REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - A-05
(June 2005)

Subject: Update on the Individual Health Insurance Market

Presented by: William H. Beeson, MD, Chair

Referred to: Reference Committee G
(Virginia T. Latham, MD, Chair)

A key component of the AMA proposal for health insurance reform is the establishment of tax credits that are inversely related to income, refundable, and advanceable, so that individuals and families can use them to purchase health insurance of their choice regardless of whether coverage is obtained through an employer or elsewhere. Thus, how well the individual (i.e., non-group) market works, or could work, has important implications for the viability of a system of individual tax credits as proposed by the AMA.

The individual market for health insurance has received considerable attention from policy makers in recent years. Both factual and philosophical disagreement regarding the individual market often lead observers to reach divergent public policy conclusions. This report summarizes current trends and status of the individual market, discusses how the individual market might be transformed in the future, and presents several policy recommendations.

TRENDS AND CURRENT STATUS OF THE INDIVIDUAL MARKET

Size of the Individual Market

Individual market enrollment has remained around 7% of the non-elderly population for the last 20 years, although enrollees represent a shrinking portion of potential enrollees (25% in 2003 versus 33% in 1988, Buntin et al., *Health Affairs*, 2004). A major barrier to individual market enrollment is high premium costs relative to comparable coverage in the group market. High premium costs are exacerbated by the lack of tax subsidy for individually purchased coverage (unless purchased by self-employed individuals), a subsidy that is conferred to employment-based insurance. The prominent health economist Mark Pauly has noted that there is a tradeoff between lower per-enrollee administrative costs in the group market and greater individual choice in the individual market, and that the tax bias for employment-based group coverage prompts "excessive groupness" in health insurance (white paper, 1998). Another enrollment barrier is lack of public awareness about the availability of individual market coverage, and how to go about selecting and purchasing a plan on the individual market.

Premiums, Benefits, and Plan Choice

Higher per-enrollee administrative and marketing costs make premiums for comparable coverage higher on the individual market than through the group market. However, there is generally greater plan choice on the individual market than through employers, including more lower-cost options. A recent study conducted by the Kaiser Family Foundation and eHealthInsurance, Inc. (August 2004) found that average premiums paid for health insurance obtained on the individual market are

markedly lower than in the group market ($1,768 vs. $3,695 per year or 52% lower for single coverage, and $3,331 vs. $9,950 or 66% lower for family coverage). The substantial premium differences are attributable in part to the younger ages of individual health insurance enrollees, as well as the fact that many people, when given a choice, opt for less generous coverage than is typically offered by employers. It also should be noted that the authorization of health savings accounts (HSAs) in 2004 greatly expanded the potential market for consumer-directed health care within the individual market. As of the beginning of 2005, at least 600,000 people had HSA coverage, of which nearly 80% obtained it through the individual market (*Inside Consumer Directed Care*, January 2005 and America's Health Insurance Plans Center for Policy and Research, January 2005).

Demographics/Selection

There are conflicting reports about the degree to which the individual market enrolls an adverse or favorable selection of individuals. It is well established that, compared to those with access to employment-based coverage, the group of potential individual market enrollees are more likely to be low-income workers from small firms that do not offer coverage (Young and Wildsmith, *Health Affairs*, October 2002), or too sick to work (also correlated with higher age). However, it could be that among this group of potential enrollees, actual enrollees who have succeeded in undergoing individual underwriting and obtaining coverage represent a relatively low-risk selection of individuals. Similar to employment-based coverage, minorities are less likely than whites to enroll in the individual market (Saver et al., *Health Services Research*, 2003; and Ziller et al., *Health Affairs*, 2004). Men are slightly less likely than females to have individual market coverage, 8.65% compared to 9.96%, (Mills and Bhandari, U.S. Census Bureau Current Population Reports, 2003).

