The Role Of The Individual Health Insurance Market And Prospects For Change

The future of this market depends on policy interventions to balance supply-side and demand-side forces.

by Melinda Beeuwkes Buntin, M. Susan Marquis, and Jill M. Yegian

PROLOGUE: According to the latest data from the U.S. Census Bureau, there are now at least forty-five million uninsured Americans. Most are employed but either are not offered or cannot afford employer-sponsored health insurance. The 2004 data are not a departure from past trends: In 2003, employer-sponsored health insurance covered 700,000 fewer people than in it did in 2002. Almost 30 percent of self-employed Americans lack health insurance. Among the uninsured are entrepreneurs; consultants; small-business owners and their employees; mostly younger, often single people. In an age of increased emphasis on consumer-driven health care, what's keeping the individual market from meeting the health insurance needs of those not tied to or interested in the group model? In the paper that follows, RAND researchers Melinda Beeuwkes Buntin and Susan Marquis join forces with Jill Yegian of the California HealthCare Foundation to examine how the individual insurance market could help close the insurance gap. How many of the uninsured might jump to the individual insurance market if the market was made affordable, accessible, and known to them?

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ABSTRACT: The individual market is the only source of health insurance for the more than 20 percent of Americans not eligible for group or public health insurance, yet participation rates are low and shrinking. This paper examines this market’s structural features and assesses the likelihood that it will play an expanded role in the future. We describe how pressures such as cost growth, new technologies, and changes in the nature of the workplace are shaping the individual market. We conclude that the future of the market will depend largely on whether there are policy interventions that balance the problems of affordability, risk sharing, and adverse selection.

Individual health insurance has traditionally been viewed as a residual market—a market for the small minority of people who need private insurance but who are not enrolled in employer group plans. This viewpoint reflects the fact that only a small share of the nonelderly population purchases individual insurance (Exhibit 1). Yet this “residual” market has the potential to be quite big: For the more than 20 percent of Americans who are not eligible for group or public insurance, it is their sole insurance option. Moreover, with employer-sponsored coverage retreating and state Medicaid budgets tightening, the potential market for individual health insurance is likely to grow. However, only a small fraction of the population without other options purchases such coverage. Also, both the fraction of people in the market and the number of people purchasing individual policies has declined steadily over most of the past fifteen years.

Some policymakers hope to reverse this downward trend and expand the role of the individual market in covering the uninsured. Others argue that the problems of affordability, limited risk pooling, and adverse selection limit the role this market can play. The objective of this paper is to present an overview of the structural

EXHIBIT 1

<table>
<thead>
<tr>
<th>Year</th>
<th>Millions of nonelderly with individual coverage</th>
<th>Percent of nonelderly with individual coverage</th>
<th>Percent of nonelderly who are individual market candidates</th>
<th>Percent of market candidates with individual coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>15.7</td>
<td>7.4</td>
<td>21.8</td>
<td>33.9</td>
</tr>
<tr>
<td>1990</td>
<td>16.0</td>
<td>7.4</td>
<td>22.6</td>
<td>32.7</td>
</tr>
<tr>
<td>1992</td>
<td>15.4</td>
<td>7.0</td>
<td>22.8</td>
<td>30.5</td>
</tr>
<tr>
<td>1994</td>
<td>15.5</td>
<td>6.8</td>
<td>23.9</td>
<td>28.3</td>
</tr>
<tr>
<td>1996b</td>
<td>18.2</td>
<td>7.8</td>
<td>25.3</td>
<td>31.0</td>
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<tr>
<td>1998</td>
<td>16.5</td>
<td>7.0</td>
<td>25.2</td>
<td>27.7</td>
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<tr>
<td>2000</td>
<td>16.3</td>
<td>6.8</td>
<td>24.2</td>
<td>27.9</td>
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<tr>
<td>2002</td>
<td>15.1</td>
<td>6.2</td>
<td>25.0</td>
<td>24.9</td>
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<tr>
<td>2003</td>
<td>16.2</td>
<td>6.5</td>
<td>26.1</td>
<td>24.8</td>
</tr>
</tbody>
</table>

SOURCE: Authors’ analysis of data from the Current Population Survey (CPS), various years.
* Individual market candidates are measured from the CPS as those who have individual insurance or who are uninsured.
† CPS questions were revised in 1995, so series before and after 1995 are not comparable.
supply and demand features of this market, to examine why it has been shrinking, and to assess the prospects that it can play an expanded role in the future.

