as the emergency room or brand-name drugs) versus less costly services (such as urgent care or generic drugs) in cases where the latter are similarly effective.

- Another common situation where copays are used is when the administration of a benefit (most frequently the prescription drug benefit) is done separately. The administration of prescription drug benefits are typically outsourced to a **pharmacy benefits manager (PBM)**. Because the administration is done by the PBM, which may not have easy access to the insurer's claim records, it can be difficult to coordinate claim payment calculations with other benefits, paid under other parts of the contract. Copay administration with no deductible does not require knowledge of other benefits paid (unless they accumulate towards an out-of-pocket maximum).

  Moreover, eligibility for prescription benefits and the determination of benefits typically occur at the time the prescription is filled, and require access to benefit information to determine cost sharing, so that the pharmacy can collect it at that time. Since PBMs have historically been unable to access insurer benefit and claim information, there has been a compelling argument to use copays with prescription drugs rather than deductibles that are integrated with medical coverage.

  However, integrated plan designs have become more common under the ACA, since all cost sharing for essential health benefits, including prescription drugs, is required to accumulate towards a single out-of-pocket maximum.

[5] An **HMO** is a **Health Maintenance Organization**, a type of health insurance company, typically licensed either under a specific federal law or under a unique part of the insurance or health laws of a state, often characterized by hiring or contracting with the providers needed to provide comprehensive care to their members.

- Finally, copays are attractive to members who value certainty and transparency in what their out-of-pocket expenses will be. For example, lower-income individuals may value knowing ahead of time what their copay will be for a given service, versus the variable amount due under a coinsurance plan design, so that they can plan for the expense.

2.1.4 Out-Of-Pocket Limits

As mentioned earlier, it is generally considered a good idea to provide a financial incentive to the insured to make cost-conscious decisions regarding their own healthcare through the use of cost-sharing. Once a claim reaches a particularly large amount, however, there is usually a provision that relieves the insured of the cost of any additional covered expenses. This is often called an **out-of-pocket (OOP)** provision or a **stop-loss** provision.

OOP limits can also be considered 100% coverage once a claim trigger occurs. That trigger can be expressed either in terms of covered expense (such as $5,000) or out-of-pocket expenses (such as $2,000). They can also be expressed to include or exclude the deductible.

Similar to family deductibles, family OOP limits can be aggregate or embedded. An aggregate OOP limit is met when claims for the entire family reach an aggregate trigger. In an embedded OOP limit, there will be one OOP limit for each individual, and a separate trigger for the family as a whole, in case no single person hits the trigger but there are numerous moderate-sized claims. Embedded OOP limits are required in ACA-compliant family plans. The ACA also sets limits on the maximum OOP limit for individuals and family plans, which vary based on the income level of the enrollee.

We will now work through an example of the cost to the plan under an embedded OOP limit and an aggregate OOP limit, where both plans have the same family OOP limit.

Example 2.2. Make the following assumptions:

- Coverage is for a family of two with the following claims:
    - Member One incurs claims totaling $8,000 early in the year. The cost-sharing parameters result in $3,000 in plan liability and $5,000 in cost-sharing before the OOP limit.
    - Member Two incurs claims totaling $3,000 later in the year. The cost-sharing parameters result in $1,000 in plan liability and $2,000 in cost sharing before the OOP limit.
- The embedded OOP limit is $2,700 per individual;

- Both plans have a family OOP limit of $5,400 (Double the individual OOP limit for the embedded OOP limit plan);

- In both plans, the limit is based on total out-of-pocket expenses, including the deductible, and all expenses incurred accumulate towards the OOP limit for both members.

Under the embedded OOP limit, the plan makes the following payments:

- Member One reaches the individual OOP limit, and the plan pays $(\$5{,}000 - \$2{,}700) = \$2{,}300$.

- Member Two does not meet the individual OOP limit, and the total OOP paid by both members combined is $(\$2{,}700 + \$2{,}000) = \$4{,}700$, which is below the family OOP limit, so no additional payment is made for Member Two.

With an embedded OOP limit, the plan pays an additional $2,300 on top of the $4,000 paid for the two members' claims, and the family pays $4,700 in cost sharing.

Under the aggregate OOP limit, the plan makes the following payments:

- Member One does not reach the aggregate OOP limit, so no additional payment is made.

- Member Two's claims cause the total OOP expense to be above the OOP limit, so the plan pays an additional $(\$5{,}000 + \$2{,}000 - \$5{,}400)$ = $1,600.

With the aggregate OOP limit, the plan pays an additional $1,600 on top of the $4,000 paid for the two members' claims, and the family pays $5,400 in cost sharing.

2.1.5 Maximum Limits

Sometimes a policy will have an overall maximum benefit payable on behalf of an individual. This limit can be expressed in terms of benefits per year (e.g., $1 million in benefits per year), over the life of the individual (e.g, $2 million in lifetime benefits), or both.