Cross-Subsidization

As discussed in Council on Medical Service Report 3 (A-01), Pauly and Herring (1999) examined whether employment-based group insurance is more effective than individual insurance at cross-subsidization from low-risk to high-risk individuals. Although they found premiums in the individual market to be generally high, they found that the differences in cross-subsidization between the individual and group markets to be much less than commonly believed. They also found that, although individual-market premiums for a given level of coverage vary considerably, the variation is far from proportional to risk. Specifically, people with estimated expected costs twice the average pay premiums only about 20-40% higher for a given policy. Further, in contrast to some other studies (e.g., Pollitz et al., Kaiser Family Foundation, 2001), premiums paid for individual market coverage do not appear to vary with the presence of high-risk chronic conditions, although this might not take into account limitations on covered benefits, or the fact that individuals with more severe chronic illness might be excluded from the group of enrollees.

Access to Coverage

Several recent studies have illustrated the difficulty individuals can encounter in trying to obtain coverage on the individual market, particularly if they have less-than-perfect health or are middle age or older (e.g., Polilitz et al., Georgetown University and the American Diabetes Association, 2005; Gabel et al., *Health* Affairs, 2002, Pollitz et al., Kaiser Family Foundation, 2001; Simantov et al., *Health Affairs*, 2001; and Families USA, 2001). Council on Medical Service Report 2 (I-01) presented an analysis by the AMA Center for Health Policy Research that contested some of the

methodology and interpretations of these studies, and concluded that reasonable options on the individual market exist for most people. Under the AMA proposal, expanded options would exist for most people, provided that tax credits are appropriately structured, and that special measures are taken to address the needs of individuals with chronic illness or disability.

Many studies of the individual market are inclined to call the glass "half empty" rather than "half full." For example, one study reported that half of all adults with individual market coverage pay annual premiums of more than $2,000 (Simantov et al., 2001), rather than reporting the more remarkable finding that the other half pay less than $2,000 per year. A different study examined the experiences of seven hypothetical applicants for health insurance on the individual market (Pollitz et al., Kaiser Family Foundation, 2001). The study reported that a hypothetical non-smoking 25-year-old woman could not get coverage for less than $1,000 per year in six of 25 states surveyed, rather than that she *was* able to obtain coverage for less than $1,000 in 19 (78%) of the states surveyed (and that a hypothetical 55-year-old was able to get coverage for less than $1,000 in 7 or 28% of states). The study also understated access to coverage in the individual market by reporting results in terms of the number of rejected or accepted applications rather than the number of rejected or accepted applicants. For example, the study reported that a hypothetical seven-year breast cancer survivor had benefit limitations or higher premiums on most offers of coverage, and that over 40% of her applications were rejected outright – but the study failed to point out that she received at least one "clean offer" (i.e., same premium and benefits as if she had a history of perfect health) in every state. Similarly, the report noted the frequency of rejected applications, not that, on average, applicants found coverage without pre-existing condition limitations in 73% of states. (Excluding the hypothetical HIV-positive applicant, who was rejected by all insurers, would bring this figure up to 85%.)

Likewise, there is nothing surprising about the fact that premiums vary on the basis of age, gender, health history, and geographic location; that premiums for the same coverage are higher in the individual market than in the group market; or that insurers sometimes impose benefit limitations based on pre-existing conditions (a practice not uncommon even for employment-based coverage). The more surprising finding, consistent across studies, is that the approach to setting premiums (i.e., medical underwriting) varies widely across insurers, as do premiums offered by different insurers, even for the same individual. Thus, it pays to shop around for coverage in the individual market.

Market Regulation

In addition to federal laws such as the Employee Retirement Income Security Act of 1974 (ERISA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), there are 51 different sets of state market regulations governing premium rating, terms of issue, and benefit mandates. Variation in basic "market rules" serves as a barrier to entry for insurers, particularly in the individual market, and impedes the formation of multi-state pooled purchasing arrangements for individuals and small groups. Differences in state and federal regulations for the individual, small group, and large group markets (including different tax treatment) also lead to interactions between the individual and group markets. State experience has shown that market reforms such as guaranteed issue and strict community rating led to reduced coverage overall, although with somewhat lower premiums for those high-risk individuals who purchase coverage (Monheit et al., *Health Affairs*, 2004; Williams and Fuchs, Robert Wood Johnson Synthesis Project Policy Brief no. 4, 2004). In

many states, market concentration and monopoly power are even higher for the individual market than for the group market, in part because market regulations have driven individual insurers out of business. In addition to regulations regarding premium rating and terms of issue, some states also have enacted measures to insulate the individual market from adverse selection of high-risk individuals (e.g., via high-risk pools, risk adjustment, and reinsurance), consistent with AMA policy.