**Data And Methods**

- **Data.** Our analysis draws on data from several sources. Overall trends in purchasing come from the annual March Current Population Survey (CPS). We also use data from our study of the individual insurance market in California. Although these data are limited to a single state, they provide insights about the market that are not available from other databases. Our data include administrative records from the three largest carriers selling individual insurance in California. We also conducted a survey of market candidates (subscribers to individual coverage and the uninsured) to collect information about their attitudes about individual insurance.

- **Interviews.** In addition, we interviewed six executives in the individual insurance industry and three insurance market regulators in California to gain the industry perspective on recent trends and new directions for the market. We also interviewed two national experts to identify how national trends and perspectives differ from those in California.

**Structure Of The Market: Supply Side**

The supply side of the individual insurance market has three distinctive characteristics: It is small, enrollment is voluntary, and choices are made by individuals. These characteristics cause insurers to worry about adverse selection and about garnering sufficient market share. These concerns drive much of insurers’ behavior and are leading to changes in product design and marketing.

- **Adverse selection.** Purchasers in the individual market make voluntary, individual choices and have an incentive to purchase insurance only when they expect to need medical services. Because the market is small, the medical spending by high-risk people who purchase individual insurance is difficult to spread broadly. Therefore, if allowed by state law, insurers in the individual insurance market underwrite to manage costs by not enrolling very high risks and by segmenting risks into groups that are charged different prices.

As a result, those who buy coverage tend to be healthier than those who remain uninsured, even though we expect demand for insurance to be greatest among the sick. Underwriting prevents some market candidates from obtaining insurance: Estimates of denials range from 8 percent to 18 percent of applicants. Among those who purchase individual insurance, however, there may be more risk pooling than commonly supposed; that is, those in good health subsidize the price paid by those in poorer health. This pooling may occur because underwriting happens at the time of purchase, and guaranteed renewability—now required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996—means that deterioration in health does not lead to reunderwriting, unless the person changes products or the carrier closes the line of business. (HIPAA does not pro-
hibit explicit underwriting at renewal, but in practice this does not occur. However, recent evidence shows that mergers and acquisitions are sometimes used as an opportunity to cancel bad risks and reunderwrite individuals. Our survey of Californians shows that newer subscribers (members for less than a year) are less likely than longer-term members are to report fair or poor health status and to have one of five serious health conditions. Among new subscribers, 4.6 percent reported self-perceived health status as fair or poor, compared with 6.1 percent of longer-term subscribers in 2003; 19.5 percent of them reported the presence of heart disease, lung disease, diabetes, cancer, or hypertension, compared with 22.5 percent of longer-term members ($p < .05$).

**Drive for enrollees.** Both the fact that longer-term members are in worse health and the relatively small size of the risk pools mean that insurers feel constant pressure to attract new members and increase market share to manage risk. The insurance executives we interviewed indicated that this gives a competitive edge to carriers that have a local or regional focus (such as Blue Cross/Blue Shield plans) or strong local distribution channels, or both. In fact, the highly concentrated structure of the industry reflects the importance of market share. In thirty-four states the three largest insurers account for more than 80 percent of subscribers, and the trend is toward even greater consolidation.

**Marketing and design efforts.** Some insurers hope that information technology (IT) and better-designed products will spur overall growth of the market and also increase their own market share. Enhanced IT has reduced administrative costs; so far, however, there is little evidence that it is leading to greater enrollment. Although the Internet is altering traditional distribution channels, agents and brokers remain the main channel for individual products and, our industry interviewees reported, are at the core of success in the market. Brokers and agents interpret the market to potential consumers and thus affect what products they demand.

Insurers in California report enrollment growth because of their efforts to develop marketing tools and tailored products for certain population groups, notably Latinos and younger uninsured people. Kaiser Permanente in southern California has had tremendous success with Spanish-language television ads; other insurers in southern California are following suit. Insurers across the nation, concerned about stagnating enrollment in the group market, are focusing on niche products for the currently uninsured. Some are offering products designed for low-income enrollees or college students. CNN recently ran a segment describing insurers’ increasing efforts to market to the uninsured.

