

P E R S P E C T I V E

Of Magic Wands And Kaleidoscopes: Fixing Problems In The Individual Market

We must not simply hand out subsidies and send people to the unstructured and relatively unregulated individual market for coverage.

by **Mark A. Hall**

ABSTRACT: Policy analysts sometimes imagine that problems in the individual market can be fixed by waving a magic wand that makes the individual market function more like the group market. However, prior studies reveal that purchasing cooperatives fail to achieve substantial economies of scale; market reforms that reduce the impact of medical underwriting are difficult to implement in the individual market; and it may not be as easy as imagined to induce people to purchase over the Internet or from new or smaller companies that are at higher risk for exiting the market. The best solution is to limit the use of subsidies to certain purchasing options, such as with purchasing cooperatives that abide by rating, issuance, and renewability rules. What is not acceptable is to hand people subsidies and send them to the unstructured and relatively unregulated individual market, nor will it work to give people unhindered choice between two basically different market segments.

THE PROBLEMS plaguing the individual market for health insurance are well known. Based on a variety of descriptive and analytical studies, qualitative interviews, and extensive field studies, we know the following.¹ (1) Individuals purchasing insurance outside of groups are subject to intensive medical underwriting, resulting in denial or limitation of coverage, or very steep price increases, if they have even common health problems.² (2) Overhead costs for individual health insurance are several times higher than for group insurance.³ (3) The individual market is thin and somewhat volatile, with few competitors and a tendency for insurers to come and go.⁴ For instance, unpublished data from a recent survey in North

Carolina show that only a half-dozen or fewer insurers actively sell individual coverage in most locations after many larger insurers left the market in recent years. Blue Cross dominates the state's individual market, with seven times the total enrollment of the next-largest plan, and it receives the vast majority of new enrollees, according to interviews with agents. None of Blue Cross's major competitors in this state's group market (United HealthCare, CIGNA, Guardian, and Principal) sell in the individual market.

Policy analysts sometimes imagine that it is possible to fix these problems fairly easily with legislative or regulatory measures that will allow the individual market to function more like the group market. By waving a wand, or

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several wands, purchasing cooperatives can be created that replicate group efficiencies and economies of scale, market reforms can improve access and reduce the impact of medical underwriting, and more competitors can be encouraged to enter and remain in the market. My purpose in this essay is to convey how difficult these measures are to accomplish, and to gain a better sense of how best to approach these laudable goals.

Increasing Competition And Guaranteeing Renewability

Greater use of the individual market will not be productive unless there is a large increase in viable competitors. The infusion of large subsidies for individual purchasers should greatly enhance insurers' willingness to invest in this market segment, but this was also the hope for

Medicare+Choice, which has seen a massive exodus of plans. The two situations certainly are not parallel, but this illustrates that an optimistic outlook is sometimes not accurate.

For example, in recent interviews with insurance agents in North Carolina, I was frequently told about the following stumbling block for increased competition in the individual market. Although there are technically a half-dozen competing carriers in the market, most agents did not think that these carriers presented much viable competition for the dominant plan (Blue Cross), for several reasons. First, only Blue Cross has sufficient market share to build large preferred provider organization (PPO) networks, especially in more rural areas, which gives it a large cost advantage. Second, agents are reluctant to sell to carriers with smaller market shares for fear that they will exit the market, leaving policyholders who have developed health problems with no coverage. This concern creates a sizable barrier to entry or expansion in the market.

To better understand the latter point, one

must realize that the individual market in most states requires only guaranteed renewability by one's current insurer. Portability to other insurers is not allowed if one's current insurer exits the market. Moreover, portability does not exist even within a given insurer's line of products. In North Carolina, as in many other states, guaranteed renewability applies only to a particular policy type, and it applies only so long as the insurer chooses to offer the policy type. Insurers are free to stop selling a

policy type and only renew it, or to terminate it altogether without offering replacement coverage, even though the insurer begins to sell a new policy type that is very similar to the old one. This practice, known as "churning," can happen either as a deliberate strategy or simply as the natural evolution of new product development. Eventually, the older policy types cease to be vi-

able in the market, and insurers stop selling them. When this happens, holders of older policies are stranded if they can no longer meet new underwriting criteria. If an old policy is terminated, these people will lose coverage; if it is renewed without being sold to new holders, its price will spiral up as healthy members of the underwriting pool leave for lower-price, freshly underwritten new policies.

It is not known how frequently these practices occur, but they occur often enough that most agents I have interviewed in North Carolina are reluctant to sell individual insurance from any company other than the one they believe has the longest-term commitment to the market. Even committed insurers, however, regularly create new products that are open only to better risks. Existing laws do not address this problem effectively, since the protections in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that deal with these kinds of concerns are limited to people who leave group coverage and

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enter the individual market, not those who move within the individual market. Therefore, the individual market would greatly benefit from measures to prevent stranding individual policyholders and to limit risk segmentation through churning of similar policy types. Not only will this strengthen consumer protections, it will enhance competitive conditions by making it safer to buy coverage from new market entrants and smaller companies whose long-term commitment to the market may be uncertain.

