

# The Individual Insurance Market: A Building Block for Health Care Reform?

## Insights from HCFO Research Results

See companion Policy Brief at [www.hcfo.net/pdf/policybrief0508.pdf](http://www.hcfo.net/pdf/policybrief0508.pdf).

### Introduction

Health care reform is high on the agenda of policymakers at both the state and federal levels. The individual insurance market is central to many proposals, including some under discussion as well as some in early implementation. In 2006 Massachusetts enacted an ambitious reform plan that requires all adults in the state to purchase coverage; the idea of an individual mandate is also part of some federal proposals. Various federal proposals include substantial tax deductions or tax credits for those purchasing health insurance in the individual market. Both would eliminate the favorable tax treatment that employer-sponsored coverage currently enjoys relative to most individual coverage.

While these developments envision a larger, more prominent role for the individual market, considerable disagreement remains about the current state of this market and its potential as a vehicle to significantly expand coverage. Some elements of the current ideas for reform—such as an individual mandate—are new and untested, and the dynamics of insurance markets that both inspired and bedeviled reform efforts in the 1990s—such as managing adverse selection when individuals have a choice of products and carriers—may remain even in a reformed market. Insights gained from prior research and reform efforts may offer valuable lessons as policymakers consider the current crop of proposals, raising flags for issues likely to resurface and providing guidance for how unintended consequences might be mitigated.

This synthesis focuses on a group of projects exploring various aspects of the individual insurance market funded by the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) initiative throughout the past decade.<sup>1</sup>

These projects vary broadly in scope and method. They cover a wide array of topics, including studies of the participants in and dynamics of the individual market, evaluations of state attempts to stabilize the individual market, early experience with a health insurance tax credit, and lessons that might be learned from Association Health Plans (AHPs), which have many similarities to the individual insurance market. Methodologically, the projects range from a theory-based exploration of guaranteed renewability to several qualitative studies (see Table 1: HCFO Projects Addressing the Individual Insurance Market).

The approach and findings of each project, including lessons that might be usefully applied in formulating and analyzing current reform proposals, are discussed. While the research included in this synthesis is not comprehensive, the breadth and depth of the work, as well as sufficient commonality among the findings, permit the development of lessons from experience with the existing individual insurance market, as well as a framework for evaluating future policy proposals supporting its expansion.

### What Distinguishes the Current Individual Market, and How Might It Change?

#### Dynamics of Individual Coverage

We have long understood that the individual market is quite small, and data from surveys such as the Current Population Survey (CPS) suggest that it is a transitory market for at least some of its participants (Chollet, 2000). Andrew Coburn and colleagues (Ziller et al., 2004) extend our understanding of market dynamics using panel data. They use data from the 1996-2000 Survey of Income and Program Participation (SIPP) to examine the length of spells of individual coverage and to look at insurance status before and following those periods in the individual market. They find that most purchasers use individual coverage as a bridge between spells of employer coverage—two-thirds of spells began *or* ended with employer coverage, and 58 percent both began and ended that way. This finding confirms the dynamic hinted at in cross-sectional CPS data, where Chollet (2000) found that a third of respondents reporting individual coverage in a year also reported having employer-based coverage at some point during the same time period.

Coburn and colleagues use the longitudinal nature of the SIPP data to offer insights about how spells of individual insurance end. They find striking differences between subgroups: Among the very young (18-24 years old), 40 percent of individually insured spells transition to uninsured, compared with 6 percent among those age 55 to 65. Similarly, among those in excellent or good health, 17 percent of those with individual insurance end up uninsured, while only 9 percent of those in fair or poor health do. The much greater willingness by the young and healthy to drop coverage suggests that there is a basis to insurers' fears



Robert Wood Johnson Foundation

Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.