Insurers are also redesigning products with higher deductibles and greater cost sharing to attract and retain customers, who are demanding more affordable products. Separate deductibles for drugs and other benefits are common, and even health maintenance organizations (HMOs) increasingly include a deductible. Individual insurance plans also tend to manage drug benefits closely, often limiting the types of drugs available. For example, Blue Cross of California offers a product...
with three drug options: none, generic only, or comprehensive. Other cost-controlling innovations in the group market are beginning to reach the individual market. For example, Blue Shield of California recently introduced a “consumer-directed product” in the individual market.

Do these supply-side changes mean that reductions in the number of uninsured people are at hand? Not necessarily. To attract the uninsured, carriers are offering low-cost products with restricted benefits. These low-cost products may also attract healthy insured people from current coverage. Some uninsured people stand to benefit from purchasing these new products; however, the resulting separation of risks may reduce access to affordable insurance for others.

**Structure Of The Market: Demand Side**

Demand for individual policies is constrained by high prices and barriers to obtaining the information needed to purchase coverage. If consumers can find and pay for a policy, however, an individual plan will offer some advantages over employer-sponsored plans.

- **Prices and declining coverage.** Affordability is an especially large factor in demand for individual insurance because potential purchasers are predominantly low-income. About half had incomes below 200 percent of the federal poverty level in 2003, and fewer than 15 percent of these low-income candidates purchased individual insurance (Exhibit 2). This is not surprising, given that even a healthy person with income at 200 percent of poverty would have to pay almost 15 percent of income in premiums, based on premiums we measured in the California market. Less healthy people would face even higher premiums; however, a recent industry survey indicated that 70 percent of applicants, and 80 percent of those offered coverage, are quoted the standard price.14

Declining purchase rates are seen across all segments of the market: among low- and high-income market candidates, among the young and old, and among the self-employed and others (Exhibit 2). The much higher purchase rates by the self-employed (a difference that persists when we control for income differences) strongly suggest that the price break in the tax system stimulates demand for coverage. Beginning in 1986 the federal government allowed the self-employed to deduct 25 percent of the cost of their premiums from their federally taxable income. That percentage has since risen to 100 percent. The decline among the self-employed occurred, therefore, during the period in which the share of the premium they pay in before-tax dollars increased. In short, even among people with increased incentives to purchase, the individual insurance market shrank markedly.
What accounts for this decline? The prime culprit seems to be rapidly rising premiums. In California, premiums for a standardized product increased 45 percent between 1996 and 2003 (in constant dollars). For the nation, the increase may have been even greater. Based on the best estimates of the elasticity of demand in this market, a 45 percent price increase would lead to a decrease in purchase rates of about 2.8 to 5.7 percentage points, accounting for 45–85 percent of the 6.6-percentage-point decline in purchase rates.

Other barriers to participation. While high prices in the individual market are probably the dominant factor in the low participation rates, there are other barriers to participation. In states that subsidize private health insurance for low-income populations, such as Washington’s Basic Health Plan and New Jersey’s short-lived Access Program, many eligible people remained uninsured even with substantial subsidies. Our survey of market candidates in California indicates that uninsured people perceive greater difficulty in obtaining adequate information about buying individual insurance plans than insurance purchasers do (Exhibit 3). They believe that there are costs in applying for insurance stemming from disclosure of private data and excessive paperwork. The uninsured are more likely to believe that there are alternatives to private insurance available to them and that medical care is not efficacious. They are also more willing to take risks.

Advantages of individual plans. There is a lot of variability in the characteristics of plans purchased in the individual market. This suggests that consumers are heterogeneous in their coverage preferences. One of the good things about the individual market is that it offers the opportunity to select benefits to match individual preferences. In contrast, consumers in the group market have more limited choice.

Portability of coverage is also an advantage for those who purchase in the individual market. For individual-insurance customers, coverage is not tied to a par-
ticular job and is not lost when employment circumstances change. This is an important part of individual plans’ attraction that may grow. Technology and globalization are producing changes in the nature of employer-employee relationships. Fewer workers have lifetime employment relationships; more frequent job changes may lead to demand for greater portability in insurance. About 25 percent of workers are in nontraditional work relationships, such as self-employment, contract work, and temporary work, and this number will almost certainly continue to rise. Employer-sponsored coverage is likely to continue to erode with the increase in nontraditional arrangements, thus creating an even larger potential market for individual insurance.

Even now, those who purchase individual coverage are an occupationally mobile population. More than one-third of individual-policy subscribers in our California survey reported having changed or expecting to change a job within a year. Many believe that individual coverage serves largely as bridge coverage between jobs and that turnover in the individual market is fueled by unstable employment. In California we found that turnover in the individual insurance market occurs primarily among those who have lost or gained employer coverage. About 56 percent of those joining the individual market had employer coverage in the previous month, and 69 percent leaving the individual market obtained employer coverage.