Interstate Sales of Health Insurance

Disparate state regulations have contributed to wide geographic variations in health insurance premiums, for example averaging less than $100 per month for single coverage in Iowa compared to $337 in New Jersey (e-HealthInsurance.com, 2004), a state with heavy health insurance market regulation. Recently, allowing the interstate sale of health insurance has been proposed by the Bush Administration and others as a means of achieving greater regulatory uniformity and lower health insurance premiums. Advocates maintain that interstate insurance sales would foster market competition without the major budgetary expense of tax credits (Gratzer, *New York Times*, January 25, 2005). Critics raise concerns about insurers operating from states with the least stringent regulations, thereby undermining other states' solvency requirements and patient safety protections.

Sham Insurance

In March 2004, the General Accounting Office released a study and the Senate Finance Committee held a hearing on increased reporting of "sham" health insurance plans and companies. Between 2000 and 2002, at least 144 unauthorized insurers covered at least 15,000 employers and 200,000 policyholders, and left at least $252 million in unpaid medical claims. Sham insurers typically evaded state regulations by failing to register with states, engaged in deceptive marketing practices such as adopting names similar to legitimate carriers, and initially paid claims while collecting additional premiums before ceasing to pay claims. Unchecked, such a trend could give credence to the view that individuals are not able to safely navigate health insurance markets, particularly under a system of individually selected and owned insurance as proposed by the AMA.

TRANSFORMATION OF THE INDIVIDUAL MARKET

Under the AMA proposal, a number of developments could be expected in the individual market. Combined, these trends could expand both coverage and plan choice, as well as blurring the distinctions between the individual and group markets. It should be noted that the rate of market transformation depends in part on how broadly or narrowly tax credits are targeted.

Pooled Purchasing Arrangements

A common misconception about individually based insurance is that insurance can not be purchased through groups at all, or other than employment-based groups. AMA policy supports allowing pooled purchasing arrangements–arranged through either employers or other sorts of groups–to exist to the extent that the market demands them. This would involve removing existing regulatory barriers to such arrangements, as well as possibly creating new "enabling" legislation.

Internet Purchasing of Insurance

A trend already well under way is increased availability of individual market insurance through Internet vendors such as eHealthInsurance.com. This trend creates greater opportunity for risk pooling (as distinct from cross-subsidization) outside the context of employment, although under current law, individuals' choices are limited to plans licensed in their states, even if coverage is obtained through the Internet.

Market Competition and Innovation

A system of individually based health insurance, financed in part through income-related tax credits, will transform health insurance markets in ways that will ultimately benefit people across risk and income classifications. For example, analysts expect a "premium rating conversion" to reduce or mitigate any loss of cross-subsidization under individually based insurance. Under a premium rating conversion, the influx of a critical mass of average-risk individuals into the individual market would reduce the cost-effectiveness to insurers of individually risk rating applicants. Costly medical underwriting practices would likely be replaced by simplified, automated ones, particularly as purchasing insurance over the Internet becomes more common. The result would be de facto modified community rating, but as the natural byproduct of market function rather than by market regulation.

Multi-Year Insurance Contracts

The emergence of multi-year insurance contracts also would compress premium differentials that would normally occur under individual risk rating. As an individual ages, premium increases would be relatively flat compared to annual age-rating, with the individual paying somewhat more than he or she otherwise would when young and somewhat less when older. During the contract period, enrollees would have guaranteed renewability-type protection from premium increases due to illness. Multi-year contracts would limit enrollment and disenrollment opportunities, thus preventing individuals from "gaming" the system by switching coverage on the basis of changes in health status. Multi-year year contracts also could result in lower premium levels by reducing the degree of uncertainty about claims costs and by reducing annual transaction costs.