AcademyHealth  
Advancing Research, Policy and Practice

# HCFO Projects Addressing the Individual Insurance Market

**Table 1**

Project	Principal Investigator	Dates	Publications
Evaluation of Reforms of the Market for Individual Health Insurance Coverage in New Jersey	Katherine Swartz, Ph.D.	9/95-12/97	Garnick, D., Swartz, K., and Skwara, K. 1998, "Insurance Agents: Ignored Players in Health Insurance Reform," <i>Health Affairs</i> , Vol. 17, No. 2, pp. 137-143.  Swartz, K. and D. Garnick, 1999. "Hidden Assets: Health Insurance Reform in New Jersey," <i>Health Affairs</i> , Vol. 18, No. 4.
An Evaluation of the Primary and Secondary Effects of Insurance Market Reform	Mark Hall, J.D.	9/96-12/00	Hall, M. 2000. "An Evaluation of New York's Reform Law," <i>Journal of Health Politics, Policy, and Law</i> , Vol. 25, No. 1, pp. 71-100.  Hall, M. 2000. "An Evaluation of Vermont's Reform Law," <i>Journal of Health Politics, Policy, and Law</i> , Vol. 25, No. 1, pp. 101-132.  Hall, M. 2000. "The Geography of Health Insurance Regulation," <i>Health Affairs</i> ; Vol. 15, No. 2, pp. 173-184.  Hall, M. 2002. "Of Magic Wands and Kaleidoscopes: Fixing Problems in the Individual Market," <i>Health Affairs Web Exclusives</i> 2002, pp. W353-358.
Expansion of the Evaluation of the Effects of New Jersey's Individual Health Coverage and Access Programs	Katherine Swartz, Ph.D.	5/98-4/99	Swartz, K. and D. Garnick, 2000. "Lessons from New Jersey," <i>Journal of Health Politics, Policy, and Law</i> , Vol. 25, No. 1, pp. 45-70.
Premium Variation and Insurance Demand in the Individual Market	Mark Pauly, Ph.D.	3/99-10/00	Herring, B. and M. Pauly, 2001. "Premium Variation in the Individual Health Insurance Market," <i>International Journal of Health Care Finance and Economics</i> , Vol. 1, pp. 43-58
Patterns of Individual Coverage	Andrew Coburn, Ph.D.	10/01-6/03	Ziller, E., A. Coburn, T. McBride, and C. Andrews, 2004. "Patterns of Individual Health Insurance Coverage, 1996-2000," <i>Health Affairs</i> , Vol. 23, No. 6, pp. 210-221.
Guaranteed Renewability in Individual and Group Health Insurance: Functioning and Future Prospects	Mark Pauly, Ph.D.	11/01-10/02	Herring, B. and M. Pauly, 2006. "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," <i>Journal of Health Economics</i> , Vol. 25, pp. 395-417.
Sustaining Individual Health Insurance Markets Under Community Rating and Open Enrollment	Joel Cantor, Sc.D.	4/02-9/03	Monheit, A., J. Cantor, M. Koller, and K. Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey," <i>Health Affairs</i> , Vol. 23, No. 4, pp. 167-175.
Private Insurance Markets: The Missing Link—Association Health Plans and Other Pooled Purchasing Arrangements	Mila Kofman, J.D.	4/03-4/05	Kofman, M., K. Lucia, E. Bangit, and K. Pollitz. 2006. "Association Health Plans: What's All the Fuss About?" <i>Health Affairs</i> , Vol. 25, No. 6, pp. 1591-1602.
Monitoring the Early Experience with Federal Health Insurance Tax Credits	Karen Pollitz, M.P.P.	2/04-7/05	K. Pollitz. 2007. "Complexity and Cost of Health Insurance Tax Credits," <i>Journal of Insurance Regulation</i> , Vol. 24, No. 4, pp. 3-22.

about the vulnerability of this market to adverse selection (or adverse retention, in this instance). The young and healthy are more likely to end an individual insurance spell uninsured, while older and sicker persons are much more likely to end an individual insurance spell by entering public insurance (Medicare or Medicaid). One-fourth of 55- to 64-year-olds and nearly 40 percent of those reporting fair or poor health transitioned from individual to public coverage.

Not only did individual market participants tend to shift to other insurance states during the observation period, but their stays in this market were quite short—the median length of new spells of individual coverage was just eight months. Almost half of those spells were six months or shorter, and two-thirds of new spells were shorter than one year.

Coburn's work confirms prior studies that the individual market in its current state is a residual market, where individual coverage serves as a bridge between other insured states, and a brief one at that. Policy changes such as equalized tax treatment or an individual mandate might make this market both larger and a longer-term source of coverage for participants, and Coburn's work suggests that such a market might look and function very differently from non-group markets today. At a minimum, it would be larger and potentially have more permanent and semi-permanent inhabitants. But how many more consumers would be enticed into the market and how long they would stay would continue to depend on the range of products and prices they are offered. Those issues are the focus of the next set of projects discussed.

### **What Makes the Individual Market Different?**

Mark Hall conducted a series of case studies of states using field studies and extensive interviews with insurance agents, health insurers, and regulators. One recurrent theme in his work is the need to understand the fundamental characteristics of the individual market that make it unique. A second theme concerns the boundaries between markets and the disruptions that can occur when those boundaries are crossed or ignored. Hall identifies a number of problems in the individual market, including the fact that insurers underwrite aggressively; products carry high

administrative loads; and markets are thin and volatile, with little competition. These problems exist across the span of regulatory environments, they are not easily solved, and policy alternatives such as purchasing cooperatives and market reforms are not “magic wands” to create group-like efficiencies and more competitive, accessible markets (Hall, 2002).