However, it is important not to overstate the connection between individual insurance and high job mobility. Based on administrative records in California from 1997 to 2001, 63 percent of the people who buy coverage hold it one year later, and 31 percent hold it three years later. For these long-term purchasers, HIPAA’s guaranteed renewability assures coverage that is portable across changes in employment and health circumstances. However, this may come at the expense of choice.

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**EXHIBIT 3**
Perceived Barriers To And Costs Of Insurance Purchase By Insurance Status Among Californians, 2003

<table>
<thead>
<tr>
<th>Cost of obtaining information</th>
<th>Insured (%)</th>
<th>Uninsured (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50.9</td>
<td>62.7**</td>
</tr>
<tr>
<td>Burden of disclosure requirements</td>
<td>56.8</td>
<td>67.7**</td>
</tr>
<tr>
<td>Availability of free care alternatives</td>
<td>23.9</td>
<td>28.9**</td>
</tr>
<tr>
<td>Risk taker</td>
<td>32.9</td>
<td>44.0**</td>
</tr>
<tr>
<td>Low efficacy of medical care</td>
<td>43.3</td>
<td>53.6**</td>
</tr>
</tbody>
</table>


**NOTES:** Each barrier is an index measured as the sum of “strongly agree” or “agree” responses to construct/number of questions. Information costs questions: searching is difficult, requires time, don’t know where to search, no one to trust. Burden of disclosure requirements questions: search reveals too much information, too much paperwork. Availability of free care questions: good care at low cost in clinics, health care easy to get without money. Risk taker questions: take risks more than average. Efficacy of medical care questions: Own behavior determines health, can overcome illness without doctor, home remedies better. Estimates are corrected for differences between insured and uninsured in education, income, race, health status, and family type (single adult, married couple, family).

**p < .05**
that the market offers. Guaranteed renewability applies only to the purchased product, and people wishing to switch products would face renewed underwriting; thus, subscribers may be locked into insurance features that no longer meet their needs. In addition, the natural course of new product development or strategic design by insurers may lead to a deteriorating risk pool for old products, rendering them prohibitively costly and forcing subscribers to be newly underwritten.

**Federal And State Policies That Affect Market Structure**

Insurance regulation is largely the province of the states; thus, state policies control the behavior of suppliers. There are some national policies directed at insurers, such as HIPAA’s renewal guarantee, but most federal policies are aimed at influencing demand.

- **State policies.** Not surprisingly, state-based regulation leads to considerable variation in the structure of the individual insurance market. In the 1990s a number of states adopted individual-market regulations—especially guaranteed issue and community rating—to force suppliers to pool risks more broadly and make insurance more accessible and affordable for the sick. Most quantitative studies indicate that these led to small increases in premiums and a small reduction in coverage, although qualitative case studies found that they produced marked instability in some states and forced the rollback of reforms. Furthermore, restrictions on underwriting and pricing provide insurers incentives to find other ways to segment risks. In some markets, reforms produced resegmentation along product lines.

States can overcome these problems. Risk adjustment or mandatory reinsurance can help address insurers’ concerns about adverse selection, thus limiting incentives for favorable risk selection. Although these techniques have not been widely adopted, they might lead to broader pooling in the individual market. The Healthy New York program, for example, includes a state-financed reinsurance scheme that limits insurers’ liability and uses general taxes to spread the cost of high-risk eligible people among all taxpayers.

Instead of legislating guaranteed access, many states have created high-risk pools that offer subsidized products to those unable to obtain affordable individual coverage. Subsidies—usually financed by tax dollars or by assessments on insurers’ premiums across all lines of business—help to spread the cost for these high-risk cases more broadly among the population. In theory, this seems like a promising approach. In practice, though, enrollment has historically been low, and pools have had funding problems. However, the federal government authorized funding under the Trade Adjustment Assistance Act of 2002 to encourage new risk pools and to assist states with risk pool losses. In 2003, risk pool enrollment increased 13 percent over 2002 levels.

- **Federal policies.** The federal government’s policies have focused on stimulating demand by making individual insurance more affordable. It has established policies that provide the tax benefits of group coverage to some people buying individ-
“The insurers we interviewed believe that the jury is still out on the role of HSAs in the individual market.”

