

INDIVIDUAL (NON-GROUP) POLICIES

What are they?

An individual health insurance policy is one that is purchased outside a group setting. (Most employment-based insurance is group insurance.) For this reason individual policies are also called “non-group” policies. Individual policies are often more expensive than group plans with comparable coverage. They may also offer less coverage than group policies.

Who are they for?

Individual policies are usually written for people who are unable to purchase health insurance through a group. Individual policies can, however, be issued to people who have group coverage available to them. For instance, some people choose to purchase individual policies to supplement their group plan. Others may purchase non-group policies so that their health insurance coverage is not dependent on their employment.

Non-group policies can be written for individuals or families — a policy written for more than one member of a family doesn't make it a group policy. The difference is that an individual policy, whether written for one person or for a family, is not part of a master policy issued to a group.

How to obtain coverage

Individual policies can be purchased through insurance agents. Please see the information on choosing an agent in “How to shop for health insurance,” Chapter 2 of this guide. Bear in mind that there are literally thousands of insurance policies being offered for sale in North Carolina. You should be prepared to spend some time shopping for a policy that meets your needs.

INTRODUCTION

With some exceptions, almost anyone can purchase an individual health insurance policy. As a rule, non-group policies are written for individuals or families who do not qualify for group coverage. However, some people who are eligible for group coverage choose to purchase individual policies — just being eligible for a group policy does not make you ineligible to purchase an individual policy. Individual policies often have much higher administrative expenses, making the premiums more expensive than similar coverage for groups. In addition, some people may be excluded from coverage based on their health status.

Non-group plans come in a variety of types. Some of the plans are more comprehensive than others in covering a wide range of medical services. Non-group coverage falls into the following broad categories.

Managed Care Plans: In a managed care plan, you will generally get your medical care from a set list of medical providers approved by the plan (“network”). These plans often emphasize preventive health services. They also offer comprehensive coverage of other medical services (for example, physician visits and hospital stays). Managed care plans include Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), or Point-of-Service plans (POS). HMOs generally limit coverage to network providers. PPOs and POS plans allow you to choose a medical provider outside the network, but the plan will cover a smaller portion of a medical bill from an out-of-network provider. HMOs and POS plans are usually limited to employment-based group insurance plans. PPOs, however, may be offered to people purchasing non-group insurance.

Major medical insurance policies: Major medical insurance provides broad coverage for outpatient expenses (such as doctor visits) and hospital stays. Major medical policies have some limitations but they usually provide high maximum benefit amounts.

Catastrophic policies: Catastrophic policies have large deductibles (\$5,000 or \$10,000 a year). After you meet this large deductible — usually because of a devastating accident, a major illness, or a prolonged hospital stay — the catastrophic policy begins to provide coverage. Because of the large deductible, this type of plan ordinarily offers little or no coverage of primary or preventive services, but its coverage of catastrophic illnesses or accidents is quite comprehensive.

Indemnity insurance policies: Indemnity insurance provides a specified dollar amount for a given medical service. For instance, an indemnity policy would pay a set dollar amount (not a percentage of the actual charges) for each day of a hospital stay.

Dread disease policies: Dread disease policies provide benefits solely for the treatment of a disease named in the policy — most typically cancer or heart disease. As with indemnity insurance, described above, these policies usually pay a fixed dollar amount for specific items outlined in the policy. For instance, a “dread disease” policy covering cancer might guarantee the payment of X dollars for radiation treatment. This type of policy often offers substantial maximum benefits; that is, it will pay a large amount over a person’s lifetime for treatment of the covered condition. But this type of coverage is otherwise very limited. A “dread disease” policy covering cancer, for instance, would provide no benefits for the treatment of an injury or any medical condition other than cancer. A “dread disease” policy should only be considered a supplement to other insurance.

that is, the insurance company can ask about your medical history and can refuse to offer you coverage because of it.

If you have been refused coverage because of a medical condition, you may be eligible for the Access Program of Blue Cross and Blue Shield of North Carolina. Please see Chapter 4 of this book for more information.