Most states' individual markets lack competition; one or a few competitors—frequently a Blue Cross Blue Shield plan—hold overwhelming market share. Hall describes a self-perpetuating cycle of highly concentrated markets in which insurance agents are reluctant to sell the policies of companies with small market share for fear that these companies will exit the market and strand their customers, and those insurers frequently wind up exiting the market due to low volume of sales.

Hall expands upon this idea of distinct markets with very different dynamics in an article on what he terms the “geography” of health insurance (2000). He argues that the large-group, small-group, and non-group markets are fundamentally different markets, with different products, different sales channels, different companies, and very different regulatory environments. Many of the differences are due to underlying differences in the markets, and Hall argues that policymakers should be careful about assuming that the individual market, however large, is capable of acquiring the characteristics of the large-group market.

In the non-group market, the individual chooses whether and when to purchase insurance, how much coverage, and for how long. The individual knows, and may take into account, tastes for medical care, non-obvious underlying health conditions, and anticipated needs (e.g., plans for a pregnancy), whereas the benefits manager at a large company is unlikely either to know or care about such particulars when purchasing insurance for the group. Insurers are acutely aware of this difference in markets and use underwriting and marketing as best they can to avoid attracting only the “hand raisers” among potential purchasers. While subsidies administered through the tax code as either credits or deductions may lure additional healthy lives into the market, individuals still would tailor their insurance purchases to their own needs given the opportunity to do so.

In the non-group market, individuals see and pay the “sticker price” for their insurance, and so are much more likely to be price-aware. In the group market, not only is coverage generally subsidized by the employer, but the employee has only a vague awareness of how much insurance is costing them. And although an economist would argue that the employer's subsidy is not “free” since it represents foregone wages, that is not the general perception (Pauly, 1999).

In addition, workers do not take or leave jobs solely on the basis of the implicit cost of a health insurance benefit. Although awareness and transparency in pricing is a good thing in general, when coupled with the individual knowledge and mobility described above, they can amplify rapid sorting of risk and instability in the market. Whereas young, healthy employees in a company may be only dimly aware that they are subsidizing older, sicker co-workers, a young and healthy individual in the non-group market is more sensitive to the price of risk pooling, both because they are paying the full cost, and because their insurer or a competitor insurer will be quick to point out a more affordable product if they can be re-underwritten. While tax subsidies could dampen this price sensitivity, individuals would still be acutely aware of the price they could pay elsewhere. As Hall puts it, “Large employer groups are stable and have low overhead costs, not simply because they are large, but also because the employer selects and pays for the insurance.”

Given this combination of mobility and price-sensitivity, what Hall terms gradients between markets can translate to large and rapid market shifts if insurers and purchasers are able to exploit breaches in the walls that separate markets. Examples of such breaches include the association plans that sprang up in Kentucky following that state's reform effort, the use of group trust arrangements in various states that insurers use to circumvent individual market rules, and the flight of eligible individuals from the non-group to the employer markets in New Jersey (Kirk, 2000; Monheit et al., 2004).

### **Lessons from Association Health Plans**

Some policymakers propose greater use of AHPs as a vehicle to offer the benefits of group coverage to individual purchasers. AHPs are group health plans sponsored by trade, industry, professional, chamber of commerce, or similar business

associations. They are also sometimes organized around associations formed by insurers themselves. AHPs share many characteristics with the individual market, including the increased price awareness and mobility of individual purchasers. Because many states exempt national associations from all or some regulations regarding product and rate filings, AHPs raise exactly the sort of boundary issues identified by Hall as an important source of instability in the individual market.

To a large extent the states regulate individual and small-group health insurance, but AHPs operate across state lines and, even within states, typically operate outside the reach of individual or small-group regulation. Federal proposals to relax state regulations regarding AHPs are introduced in Congress perennially, despite the misgivings of state insurance regulators and others. Other reform proposals include the concept of multi-state products.

Kofman and colleagues examined the AHP regulations and practices currently in place (Kofman et al., 2006). Their conclusions serve as a cautionary note to those who would expand AHPs with the intention of improving how these markets function.

Kofman explains that if individuals residing in a state where associations are exempt from regulation purchase coverage through an AHP, regulation falls to the state where the master contract is issued—typically a state that lightly regulates such plans. Given that funding constraints may make it difficult for state regulators to assist their own residents, out-of-state residents may have no effective regulatory recourse. Similarly, regulators in the state of an individual's residence may find themselves adjudicating problems that were not of their making. This may be of particular concern in instances where the association was established explicitly to avoid regulatory oversight.