Overall benefit maximums were quite common early in the development of major medical policies. As time went on, the original maximums (some as low as $25,000, for example) sometimes seemed absurdly out of date, in light of modern health care costs. Those maximums continued to grow over time, to multiple millions of dollars in the 1980s and '90s.

Over time, many policies eliminated maximums. Ironically, some companies then reintroduced maximums for marketing purposes. Some marketers found that the public views a "$5 million maximum" more favorably than an "unlimited maximum." It turns out that the premium cost for such differences is quite minor, although the risk can be significant for the small insurer who happens to find a rare multi-million-dollar chronic claim. (Such an insurer might have stop loss reinsurance – that is, enter into its own insurance contract with another insurer – to cover the risk of such a claim.)

Some policies with limited lifetime maximums will have a provision that will gradually reinstate eligibility for benefits, even though the maximum has been reached. A policy might, for example, reinstate $50,000 of benefit eligibility each year, after (and despite) the lifetime maximum having been reached. This allows an insured who has previously had a catastrophic event to maintain modest amounts of coverage.

Under the ACA, major medical policies (grandfathered or not) can no longer have lifetime dollar limits on covered services deemed to be "essential health benefits." In addition, annual dollar limits on essential health benefits that previously existed had to be phased out for non-grandfathered plans by 2014. For some types of coverage (such as dental coverage), annual maximum benefits are common plan features.

2.1.6 Internal Limits

Historically, there have sometimes been benefit limits defined in a policy that apply only to specific subsets of benefits. The most common internal limits related to mental health benefits, substance use disorder benefits, and chiropractic benefits. In addition, these benefits also sometimes had per service limits. An outpatient mental health benefit might, for example, have been limited to $40 per visit and 20 visits in a year. As in this example, the overall limit might be expressed either in dollars or in number of services.

The ACA prohibited annual dollar limits on essential health benefits for major medical policies; this also prohibited internal limits on those benefits that are based on a dollar value. Because the law does not prohibit limits on the number of services of a given type that are covered, in many cases, plans replaced annual dollar limits on particular services with annual limits on the number of those services.

Since 2014, individual major medical plans have also been required to comply with parity requirements in the **Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)**. The details are complex, but in general the inside limits applied for mental health and substance use disorder services cannot be more stringent than those applied to other services.

Some Blue Cross plans historically had limits on the number of inpatient days covered per spell of illness. In the past, this was often considered equivalent to an overall maximum, since the bulk of covered charges (for very large claims) was almost inevitably due to inpatient costs. With the growing number of transplants (and their associated surgical costs), and the sometimes major costs associated with new drugs, a limit on covered inpatient days would likely start to look more like an internal limit.

Early in the development of major medical benefits, internal benefit limits were commonly used to limit exposure to broad categories of benefits deemed to be the greatest risk for cost, such as inpatient and outpatient hospital benefits. Such benefit designs were made without benefit of foresight of what would happen to benefit costs over time. In such cases, hospital inpatient benefits might have been contained to a fraction of inflationary trends (with hospital inpatient benefits maxing out), while ancillary services might continue to grow because there are no internal maximums. In many cases, the non-limited benefits (like ancillary services) eventually became the major portion of benefits for the persisting book of business.

2.1.7 Formularies

A formulary is a list of drugs covered by a plan, along with rules for access and a categorization of how those drugs will be treated with respect to member cost-sharing. The actual member cost-sharing parameters, such as copay values, may vary among benefit plans that use the same formulary. The three main types of formularies are closed, open, and tiered.

In a closed formulary, the plan pays a specified portion of the cost of drugs on the formulary, and pays no portion of cost for drugs that are not on the formulary. Cost-sharing is typically a coinsurance, which may vary based on whether the drug is brand or generic. Closed formularies typically must have a process to allow for exceptions to cover drugs based on medical necessity.

Open formularies will cover a portion of the cost of drugs not listed on the formulary, but at a higher level of cost-sharing than formulary drugs.

Tiered formularies divide drugs into cost-sharing tiers. A tiered formulary may still be open or closed. In an open tiered formulary, there is typically one or more "non-preferred drug" tiers with higher cost-sharing than others. A plan may have as few as two tiers or as many as six or more. Each tier will have its own cost-sharing provisions and may mix coinsurance and copays. Furthermore, some tiers may be exempt from the deductible, while others may not. Tiered formularies may be used to control costs for the insurer by encouraging the use of lower-cost drugs or adherence to treatments for chronic conditions that might become more severe if patients do not take their medications due to cost-sharing. An example of a four-tier formulary and an associated set of cost-sharing parameters is shown below.