Individual coverage and that use the tax system to subsidize the purchase of insurance. As noted earlier, the self-employed can now fully deduct their premium payments for individual insurance. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 created health savings accounts (HSAs), permitting individuals covered by a high-deductible health plan to make tax-deductible contributions toward health expenses. This constitutes a first step toward providing comparable tax treatment to those who purchase in the individual and group markets. In addition, the Bush administration proposed a new tax deduction for the health insurance premiums paid by individuals purchasing a high-deductible plan and having an HSA, which would provide full tax parity with those in the group market for people in the individual market participating in HSAs.27

However, the insurers we interviewed believe that the jury is still out on the role of HSAs in the individual market. Brokers and agents, who are the keys to this market, will have little incentive to explain HSAs to clients because they don’t receive compensation for HSA participation. In fact, our respondents argue, there is a disincentive for brokers to sell high-deductible, lower-premium products because compensation is proportional to premiums. Insurers in California are planning to offer insurance products that are eligible for HSAs, but not all are planning to offer an integrated financial services component. They believe that HSAs will be costly to administer because they involve a large number of transactions and a small amount of money. On the demand side, although we did not ask specifically about HSAs, our survey of individual policyholders in California found that most of them were willing to pay much higher premiums to avoid high-deductible plans. There is also evidence that employers are expressing doubts about HSAs’ appeal to employees.28 These observations suggest that at least, it might take some time for HSAs to catch on in the individual market.

Tax credits to help low-income families purchase individual coverage have also attracted attention in recent years. The Trade Act of 2002 took a step in this direction. It creates health coverage tax credits that pay 65 percent of the cost of premiums for qualified coverage for certain workers displaced by international trade. Although initial participation in the program is low, it nonetheless may serve as a model for the design of tax credits.29

The federal government has also guaranteed the supply of insurance for some population groups. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 establishes the right for workers who leave a job with group coverage to continue that coverage for up to eighteen months (thirty-six months in some cases) at their own expense. HIPAA guarantees group-to-individual portability of coverage for workers once they exhaust other sources of coverage.
The Future Of The Individual Insurance Market

The growth in health care costs, new information technologies, and changes occurring in the nature of the workplace described above will help determine whether more people will turn to the individual market or whether it will continue to erode. These changes also offer opportunities and challenges to insurers to develop new products and strategies to expand the market. However, the future of the individual insurance market may largely be shaped by the direction of public policy.

The entrepreneurial class at the vanguard of the movement toward freelance work has begun to take note of the problems with the individual market and has the means to make their concerns known to policymakers. Indeed, the travails of an affluent couple denied health insurance was the subject of a recent spread in the New York Times Magazine. Moreover, most Americans support some form of health care reform, and almost 60 percent say that candidates’ views on reform are important in their voting decisions.

If the individual market is to play a vital role in these reforms, policies must be developed to balance demand-side needs for affordable coverage and individual choice with supply-side concerns about risk pooling and adverse selection. Federal policymakers are proposing ways to address these shortcomings in the individual market. However, the approaches offered by the two political parties differ greatly. The approach favored by Republicans focuses on affordability and would stimulate demand by offering tax credits to low-income workers and tax deductions for premiums paid for high-deductible individual plans with HSAs. How much these changes would stimulate demand remains unknown. Most quantitative analyses of tax credits suggest that they are likely to have only modest effects, unless sizable credits are offered. In contrast, the approach offered by many Democrats would increase risk pooling by creating a new group-purchasing option available to both individuals and employers. Over time, this would be expected to replace the individual market as we know it, because it offers the advantages of choice, portability, and long-term security at more affordable rates. Some Democratic proposals would also offer reinsurance to protect insurers from adverse selection in the new purchasing option.

Both sets of policies involve an expanded federal role and federal financing, which is in short supply. Thus, health care cost containment policies could also affect the individual market. Without them, continued cost increases would erode the value of any tax credit or direct subsidy, compromise other efforts to expand coverage, and lead to continuing declines in enrollment in individual policies.

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NOTES

1. Because of data limitations, our estimate uses the number of people with individual insurance or who are uninsured rather than those not eligible for other sources, which will somewhat overstate the size of the potential market.


15. Chollet et al., Mapping State Health Insurance Markets, reports a 71 percent increase between 1997 and 2001; however, this also reflects changes in benefits and any changes in underwriting.