Condition-Specific Integrated Delivery Systems

Another factor that could benefit high-risk individuals is the development of integrated delivery systems for people with specific chronic conditions, such as specialized diabetes clinics that offer the full range of services required to manage and treat diabetes and common co-existing conditions. Such condition- or procedure-specific facilities have been called "focused factories" by Harvard Business School professor Regina Herzlinger, who maintains that they would reduce costs, reduce variation in costs, and improve quality of care for many high-risk individuals. Thus, although people with chronic conditions might face premiums more closely reflecting their expected costs, those costs would be brought under greater control.

RELEVANT AMA POLICY

The AMA proposal to expand health insurance coverage and choice includes three key elements: (1) a preference for individual rather than employer ownership and selection of health plan (Policy

H-165.920[5], AMA Policy Database); (2) the use of income-related, refundable, advanceable tax credits toward the purchase of health insurance (Policies 165.920[12] and H-165.865[1]); and (3) appropriate market regulation based on the recognition that neither free-market mechanisms nor market regulations alone will fully meet the needs of those with expensive medical conditions (Policy H-165.856). Further, the AMA supports the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits (Policy H-165.865) and when designed to enable individuals to purchase individually owned health insurance. (Policy H-165.853)

At the 2004 Interim Meeting, the House of Delegates established policy supporting the implementation of individual tax credits for the purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, and the chronically ill; as well as incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion of employment-based health insurance (Policy H-165.851).

Policy H-165.856 contains a set of nine principles to guide health insurance market regulation, including greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; replacing strict community rating with modified community rating; replacing guaranteed issue regulations with guaranteed renewability; and removing legislative and regulatory barriers to the formation and operation of group purchasing alliances, and to the development of multi-year insurance contracts.

Finally, the AMA encourages the formation of small-employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small-group rating laws, while safeguarding state and federal patient protection laws; and through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope (Policy H-165.882[14,15]).

DISCUSSION

The individual market for health insurance currently serves as a valuable source of coverage for those without access to employment-based or public coverage. As such, the Council is encouraged by the results of the 2004 Kaiser Family Foundation/eHealthInsurance, Inc. study, which showed that individual and family health insurance coverage can be purchased on the individual market at prices that are markedly lower than the group market. These results demonstrate that when faced with a range of plan choices that present a tradeoff between lower premiums and more generous benefits, people often choose less expensive coverage than employers choose on their behalf.

Nevertheless, one enrollment barrier continues to be lack of public awareness about the availability of individual market coverage, and how to go about selecting and purchasing a plan on the individual market. The Council believes that, under a system of individually selected and owned health insurance as proposed by the AMA, the individual market will continue to expand and

evolve, offering a greater choice of affordable coverage options, and possibly becoming less distinguishable from the group market. The Council also recognizes that special measures are needed to address the needs of individuals with chronic illness or disability, who might otherwise have difficulty obtaining coverage outside the employment-based system. For this reason, the AMA reform proposal includes high-risk pools, rational market regulation, and related approaches designed to both protect special populations and permit insurance markets to function properly.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That the American Medical Association (AMA) provide information to the public about the availability of health insurance on the individual market. (Directive to Take Action)

2. That the AMA encourage local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers. (Directive to Take Action)

3. That the AMA reaffirm Policy H-165.856, which supports principles of health insurance market regulation that would improve coverage and choice through the individual market (e.g., greater uniformity of market regulation across states, appropriate rules regarding premium rating and terms of issue, and reduction of legislative and regulatory barriers to market innovation in product development and purchasing arrangements). (Reaffirm HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Advocate to regulatory agencies and produce informational materials to be posted on the AMA Web site at estimated total cost of $4,190.