The concerns that Kofman has raised—as well as the market boundary issues raised by Hall and the experiences of New Jersey, Kentucky, and others—point to the importance of formulating federal policy with a view to avoiding the creation of additional market boundary issues. For example, if tax laws are changed to offer tax credits or tax deductions for individual insurance, policymakers should give careful thought to defining what sorts of policies would qualify for the favorable tax treatment—not only in terms of scope of benefits, but also with regard to the regulatory status

of the policy in the purchaser's state of residence. Kofman and colleagues cite the experience with Multiple Employer Welfare Arrangements (MEWAs) as a cautionary tale for federal policymakers contemplating federal laws that would ease restrictions on AHPs. Although the Department of Labor (DOL) now has the authority to require MEWAs to register with them, Kofman identifies various weaknesses in that system. These include a percentage of clearly faulty registrations (with missing or inaccurate information), evidence that MEWAs are operating in some states illegally, and failure by the DOL to exercise its authority in levying fines for incomplete or inaccurate filings. DOL estimates that fewer than half of existing MEWAs are registered with them as required. Kofman cautions that Congress should review the case of MEWA regulation very carefully before concluding that more regulatory authority of AHPs should be transferred from the states to the federal level via federal initiatives, such as the creation of multi-state individual products.

Kofman and colleagues also review the contention that AHPs provide large associations with negotiating clout and thus lower prices. Like Hall,

## Lessons Learned

### The Current Individual Insurance Market

- The current individual market is a residual market, where individual coverage generally serves as a bridge between other insured states.
- How many more consumers would be enticed into the market and how long they would stay would depend on the range of products and prices they face.
- The large-group, small-group, and non-group markets are fundamentally different markets, with different products, different sales channels, different companies, and very different regulatory environments.
- Increased price-sensitivity and mobility in the individual market can lead to market instability.
- No matter how large it grows, the individual market is unlikely to acquire the characteristics of the large-group market.
- An individual mandate may result in an influx of lower-risk individuals into

the individual insurance market, but if enrollees are offered lower-cost coverage in the group market, they are likely to take it, potentially affecting the stability of the market.

- Lower prices in the individual market, when present, are more likely the result of risk segmentation than low administrative costs.
- Preemptive, defensive pricing in the individual market can turn insurers' fears of adverse selection into self-fulfilling prophecies, since high rates deter all but the sickest from enrolling.

### Lessons from Reform Efforts

- Consumers and insurers respond to the incentives established through reform, both those that are intended and those that are not.
- It is important to formulate state and federal health insurance market policy in ways that do not exacerbate the sometimes shaky relationships at the intersection of the individual, small-group, and large-group markets.

- Federal policy must consider market boundary issues and define what sorts of policies would qualify for the favorable tax treatment—not only in terms of scope of benefits, but also with regard to the regulatory status of the policy in the purchaser's state of residence.
- In a larger market with more permanent policyholders, consumers might be willing to pay some additional cost for the smoothing effect on premiums that guaranteed renewal provides. However, this is contingent on insurers honoring their commitment to provide long-term coverage.
- When implementing tax credits, especially for an economically stressed population, insufficient subsidy and a delay in implementation or uncertainty about the program can result in low participation.
- High-cost individuals affect the behavior and stability of the individual insurance market, which must be anticipated when considering policies that would expand the market.

Kofman asserts that lower prices in the individual market, when observed, are more likely the result of risk segmentation than low administrative costs. She points out that association plans are subject to the same selection into and out of coverage, with the same defensive responses of insurers to the prospect of adverse selection, and the same administrative inefficiencies of individual transactions: "...in the insurance context, large does not always equate with negotiating power to obtain better rates and benefits."

## Efforts to Reform and Stabilize Individual Insurance Markets

### Potential and Current Role of Guaranteed Renewal

Guaranteed renewability assures a policyholder that the policy will not be cancelled at the end of the contract period. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires most health insurance policies to be guaranteed renewable. Many, although not all, states also prohibit carriers from re-underwriting coverage at renewal; therefore, rate increases reflect the cost experience of, at a minimum, the policyholder's rate class, not the policyholder's own claims experience. Two HCFO researchers examined the role of guaranteed renewal (GR) in stabilizing the individual market. In his study of various state insurance markets, Mark Hall concludes that GR, as currently formulated, is inadequate to protect consumers (Hall, 2002). Mark Pauly and Bradley Herring examined the theoretical role of guaranteed renewal policies in the individual market and explored the degree to which the theoretical premium path for guaranteed renewable policies matches that of actual premiums (Herring and Pauly, 2006).