Table 2.1

Example Four-Tier Formulary		
	Description	**Cost sharing**
Tier 1	Generic	$5 copay
Tier 2	Preferred Brand	$15 copay
Tier 3	Non-Preferred Brand	50% coinsurance
Tier 4	Specialty Medications	25% coinsurance

Formulary tier placement will consider a number of different factors, including but not limited to:

- For brand drugs, whether there is a generic equivalent or a therapeutically equivalent lower-cost brand drug available;
- The "value" and clinical efficacy of the drug, in the sense that it may help avoid costly medical events;
- Competitor formulary designs, both to ensure competitive plan offerings and manage selection effects that may be caused if a plan covers specific high-cost drugs at a lower cost-sharing level than is typical in the market (in which case those who need those drugs may disproportionately enroll);
- Regulatory requirements, if applicable (for example, both ACA major medical and Medicare Part D plans must meet many regulatory requirements on formularies, which must be filed with the government); and
- Rebates or other incentives offered by manufacturers and PBMs in exchange for placement on preferred tiers.

Formularies may also define restrictions that will be imposed on the access of some listed drugs. For example, some drugs may require prior authorization from the insurer before they will be covered. Another form of access restriction is referred to as a **step therapy** program. In these programs, for some higher-cost drugs, a patient must first demonstrate that they have tried one or more lower-cost alternative drugs before the higher-cost drug will be covered.

Formularies have to be monitored and updated continuously as new drugs and generic versions of existing brand drugs are released on the market. Given the complexities and expertise required, many insurers outsource formulary management to a PBM. As

prescription drug cost has become a larger portion of overall health care costs, management of drug costs using formularies and other tools has become more important to insurers.

2.1.8 Variations on a Theme – Related Products

2.1.8.1 Obsolete Coverages

With the coverage requirements introduced under the ACA, many types of medical coverage that used to be offered have been eliminated, either because they do not meet the definition of minimum essential coverage or because there is no longer a need for them.

One of these is **comprehensive major medical (CMM)** coverage. Historically, major medical coverage often had substantial deductibles since its original intent was to insure against "major" costs rather than more frequent lower-cost medical expenses. CMM was distinguished from these traditional major medical coverages by low deductibles, intended to cover these smaller expenses.

On the other end of the spectrum from CMM was **catastrophic major medical** (not to be confused with the ACA's "catastrophic" plans which provide richer coverage than the catastrophic plans described here). These policies had very high deductibles, often upwards of $25,000, and were sometimes purchased to roughly wrap around older policies that might have outdated overall maximums. The ACA caps out-of-pocket maximums for major medical policies, effectively prohibiting these catastrophic policies. The highest out-of-pocket maximum allowed in 2020 was $8,150 for a single policy, or $16,300 for a family.

High-risk pool plans were used by some states prior to the ACA to provide coverage for individuals who had been locked out of the individual insurance market because of a pre-existing condition. As mentioned in Chapter 1, states with high-risk pools either terminated them or began winding them down starting in 2014, since health status underwriting was prohibited in the individual market nationwide at that time. However, some states have used the 1332 State Innovation Waivers to establish a version of high-risk pools where the state pays a portion of the medical costs for individuals in the pool with costs above a certain level.

2.1.8.2 Short-Term Medical

Some major medical insurers found in the past that a sizable proportion of newly issued individual major medical policies were sold to insureds who only intended to keep their coverage in force for short periods. This led to substantial lapse rates in the first duration of policies. Each of those issued policies had a substantial investment by the insurer

5

Setting Premium Rates

Before discussing the details of how premium rates are set, it is important to first understand the context and the overall rate setting process. In addition to the information in this chapter, there are valuable guides in the U.S. *Actuarial Standards of Practice*.[1]

5.1 The Rate Setting Process

Rate setting generally involves two different approaches, depending on whether rates are being set: (1) based on direct, existing experience (such as the experience of an existing block of policies), sometimes called **rerating**, or (2) based on **fundamental pricing** – rating from other data sources (used as benchmarks), which are adjusted to apply to the current situation. All pricing processes use one or both of these approaches in setting rates. These two methods are discussed in detail later in this chapter.

In all methods of rate setting, the fundamental nature of the process is the same: (1) measuring the past, (2) evaluating and adapting it to the future, and (3) using the results of (1) and (2) to project the future in order to determine needed rate levels. How each of these is accomplished, however, often is challenging in many ways.

Rate setting occurs in multiple contexts, each of which will impact the rate setting process. Some of the major considerations are:

- *The market:* The marketplace itself is a major factor. How the product is priced by competitors sets expectations for consumers, and thereby limits insurers' pricing options. This can apply to rate guarantees, margins, rate structures, and the level and type of pre-funding, if any.

[1] See www.actuarialstandardsboard.org/asops.asp.

- *Existing products:* If a company is already in the given marketplace, expectations by producers and the market will have an impact. If, for example, a company's strategy is to have a low initial rate for a product, but then apply large rate increases later, this will draw producers and policyholders who prefer that approach. Changing strategies will cause a disruption to the expectation of the groups, and could impact sales. As with all changes in direction, such changes in strategy should be made considering any potential impacts.