LIMITATIONS AND EXCLUSIONS

People who are considered high-risk, or who have a history of medical problems, may not be able to purchase a regular non-group policy at all. However, insurers may not refuse to cover some individuals because of their health status. To qualify for this special protection, you must meet the following criteria:

- ◆ You must have had prior health insurance coverage for at least 18 months, through an employer-based group health plan, governmental plan, or church plan
- ◆ You must not be eligible for health insurance under a group health plan, Medicare or Medicaid, and may not have other health insurance coverage
- ◆ You did not have your health insurance coverage terminated because of non-payment of premiums or fraud
- ◆ You elected COBRA continuation coverage if offered
- ◆ You exhausted your COBRA continuation coverage (if applicable)

Insurers that market health insurance in the non-group market must offer coverage to any individual who meets the criteria set out above. Further, they may not impose

a pre-existing condition exclusion. They must offer the two most popular non-group policies to these qualified individuals. (Generally, one of the policies must have comprehensive coverage, and the other may be more limited.) However, there is no limit on what the insurer can charge. So effectively, insurers can set their premium prices high enough to discourage most people with pre-existing medical conditions from purchasing insurance.

Individuals who do not meet the criteria above may be denied a non-group policy based on their health status. If you have been denied insurance because of a medical condition, you may be eligible for the Access Program of Blue Cross and Blue Shield of North Carolina.

Insurers may impose pre-existing condition exclusions on the policy if you are offered health insurance coverage, but do not meet the criteria above. Insurers are permitted to impose a waiting period of up to 12 months before they will begin paying benefits on certain pre-existing conditions. For instance, if you were treated for migraine headaches within six months before purchasing your individual policy, it might not pay any benefits for treatment of migraines until you have had the policy for 12 months. After the waiting period is over, however, the condition must be covered.

Individual policies may also contain “riders.” If you have a policy with a rider, you may have comprehensive coverage of every condition except the one named in the rider. If, for instance, you were treated for epilepsy before you purchased an individual policy, a rider may deny coverage of any epilepsy treatment for as long as you hold the policy.

NOTICE

When you buy an individual policy, the company must furnish you the official policy (not just a brochure or summary). The policy outlines your rights, benefits, and responsibilities under the plan. If material changes are made to the plan, you must be provided information about these changes. Proposed changes must also be filed with the Commissioner of Insurance. The Commissioner has the authority to approve or deny proposed changes in a policy’s coverage.

RENEWABILITY

Individual policies may be sold as either guaranteed renewable, conditionally renewable, or optionally renewable. Guaranteed renewable policies must be continued, as long as the covered individual pays the premium. Conditionally renewable policies are generally renewable, until the covered individual reaches a certain age that was specified in the policy (at which point, the insured individual is no longer eligible for benefits). Optionally renewable policies may be discontinued by the insurer, but only if the insurer discontinues the whole block of business. In other words, the insurer cannot single out and discontinue coverage for specific individuals (if they continue to pay the premium).

While you cannot be terminated because of your health status or use of health services, you can be denied continued coverage for the following reasons:

- ◆ Non-payment of premiums
- ◆ Fraud
- ◆ The health insurer stops offering health insurance in the individual market
- ◆ You move outside the insurer's coverage area

An insurer must provide at least 90 days notice before discontinuing a particular type of insurance coverage offered in the individual market; and at least 180 days prior to discontinuing all non-group insurance coverage. If an insurer chooses to stop providing a specific type of policy, it must offer the individuals covered under the non-group policy the option to purchase any of its other non-group policies.

PREMIUMS

Insurance carriers must file information on non-group premium rates with the North Carolina Department of Insurance. The Commissioner of Insurance has the authority to determine if a proposed rate increase is justified or not. This determination is made on the basis of established guidelines. The Commissioner uses a mathematical formula (called a "minimum loss ratio") to calculate how much of the premium dollar is being spent to pay for medical services and how much goes to company profits or overhead expenses. A large rate increase may be approved if the insurance company can show that it has paid out large medical claims under the plan.

If the Department of Insurance approves a rate increase, then the insurance company may raise the premium rates. However, the rate increase must apply to everyone with the same "policy form" (i.e., type of health insurance policy). You cannot be singled out individually for a premium increase.

If you have an individual policy, you are entitled to 45 days written prior notice of a proposed increase in your premium rates.

ADMINISTRATION

The North Carolina Department of Insurance has the legal authority and responsibility to regulate insurance carriers and HMOs. The Department's oversight of insurance includes seeing that the plans are financially solvent, meet certain quality standards, and have certain procedural safeguards. If you have questions about the administration of your insurance coverage, you may contact the Consumer Services Division of the Department of Insurance.

SOURCES OF LAW

State law(s): N.C.G.S. 58-51-1 *et. seq.*, 58-68-60 *et. seq.*

State regulation(s): 11 N.C.A.C. 12.0300 *et. seq.*
11 N.C.A.C. 12.0500 *et. seq.*

FOR MORE INFORMATION

Consumer Services Division
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