*Theory and Potential:* In a guaranteed renewal market, insurers might, in theory, charge some additional premium each year, "front-loading" the premium in anticipation of rising loss experience. Front-loading provides an incentive for healthy policyholders to renew in the out years, since they have already paid for the guaranteed renewable aspect of the policy. But individual health insurance might deviate from such theoretical predictions for at least two reasons: 1) young purchasers might be unwilling to purchase a policy with the GR part of the premium front-loaded; and 2) the GR provision might not be considered valuable by consumers if insurers aren't trusted to honor the commitment, e.g., by "churning" health risk to isolate sicker blocks of business. Pauly and Herring used expenditure data to establish

a theoretically optimal premium path for a GR policy that would extend from young adulthood to age 64. They find that two factors would reduce the amount of front-loading in the optimal policy:

1) some of the individuals who become sick early in the life of the policy die or recover; and 2) most policyholders who become unhealthy do so in the later years of the policy after paying premiums for many low-cost years.

Pauly and Herring then compare this optimal premium path with actual individual market premiums, as reported by respondents to the Community Tracking Survey (CTS). They find that the optimal GR premium path matches the actual premium path more closely than do the premium paths based on risk rating alone or age-based rating.

It is curious that the optimum path matches up with current market premiums so closely, and may speak to the validity of presumptions about consumers' ability to shape the insurance markets in which they buy coverage. Current enrollees appear to pay premiums that approximate an optimal premium for a long-duration GR policy. But the work of Coburn and others suggests a current market characterized by short stays, including some unknown portion covered by short-term or bridge policies that do not include a GR commitment. In effect, these and other policyholders who stayed in the market for only a short time paid a GR premium without ever reaping its benefits. Thus, it is not clear what current consumers are getting for the risk premium they, theoretically, would pay for long-duration GR. One possibility is that they are sufficiently risk-averse to pay high premiums, including an unmeasured but in fact sizeable increment for GR, even if they do not anticipate staying in the market for a protracted period of time.

The Pauly and Herring results also have interesting implications for a future market characterized by the sort of college-to-retirement premium duration that they modeled. In a larger market with more permanent policyholders, this work suggests that consumers are willing to pay some additional cost for the smoothing effect on premiums that GR provides. However, the value of GR to consumers is contingent on insurers honoring their commitment to GR, and eschewing practices such as durational rating and closed blocks to subvert that promise. Although there are anecdotal accounts of such insurer practices, Pauly and Patel point out that we do not know how prevalent they may be (Patel and Pauly, 2002).

*Current Thinking about Guaranteed Renewal:* Hall points out that the fear of carrier exits—either closing policies or leaving the market entirely—underlies a fundamental weakness with GR of policies. While Pauly and colleagues argue that GR is a valuable risk-stabilizing device in the non-group market that purchasers would seek out and pay a premium for (Herring and Pauly, 2006; Patel and Pauly, 2002), Hall argues that as currently formulated, GR is inadequate to protect consumers. First, it does not protect individuals when a carrier exits the market or closes the policy. While evidence suggests that carriers rarely exit, closed blocks of business (where old policies are renewed but not actively sold) are inherently unpleasant places to be for individuals in poor health; the closed block tends to enter a spiral of adverse retention as healthier risks leave the policy for freshly underwritten policies elsewhere. Although renewed individuals may not be re-underwritten (so that their rates are not raised based on their individual experience), this may be moot when all of the individuals remaining in a block of business are in poor health, and the insurer can justifiably impose large rate increases based on the experience of the block of business.

This raises a second weakness of GR that Hall notes: Guaranteed renewal neither permits individuals to switch carriers nor to switch among plans offered by the same carrier. On the one hand, there are valid reasons to permit insurers to protect themselves against individuals who purchase a bare-bones policy until they get sick, then switch to a more comprehensive policy. On the other hand, the narrow form of GR that currently prevails leaves open the possibility of insurers sorting and re-sorting blocks of business based on risk, unless state regulators carefully monitor market conduct and rates for closed blocks of business.

Hall argues that stronger guaranteed renewability protections would make consumers more comfortable buying products from new market entrants and smaller companies.

### Premium Subsidies via Tax Credits: The Case of the HCTC

Tax credits for the purchase of health insurance are one way to extend subsidies for coverage to individuals without access to employer-sponsored coverage, and to eliminate the difference in tax treatment between employer-sponsored and individual coverage. The experience of a small program provides some insights into the opportunities and challenges that this strategy might present, especially if overlaid on existing individual

insurance markets. Congress enacted the Health Coverage Tax Credit (HCTC) as part of the 2002 Trade Adjustment Assistance Reform Act. The HCTC provides a premium subsidy to workers in jobs affected by international trade, certain early retirees, and dependents of both groups. Subsidies were provided as advance-payment tax credits.