- *Distribution system:* The structure, compensation system, and level of control by the company are all relevant to the pricing process, as are expectations and understanding by the producers as to how rates are set and revised. Sudden changes can cause disruption and loss of business.

- *Regulatory situation:* How likely is it that the full needed rate increase will be allowed by the regulatory process? This is an important factor, as are more straightforward concerns, such as explicit limitations on how rates can be set. As an example, the ACA imposed new scrutiny on rate changes in the individual major medical market above certain thresholds (currently requiring additional justification if any renewing plan requires a 15% or greater rate increase).[2]

- *Strategic plan and profit goals:* Pricing is, to borrow a phrase, "where the rubber hits the road" for many individual health coverages. The ability to price competitively yet profitably is an ongoing (sometimes, seemingly insurmountable) challenge, especially for companies active in the commercial market. Pricing practices and methods should reflect and contribute to achieving the company's strategic goals.

Once the context is understood, it will generally define most aspects of how rates will be structured for a product.

5.2 Rate Structures Used Today

Premium rates could theoretically be set to vary by any factor discovered to have a material correlation to claim costs; in practice, rating variables are generally limited to those that have both a rational causal relationship and such a correlation,[3] and some characteristics related to risk may be excluded for policy reasons. Such variables, depending on the coverage, might include: age, gender, occupation, geographic area at time of issue, geographic area at time of renewal, income level, current health status, past claim history, duration of the policy since issue, benefit plan (more on this in a

[2] https://www.cms.gov/files/document/urr-py23-instructions.pdf, page 33.

[3] For a thoughtful discussion of this topic, see the 2011 American Academy of Actuaries monograph "On Risk Classification," available at http://www.actuary.org/files/publications/RCWG_Risk Monograph_Nov2011.pdf

minute), tobacco use status, marital and parental status, presence and nature of other coverage, and sometimes situation-specific factors, such as whether the policyholder converted from another plan of the same insurer.

The term **community rating** is often used to describe medical insurance rating schemes, and occurs in various forms – "modified community rating", "adjusted community rating", and so forth. The term is a popular one, particularly for public policy purposes, and refers in general to a scheme where many rating variables, which might otherwise be used, are knowingly ignored. Which variables those are will vary from situation to situation, making "community rating" a slippery term to define. Community rates will typically not vary by age, gender, occupation, income level, health status, past claim history, duration, tobacco use status, or the presence or absence of other coverages. It usually allows rates to vary by geographic area (although this variable may often be limited), marital and parental status, and benefit plan. In addition, in various regulatory settings, regulators have redefined the term for their specific use in particular situations. The bottom line is: it is important to make sure the term is well defined when using it or relying on it.

For example, the ACA imposed a form of modified community rating for individual and small group major medical coverage starting in 2014 (grandfathered and transitional plans are exempted). The allowable rating variables are:

- Age (carriers must use standard age rating factors which vary by no more than 3:1 from the highest rate to the age 21 rate);
- Tobacco (limited to no more than a 50% surcharge for users);
- Area (rating areas are prescribed by the state, but factors are set by the insurer, and have no prescribed ranges, so long as the values do not reflect morbidity differences between areas, unless limited by state law);
- Family tiering/structure (family rates must be less than or equal the sum of member-level rates, with the number of child dependents charged premium capped at three); and
- Plan (including benefits, cost sharing, and network).

Health status may not be included in any of the rating factors. States are free to impose more restrictive requirements if they want, and some do.[4]

Over the past several years, **predictive models**, used to predict future claim costs for individuals and groups based on past claim history, prescription drug use, or other information, have become an integral part of the underwriting process for most carriers (at least those allowed to underwrite risks).

[4] A handy list of state-by-state ACA rating variations may be found here: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-rating

In the property and casualty insurance market, advances in the type and quantity of data available, and methods for collecting it, have had significant impacts on rating. For example, technology now exists to monitor individual driving habits, which can be factored into rate setting for auto insurance. Insurers can also access data collected through social media, purchase records, and credit history. The use of newly available data allows for more accurate rate setting, in addition to enhanced fraud detection and understanding of historical patterns and trends. However, the use of these data elements in the rating process raises many concerns, including:

- Increase in regulatory resources needed to review complex filings;
- Potential discrimination or privacy violations;
- Lack of transparency and the potential for bias in algorithms using this data;
- Highly individualized rates that lose the benefit of risk pooling.

With the prohibition of underwriting in the individual major medical market, these data sources may instead be used in care management or population health programs. Although this does not have direct regulatory impacts, it still raises concerns over bias and discrimination in allocation of healthcare resources. Predictive modeling techniques are increasingly used in rating and underwriting of other health coverages where permissible, and regulatory scrutiny of these practices is increasing.

Descriptions of the major rating structure elements follow. In these descriptions, the rating structure variables are related to the corresponding characteristics of the underlying data. In some cases, however, the premium rate relativities chosen may not follow the claim cost relativities for the rating cells, either because of regulatory restrictions or as a business decision by the insurer. To the extent the chosen rate relativities deviate from the underlying claim relativities, subsidies are being created from one rate cell to another. Subsidies can create antiselective situations, and increase the insurer's risk.