Pollitz evaluated the results of the HCTC, interviewing state and federal officials and insurers and reviewing the regulatory record. She finds that only 7 to 21 percent of eligible individuals participated in the HCTC, and points to a number of factors that might explain such low take-up (Pollitz, 2007). Although the program provides a 65 percent premium subsidy, even the 35 percent share required of participants may have been unaffordable given that many were unemployed or otherwise had limited incomes. Participants can only claim subsidies up to the amount of taxes paid, further limiting the value of the subsidy for low- to middle-income individuals. The program placed no limit on premiums charged, and because many states used high-risk pools or other insurer-of-last-resort mechanisms to provide coverage, premiums could be very high, especially for older or higher risk individuals. High-risk pool premiums for a 60-year-old male range from \$334 per month in Maryland to \$2,221 per month in Louisiana. North Carolina's designated carrier imposed rates of more than \$9,000 a month for a 55-year-old high-risk applicant—up to seven times that of a preferred risk applicant.

The HCTC subsidy was payable on a monthly basis, but Pollitz identified delays in initial payments of over three months as another factor discouraging enrollment. Enrolling in the program was complex, frequently requiring multiple contacts with federal and state agencies as well as with private insurers. Finally, she reported high administrative costs at all levels, from the Internal Revenue Service (IRS) to the private insurers participating. In 2004, the IRS alone spent one dollar in administrative costs for every two dollars in subsidies paid. In 2006 that figure dropped to one dollar for every four dollars paid, but administrative reductions were achieved, in part, by reducing outreach efforts.

Although the HCTC was a limited program targeted to a narrow group, it represents a first effort to implement federal tax credits for health insurance, and thus holds important lessons for those contemplating federal premium subsidies on a larger scale. Pollitz argues that insufficient subsidies for an economically stressed population were one major reason for low participation—a problem exacerbated

by high premiums. As with HIPAA, the HCTC created a right to coverage for a class of individuals, but remained silent on the issue of cost, leaving it to the states to decide how affordable coverage should be. Some states subsidize their high-risk pools much more heavily than others; other states, such as North Carolina, impose no premium restrictions on their designated carriers of last resort. Pollitz also points to evidence suggesting that many participants were charged premiums much higher than warranted by their subsequent claims experience. Such preemptive, defensive pricing can turn insurers' fears of adverse selection into self-fulfilling prophecies, since high rates deter all but the sickest from enrolling. In this case, subsidies appeared to buffer that effect; the federal government picked up 65 percent of the premium cost, suggesting that subsidies can dampen the volatility of individual markets. But this result came at a high cost to the taxpayer and the policyholder, who in addition to covering high administrative costs may also have paid actuarially unfair premiums. Finally, Pollitz argues that most of the administrative costs were attributable to the one-on-one, retail nature of the transactions; these are unlikely to disappear or even diminish with a larger program.

## Comprehensive State Reform

In the mid-1990s, New Jersey implemented an innovative set of reforms designed to stabilize the individual market. The reforms were prompted by the financial difficulties of the Blue Cross and Blue Shield plan, which served as the state's insurer of last resort in the individual market. The Individual Health Coverage Program (IHCP) was designed to encourage insurers to participate in the market and to share the cost of market losses among all insurers through a "pay-or-play" mechanism that requires insurers not participating in the individual market to help cover the losses of insurers that do. Other reforms included guaranteed issue of individual coverage, modified community rating, and standardization of plans.<sup>2</sup>

Swartz and Garnick conducted an early evaluation of the New Jersey reforms (Garnick and Swartz, 1999), which anticipated many of the results of a later examination by Cantor and colleagues (2004). Swartz and Garnick's analyses provide insights into how small insurers exploited opportunities in the risk-sharing scheme, thus setting the stage for the market turmoil that followed when carriers rapidly raised premiums above their artificially low initial rates. Cantor and colleagues follow the development of adverse selection that resulted. They find that although the New Jersey reforms were intended to enlarge and stabilize the individual market, over time

the market nevertheless showed evidence of adverse selection as poorer risk remained in the market and lower risk exited. Cantor also observed strong adverse selection against particular products—specifically, the most generous indemnity plan.

The broad lesson that both sets of authors draw is that both consumers and insurers responded to incentives, whether intended or not. For example, small carriers initially responded to the promise of protection against losses by low-balling premiums to attract market share. Premiums that were initially set unrealistically low contributed to the subsequent pain and upheaval of large premium increases. Both Swartz and Garnick and Cantor and colleagues agree that the carrier responses to the reform's loss assessment mechanism (not adverse selection) caused early turmoil and a rise in premiums. Small carriers had nothing to lose by initially under-pricing their products, since their losses would be covered by carrier assessments. Consumers were also highly responsive to the incentives presented by the market. When group coverage was available, lower risk consumers migrated from the individual market where premiums were pure community-rated to the small-employer market where age bands were permitted. Thus differential rules in the non-group and small-group markets may have exacerbated adverse selection in the non-group market—another example of Hall's point about the role of regulatory walls between markets, and the instability that breaches in those walls can cause. One implication for current reform efforts is that an individual mandate may serve to pull low-risks into the insurance market as a whole, but they may not enter or stay in the individual market if they have a lower cost option in group coverage.

## The Role and Experience of High-Cost Individuals in the Market

How much trouble do individuals have in finding and retaining coverage at a reasonable cost when they are either in poor health or considered by insurers to be high-risk? As Pauly and Nichols have pointed out, this is an area of some disagreement among researchers and policy analysts (Pauly and Nichols, 2002). Pollitz and colleagues have argued that higher risk consumers can face a very hostile and expensive marketplace, depending on the state where they live (e.g., the experience of some HCTC participants as described earlier). But Pauly and Herring found that premiums paid by non-group policyholders varied much less than their expected medical expenses, suggesting that this market may spread risk more widely than is commonly perceived. Pauly and Herring

## What Do Policymakers Need to Consider?

- How will the proposed policy affect the flow of risk from one market to another, and therefore the stability of every market?
- How does the policy proposal address jurisdictional issues between the federal government and the states?
- How might federal standards about products qualifying for preferential tax

treatment interact with state oversight and policy regarding benefits and rating?

- What assumptions does the proposal make about economies of scale and administrative costs in the individual market?
- How might the policy change the dynamics and demographics of the individual market? In particular, what would be its effect on high-risk individuals?

- If a proposal (e.g., an individual mandate or individual subsidies) is expected to add lives to the individual market, how would new purchasers resemble or differ from current purchasers, and how would insurers respond to initial uncertainty if not also the opportunity to segment risk over time? Conversely, if a policy (e.g., Medicare buy-in for early retirees) would divert individuals from the individual market, how would insurers respond?

(Herring and Pauly, 2001) evaluated the degree of risk pooling in the individual market empirically, finding that premiums vary considerably less with risk than would be found under perfect risk rating.<sup>3</sup> They reported risk elasticities of 0.12-0.18 (perfect risk rating would imply an elasticity of 1). They conclude that there may be considerably more risk pooling in this market than is commonly believed, and that high-risk individuals somehow find or renew coverage for much less than their expected expenditures. However, while this study has the advantage of using actual premiums (as opposed to premium quotes that may never have any takers), it includes only individuals who are present in this market, not those who were rejected for coverage or who found coverage in the group market. In addition, it reflects the average experience of current individual policyholders (with some unknown component of renewals), not the experience of those seeking to enter the market. Finally, observed premiums do not account for differences in the scope of coverage, such as waiting periods or permanent exclusions that might have been imposed on higher risk policyholders.

Pauly and Nichols suggest that some differences among research findings may be due to differences in ideological perspectives and in one's views on what sorts of equity/efficiency tradeoffs might be acceptable. That is, to what degree should access and affordability by low risks be compromised to ensure access and affordability for high risks?

Differences in methods may also account for some of the differences in conclusions. Pollitz and others have relied on more qualitative studies of consumer distress. These findings are echoed by anecdotal but compelling accounts in the popular media of the difficulties faced by some individuals (e.g., Pear, 2007). These methods suggest that at least some high-risk individuals face difficulties, but do not explore the prevalence of difficulty. Making use of nationally representative survey data (CTS and MEPS), Pauly and colleagues attempted to address this issue, but such

data are inherently flawed—they identify only individuals who have succeeded in finding or retaining individual coverage, not those who were rejected from coverage or found it either unaffordable or of too little value to buy.

In addition, price measures confound comparison of findings in past research. Pollitz and others used quoted prices for new policies. In contrast, Pauly's work used premiums paid by actual policyholders, arguing that prices actually paid are a more reasonable measure of the market environment than the range of prices quoted to a prospective policyholder. But as noted earlier, actual prices in survey data have their own biases, because they exclude some unknown percentage of potential purchasers who were dissuaded from purchasing in this market.

Coburn and colleagues' work also raised intriguing issues about exactly how one should interpret premiums paid by individual policyholders in survey data. Their results suggested that sick people exit the individual market sooner than those in better health, but the reasons are unclear—did they jump, or were they pushed? Their work also showed a higher percentage of individuals in poor or fair health in the individual market than in the CPS data—a discrepancy that may relate to the vagueness of self-reported-health-status measures.

A better understanding of how much even a few high-cost individuals affect market behavior and stability would be helpful in understanding how public policy should anticipate supporting the current market as well as a larger market. The skewed distribution of health care costs combined with most insurers' very small market share explains why insurers fear very high-cost cases and underwrite to avoid them. But would a larger market be more stable and able to accommodate and absorb high-risk individuals? Or would insurers intent on maximizing net revenues continue to avoid and isolate high-cost cases, driving competitors to do the same?