5.2.1 Age

There are three major categories by which rate structures treat the age of policyholders. First, there is **attained age rating**. Under this approach, policyholders' rates are a function of their age at renewal. Someone age 25 who buys a policy, and pays the age 25 rate, will next year pay the (then current) age 26 rate. If the attained age rates are grouped into rate categories larger than a single age, such as in five-year (quinquennial) age groupings, this is called **step rating** or **age banding**.

If the rates reflect the age at issue, but not the age at renewal, then the rating scheme is called **entry age** or **issue age rating**. This rating scheme is usually accompanied by a corresponding reserve to offset the increasing costs in future years (called the "active life reserve," "policy reserve," or "contract reserve"). These are described more fully in Chapter 6.

In some circumstances, rating structures do not recognize age at all, which might be called a **uni-age rating** scheme. Most community rate structures are uni-age. Since age-based cost varies significantly, charging an average rate over all ages creates a significant disparity between the actual cost and the price charged. This leads to a situation ripe for antiselection. (Antiselection, and the art of dealing with it, are discussed further in Chapter 4.) Unless all carriers use similar rate structures in a given market, a company using uni-age rating can experience severe antiselection. One such example occurred with an insurer that determined, while it issued policies from ages 18 to 64 with a common rate, its average policyholder age was 57. (Premium rates for these later ages were the only ones competitive with carriers using age-based rating.) Under the ACA, all carriers selling individual major medical must use prescribed age rating factors, which may vary by state and market. We will discuss this in more detail later.

Medical and Med Supp coverages tend to use attained age rates, or, when regulated to do so, issue age or uni-age rates. These products are most easily characterized as "inflation sensitive" coverages – the claim costs tend to go up each year with increasing health care costs. The impact of claim trends tends to overshadow the impact of year-to-year age increases, so rate structures intended to level the age increases, such as issue age rate structures, can become fairly ineffective for these types of policies if claim trends remain high.

Non-inflation sensitive coverages, particularly those with relatively fixed benefits, are more prone to use age-leveling premium structures. For this reason, DI, LTC, and HI coverages all tend to be sold on an issue age basis. In this case, leveling of age increases in the premium structure can be quite effective. In fact, for noncancelable policies, the premium rates are actually guaranteed not to increase.

Claim costs do vary significantly by age for virtually all coverages. People at older ages tend to generate higher claim costs than people at younger ages for most coverages. (Two counterexamples are maternity coverage and accidental death coverage, but there are not many such examples.)

Underwriting has a particular impact on the age curve. This is because the age curve describes the relative claim costs of *average* insureds at each age. For some products, the average insureds at higher ages have significantly higher expected claim costs than the average younger insured. To the extent underwriting is effective, it has the impact of weeding out those at higher ages with chronic diseases or predictably high claim costs, having a relatively greater impact at the higher ages. This is one reason why the morbidity by age curve for individual insurance historically tended to be substantially flatter than that of large group insurance, where there was no individual underwriting.

Typical age curves for different coverages are illustrated in Figure 5.1. The relativities have been multiplied by a factor so that the average factor for each coverage, over an assumed typical population, averages to 1.00. (This process is called **normalization** of the factors over that population.) Note that the Accidental Death coverage has factors that *decrease* above the younger ages (and would be even more pronounced if the graph extended to still younger ages); this is one of the few coverages which does so. The slope of most coverages varies by duration; the slope in this graph represents an average slope over all durations.