## Applying Lessons Learned

Existing evidence and lessons from past HCFO research will serve policymakers well as they consider ways to reform the American health care system, particularly as they consider proposals that might augment the use of the individual insurance market.

## Conclusion

Common themes emerge from this body of research. Risk can shift quickly and dramatically in the individual market and policymakers should remain alert to the creation of regulatory gradients within and between markets that may set the stage for adverse selection. Imposing federal policy over state regulation of markets creates a similar set of challenges. The individual market is characterized by a series of one-on-one transactions, including marketing, product selection, payment, and underwriting. This fundamentally retail nature of the market underlies both its vulnerability to adverse selection and its inherent administrative inefficiency; policymakers should be realistic about what administrative efficiencies are possible even in an expanded market.

## About the Author

Adele M. Kirk, Ph.D., will be an assistant professor of public policy at the University of Maryland, Baltimore County in the fall of 2008. She may be contacted at amkirk@ucla.edu.

## Endnotes

- 1 For a more comprehensive review of the literature on individual insurance markets, see Beth Fuch's synthesis of the analytic literature (2004).
- 2 See the article by Swartz and Garnick for a more complete description of the rather complex pay-or-play mechanism and other reforms implemented in New Jersey.
- 3 Herring and Pauly use expenditure data from the Medical Expenditure Panel Survey (MEPS) to predict age and health-adjusted expenditures for respondents reporting individual coverage in the Community Tracking Survey (CTS). They then regress premiums paid on predicted expenditures, how many family members the policy covers, and in some cases, plan characteristics.

## References

- Chollet, D. 2000. "Consumers, Insurers, and Market Behavior," *Journal of Health Politics, Policy, and Law*, Vol. 25, No. 1.
- Fuchs, B. 2004. *Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s*, Robert Wood Johnson Foundation Research Synthesis Report No. 4. Available online at [www.rwjf.org/pr/synthesis/reports\\_and\\_briefs/pdf/no4\\_synthesisreport.pdf](http://www.rwjf.org/pr/synthesis/reports_and_briefs/pdf/no4_synthesisreport.pdf).
- Hall, M. 2000. "The Geography of Health Insurance Regulation," *Health Affairs*, Vol. 19, No. 2, pp. 173-184.
- Hall, M. 2002. "Of Magic Wands and Kaleidoscopes: Fixing Problems in the Individual Market," *Health Affairs* Web Exclusives 2002, pp. W353-358.
- Herring, B. and M. Pauly. 2006. "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics*, Vol. 25, pp. 395-417.
- Herring, B. and M. Pauly. 2001. "Premium Variation in the Individual Health Insurance Market," *International Journal of Health Care Finance and Economics*, Vol. 1, pp. 43-58.
- Kirk, A. 2000. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts," *Journal of Health Politics, Policy, and Law*, Vol. 25, No. 1.
- Kirk, A. and D. Chollet. 2002. "State Review of Major Medical Health Insurance Rates," *Journal of Insurance Regulation*, Vol. 20, No. 4.
- Kofman, M., K. Lucia, E. Bangit, and K. Pollitz. 2006. "Association Health Plans: What's All the Fuss About?" *Health Affairs*, Vol. 25, No. 6, pp. 1591-1602.
- Monheit, A., J. Cantor, M. Koller, and K. Fox. 2004. "Community Rating and Sustainable Individual Health Insurance Markets in New Jersey," *Health Affairs*, Vol. 23, No. 4, pp. 167-175.
- Pauly, M. and L. Nichols. 2002. "The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes," *Health Affairs* Web Exclusive W325.
- Pauly, M. 1999. *Health Benefits at Work*. Ann Arbor: University of Michigan Press.
- Pear, R. 2007. "Without Health Benefits, A Good Life Turns Fragile," *The New York Times*, March 5.
- Pollitz, K. 2007. "Complexity and Cost of Health Insurance Tax Credits," *Journal of Insurance Regulation*, Vol. 24, No. 4, pp. 3-22.
- Swartz, K. and D. Garnick, 1999. "Hidden Assets: Health Insurance Reform in New Jersey," *Health Affairs*, Vol. 18, No. 4.
- Patel, V. and M. Pauly. 2002. "Guaranteed Renewability and the Problem of Risk Variation in Individual Health Insurance Markets," *Health Affairs* Web Exclusive, W280-289.
- Ziller, E., A. Coburn, T. McBride, and C. Andrews. 2004. "Patterns of Individual Health Insurance Coverage, 1996-2000," *Health Affairs*, Vol. 23, No. 6, pp. 210-221.



Robert Wood Johnson Foundation

Changes in Health Care Financing and Organization is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.



AcademyHealth  
Advancing Research, Policy and Practice