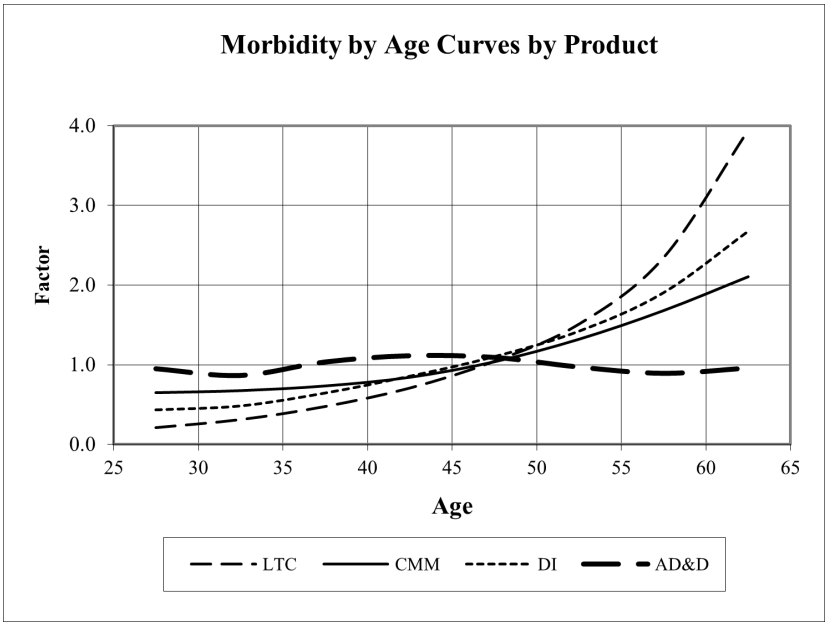

Figure 5.1

As mentioned previously, the ACA requires carriers to use prescribed age factors when setting premium rates in the individual and small group markets. Since all carriers are subject to the same rating rules, there is less chance of antiselection between carriers due to this limitation (but still a chance for antiselection against the market as a whole). While the reason for the overall restriction in the range of the age factors (3:1 for adults) may be political, the reason a standard age curve is required in each market is technical. In order to account for the age rating in the risk adjustment program (discussed in Chapter 4 on antiselection), the government decided to require all carriers in each market to use the same rating factors for age, so that they could be taken into account in the risk adjustment formula. States can develop alternative age curves as long as they vary by no more than the 3:1 ratio required by federal law. As of 2026 eight states and Washington, DC have adopted an alternative age rating curve for the individual market, and two of those states require a single rate for all ages (1:1 ratio).[5]

[5]Information on state-specific rating variations can be found on The Center for Consumer Information and Oversight, Market Rating Reforms website, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating

10

Other Insurer Functions

This chapter describes a number of the professional functions that an insurer must perform in order to successfully sell and administer its individual health business. The chapter begins by describing the many ways in which individual health insurance is marketed. It then describes the underwriting, claim administration, and policy administration and service functions.

Perhaps one way to think of the functions performed at an insurer is to examine the roles played by various insurer personnel over the life of a policy. Initial contact is made through the sales function. Then the underwriting area comes into play, determining whether and on what terms coverage will be offered. (Underwriting is discussed in Chapter 4.) If the policy is offered and accepted, policyholder services enter the picture to issue and maintain the policy. Later, claim administration will become involved if and when there is a claim.

10.1 Sales and Marketing

As you have probably noticed throughout this text, in many ways the individual health insurance market is not a single market, but rather a collection of small market segments, varying by product and type of insurer. Sales and marketing is no different, and the characteristics of the market will depend on the market segment being studied.

At the same time, there are a limited number of production conduits available. Products are sold via personal sales by agents, by telephone (telemarketing), or by mass marketing methods. Mass marketing can occur through various media (including television, radio, the internet, billboard advertising, or flyers), or brochures provided through and with other media (such as a credit card bill or a paycheck). Sometimes leads produced through mass marketing methods are handed off to agents or telemarketers for follow-up.

In the commercial major medical, disability income, and long-term care markets, most products are sold by independent brokers, although there are a small number of insurers with captive agency forces of their own, usually managed through a general agency system. Most brokers who are active in these markets specialize in the coverage being sold, as success demands specialized knowledge about the current conditions in these quickly-changing marketplaces. Brokers will sometimes "spreadsheet" rates – comparing the rates of a variety of insurers, in order to obtain the lowest rate for a particular prospect.

Captive agents are usually not as specialized as brokers, and instead are focused on providing a spectrum of products from the same company to their customers. In some schemes, with general agencies of sufficient size, and products that require specialized knowledge (such as DI or LTC), a general agency might have a product specialist who supports the non-specialized agents in the agency.

Insurers are constantly re-evaluating their products. In the major medical market, this is most notable with respect to premium rates. Seemingly minor changes in rate relativities between areas can cause significant shifts in production volume. Often the difference between selling a high volume of business and selling a little can revolve on a rate difference as little as 5%. The DI and LTC markets are often more driven by product design, although premium levels are never absent from the list of important issues.

Except for telemarketing or mass marketing, selling in these markets usually occurs through personal contact between an agent (whether employed directly by the insurer, a general agent, or a broker) and the prospect. The agent often helps the prospect fill out the application, and creates a personal connection with them. (For some coverages, agents are sometimes asked by the company to also perform some field underwriting, by doing a limited amount of simplified underwriting while interfacing with the client.) Some products, particularly those covering basic needs, require more sales effort to sell than does a lower cost supplemental policy.

General agents (GAs) are typically (but not always) appointed by an insurer to be responsible for all business provided in a given geographic area. They will hire subagents, on behalf of the insurer, to be the actual business producers, and will manage those agents. A **brokerage** is an entity formed of a group of agents, not affiliated with any particular insurer, although they may form exclusive working arrangements with them from time to time.

Within every product type, some products are designed to cover basic needs, while others are more supplemental. Most typically, it is supplemental products that are more easily sold using mass marketing methods, while basic coverages are less often sold that way. There are several reasons for this, but it seems mostly driven by the cost of underwriting. Basic coverages typically have much larger claims, and therefore constitute a much bigger risk to the insurer. Antiselection under supplemental coverages can more often be controlled by other means, such as contract language and product design.

The market for basic medical coverage (major medical) is most often self-employed persons, and individuals who are not covered (for whatever reason) by a group contract. Sometimes that lack of coverage arises because an employee is temporarily between jobs, or is a college graduate looking for a first post-graduate job. This short-term need is usually met with a short-term medical contract.

Another common situation (not met by short-term coverage) is when individuals are employed by a small business without group health insurance. This situation is becoming more frequent, as small employers are less able to afford the cost of health insurance as an employee benefit.[1]

A somewhat less comprehensive medical coverage, addressing hospitalization only, is sometimes used to provide a lower cost alternative to major medical coverage, while still protecting against major illnesses or injuries. Such limited coverage will generally not satisfy the requirement to purchase health insurance mandated by the ACA.

There are similar comparisons that can be made between basic and supplemental DI coverages. Because U.S. Social Security provides a significant disability benefit, DI products tend to be built around this. When looking at the market in total, companies will tend to disproportionately focus on higher income individuals, because those are the prospects who have the most meaningful need (if defined as the portion of earnings being replaced) for coverage above Social Security.

As discussed in Chapter 1 and throughout this text, the ACA introduced the public insurance exchange for individual major medical coverage starting in 2014. While brokers and agents can still assist individuals in obtaining coverage, the exchanges also include navigators, in-person assisters, and certified application counselors for those seeking assistance in purchasing coverage.

Participating in exchanges can involve significant administrative hurdles for an insurer. For instance, the insurer must interact with the exchange to verify eligibility and coverage, and must also complete the complex certification process for qualified health plans outlined in Chapter 9. Brokers generally have to be registered with the exchange to be compensated for exchange policies. As preparation for rollout of new exchanges drew near, industry experts questioned whether carriers would need brokers at all or whether they should instead focus on signing up consumers directly through the exchange. However, after more than five years of implementation, CMS published a white paper sharing evidence of a continued need for agents and brokers.[2] In 2020, brokers and agents accounted for nearly half (47.8%) of all open enrollments in the US. This varied significantly by state with more than 70% enrolled through agents in Florida compared to just over 5% in Hawaii. Some of the general success of broker interaction can be attributed to enhanced exchange enrollment platforms created by CMS, allowing brokers and agents to more easily assist policyholders with enrollment activities, including subsidy determination, which can be challenging to navigate without assistance.

[1] Employers with fifty or more full-time equivalent employees do face penalties if they do not offer affordable coverage to full-time employees. Smaller employers are generally exempt from this requirement.

[2] https://www.cms.gov/sites/default/files/2020-10/Agents-and-Brokers-in-the-Marketplace.pdf

Regardless of whether a broker or agent is used for enrollment, the internet has become an increasingly popular platform for individuals to identify and evaluate products in their respective markets. By performing basic searches, individuals can identify carriers that sell individual health insurance products in their area. From there, they can go directly to each carrier's website and review products available to them. They may also be able to leverage consumer-friendly tools to help them decide which product may be best for them. These tools may ask the individual about expected use of health services and preferences of providers. Using that, the tools can assist with determining expected out of pocket costs and help with determining the best product for the individual to consider. They can also facilitate the determination of premium subsidy assistance and enrollment directly or by connecting them to the appropriate state-based or federal exchange.

10.1.1 Compensation

Sales personnel are typically compensated by means of **commissions** payable on business they sell and have in force. Many times, a company with a captive agency force will provide a stipend in the first year or two of agents' careers (typically grading down over time, often to zero), in order to provide them with income while they learn their trade and build their portfolios of customers.

Commission rates are sometimes expressed as percentages of premium, and can vary by product, by duration (most commonly first year vs. renewal), by persistency of the agent's business, by volume of business placed, or by other factors. Schedules with higher first year (and possibly for a few subsequent years) commissions are said to be *heaped*, or *graded*, although "graded" sometimes refers to differences by other variables such as volume. Heaped commissions occur in both broker-driven markets and captive agencies, although more frequently in the broker market. They also are more often used by companies that have a life insurance focus, and are less prevalent among P&C companies, because the comparable scales for those other coverages are more heaped (life) or less heaped (P&C). One school of thought is that heaped commissions tend to attract brokers that are more likely to replace the business elsewhere (and thereby earn yet another first year commission), which argues that insurers' best interests lie with flat commission scales. Another consideration is that levelized commissions tend to generate better returns on investment (or equity) in pricing models. Prevailing practice in the marketplace will generally dictate whether a heaped commission scale is needed.

For coverages that are not inflation-sensitive, such as DI, non-scheduled increases in coverage are often treated as though they are first year premium for commission purposes, under the rationale that such an upgrade in coverage required selling comparable to a new policy of that premium size, and avoids the cost of issuing a new policy.

Sometimes a company will change its commission schedule in order to achieve a sales or tactical goal, such as a year-end push for new policies, or intentionally converting an existing policy to a new one.

It is important to understand that the more independent a producer is (i.e., the more easily they can go to competitors' products at will), the more competitive the compensation scheme needs to be. While we would like to think that an agent will always put their customer's needs first, the value of the commission to the agent will always have an impact on the success of the product.

For coverages that are inflation sensitive, it has long been a practice not to consider regular rate increases as first year premium. In recent years, there has also been a movement among some carriers to not consider the premium from rate increases even as renewal premium for commission purposes. This is particularly true for major medical and Medicare Supplement coverages, where premium increases can consistently outpace actual cost trends by a sizable margin. Some argue that salesmanship is needed to keep policies in force in the light of such increases. A middle ground between these arguments is to allow the increases to be commissioned, but at a lower rate. Probably the strongest inflation-controlled commission practice pays a flat commission per policy or per member. This can be indexed contractually by the Consumer Price Index or at the discretion of the insurer.

Sometimes service fees are paid to agents, to compensate for services provided through the renewal process. Renewal commissions might be composed partly of an element intended to compensate for ongoing service (service fees) and partly a payment of commission in renewal years for the original sale.

Another element of commission scales is the vesting schedule. Commissions generally become **vested** at the point when commissions become due to an agent regardless of whether the agent continues to be employed by the agency or the insurer.

General agents and brokerages are sometimes paid a commission override. This is an additional commission payable to the GA or broker, typically significantly smaller than the commission itself. Sometimes, the combined commission and override is paid to the GA or broker, who then distributes the commission out of the total.

Group conversion policies often do not generate commissions since these policies generally exist in order to comply with the law, rather than as a source of profits. They are usually marketed through the employer, or directly with the insurer. Even when there are agents involved, there may not be any commissions payable.

The ACA requires insurers to pay the same commissions for major medical products sold in and out of the public exchanges. At the same time, minimum medical loss ratio requirements are putting significant pressure on administrative costs, of which commissions make up a large part. This has shifted the compensation model for many in this market, from paying a percentage of premium to paying commissions on a flat dollar per member per month basis. In addition to addressing the medical loss ratio requirements, this payment shift helps to control the increases in costs by tying payments to explicit increases, rather than indexing to potentially leveraged premium increases.

Since OBRA 1990 became law, first year commissions on Medicare Supplement policies have been limited to two times renewal (defined as years 2-6) commission rates, presumably to help limit potential **churning** (intentional, unnecessary replacement of coverage by another carrier). This 2:1 limitation can be applied either on a dollar basis or a percentage basis. For Medicare Advantage and Part D plans, CMS annually publishes maximum fair market values of commissions that outline the maximum commissions payable on these policies. The fair market value varies by geographic region, plan type, and whether it is a first year or renewal policy.

Marketing's literal definition is "the act or process of buying and selling in a market."[3] In an insurance company context, marketing typically involves developing all the sales material, (including research), addressing the product. Product design and development, market research, sales brochures, and market strategies are typically all functions of the marketing department. In a **direct marketing company**, the marketing department also designs the interactions with customers and manages the sales process.

Some individual coverage is sold to associations of various types. An important aspect of marketing to these collections of individuals is the understanding and management of the **affinity level** of this target audience. A group with a high affinity level is one whose individuals have a strong sense of identification with the group (such as a medical association, bar association, or actuarial association). At the other end of the spectrum are groups that are essentially formed only to provide a vehicle for insurance. Other things being equal, high affinity groups tend to have better response rates to marketing programs, and have less antiselection and lower claim costs as a result.

An important function of the marketing area is to develop market strategies. It is important to segment the marketplace, defining sub-segments which differ in important ways. The differences most often are defined for one of two reasons: (1) the competitive situation is different in one market segment than another; or (2) the population being served is heterogeneous, and can be better targeted as multiple sub-populations. One of the critical success factors of most companies is adequately defining these market segments. A major medical carrier will typically have its biggest division be geographic, for reasons described earlier. DI carriers will more typically segment their market by occupation class, or even by subdivisions of those occupation classes.

A major part of the last remaining pool of uninsured has been the young, healthy people who do not purchase coverage. At least a few insurers have tried to penetrate this market segment with new products designed to appeal to this segment. The ACA's individual mandate intended to induce all such "young invincibles" to sign up for coverage. In most cases, however, the penalty for flaunting the mandate was much lower than the cost of coverage, even after premium subsidies were taken into account. It was originally estimated that, in order to create a stable rate environment, 40% of enrollees on the exchanges should be in the 18 – 34 age range. However, between 2017 and 2026, these members made up only 25-28% of exchange enrollment each year.[4]

[3] *The American Heritage Dictionary of the English Language*, Fourth Edition, Houghton Mifflin Co., 2000.

[4] https://www.kff.org/health-reform/state-indicator/marketplace-plan-selection-by-age