Rating Reforms And Risk Adjusters

The Achilles' heel of the individual market is adverse selection. The tendency of people to buy insurance based on their anticipated medical needs causes insurers to adopt various forms of medical underwriting and results in exclusion of more predictable medical needs such as maternity care, mental health, and treatment of preexisting conditions.⁵ Adverse selection is greatly intensified in the individual market because each person purchasing insurance is, by definition, considering his or her own health circumstances in deciding whether, what, and how much to buy. Groups greatly mitigate this problem because someone else (the employer) makes the major decisions and makes them on behalf of the entire group, with only slight consideration for any one person's situation.

Because of adverse selection, market reforms that work well in the group market can cause massive problems in the individual market. Guaranteed issue cannot work without fairly strong rating reforms that keep prices within reach for older or sicker people. But risk factors vary to a much greater extent across a full range of individuals than across a range of group averages. Rate compression inherently tends to force lower risks out of the market and therefore tends to increase average market rates or to reduce covered benefits (for example, by raising deductibles), and these effects are much more severe for the individual market than for the group market.⁶ Therefore, the individual market cannot tolerate the same

degree of rate compression that the group market can. This is well documented in examples from states such as New York, New Jersey, and Vermont, which apply pure or near community rating to both the individual and group markets.⁷ The only fix for this problem is to limit the degree of rate compression, but this undercuts the goal of making insurance affordable to more than only the young and healthy.

One possible fix for the problems of rate compression is to risk-adjust the level of subsidy given to individual purchasers, so that those with higher risk factors have more assistance in purchasing coverage. However, the magic wand of risk adjustment also has much less potency than is often acknowledged. Risk-adjustment measures in common use remain crude and far from sufficient to reflect the actual patterns and extent of variation in risk factors. This is partly illustrated by the risk-adjustment difficulties for Medicare health maintenance organizations (HMOs), but the difficulties here are even greater. Risk-adjustment measures that are serviceable for group averages are grossly inaccurate when used for individuals. Some people will receive large windfalls, and others will be charged far higher rates than are reflected in their risk-adjusted subsidies. One fix for this problem is to set subsidies at a certain percentage of actual premiums charged, but this is expensive since the percentage needs to be high enough to keep insurance affordable for higher risks, including people whom insurers now refuse to cover altogether.

Perhaps the best solution is a combination of these two ideas: limit overall rate variation to a range of five- or tenfold, according to specified factors, and then set premium subsidies at a percentage of the premiums actually charged. Some people will still have to pay much more than others will, but the expense for people in the higher range might be kept within reasonable bounds. This proposal creates other difficulties, however, to which I now turn.

Regulatory Gradients

A set of subsidies and market rules that make sense for one market segment in static

mode may nevertheless encounter great difficulties when implemented alongside other market segments in a dynamic environment. This is because purchasers, informed by agents and advocates, will seek out the best deal for their particular risk situation. If different market segments treat risk characteristics differently, these regulatory gradients will be exploited over time. For instance, low-risk family members are often finding they can purchase coverage more cheaply in the individual market than by joining their breadwinner's group policy, especially where the employer does not contribute anything to the extra cost of family coverage. Contrariwise, insurance agents advise higher-risk individuals to form "mom-and-pop" businesses to buy insurance for themselves at group rates when they are subject to being turned down as individuals.⁸

Markets can tolerate a certain degree of bleeding across the borders, but at some point these strategic movements can destabilize risk pools. The most prominent examples involve association groups that use experience rating alongside markets that require community rating. In states such as Vermont and Kentucky, healthy employers or individuals have flocked to association plans to avoid paying higher community rates or have flocked from one association to another to find the lowest association rate.⁹ (High-risk purchasers also may be eligible to seek out these better prices, but sick people are inherently less willing to switch insurance. This phenomenon is known as "adverse retention.")¹⁰ In North Carolina, the state employees' plan had to cease offering any options other than the standard self-insured indemnity plan because market differentials like these caused such serious adverse selection by family members that all of the insured plans left the program.

The fix for this problem is to more hermetically separate market segments. This can be

done either with strict rules about who is entitled to purchase where (for instance, by restricting association membership to certain well-defined criteria) or by limiting the use of subsidies to certain purchasing options. For instance, subsidies could be given only to those who purchase through arrangements such as purchasing cooperatives that abide by market-reform rules like guaranteed issue, portability, and modified community rating. Purchasing in the open market would not be

forbidden, but those who do so would receive no subsidy. If the subsidy were large enough, in most instances it would offset the gain from seeking out other market segments with different rules that favor one's particular risk situation.

Purchasing Cooperatives

Purchasing cooperatives will greatly help the functioning of individual markets, but they are not a magic wand for all of the problems, either. Careful study of existing cooperatives for small employers reveals that they fail to amass much purchasing power or administrative efficiency.¹¹ Cooperatives may offer more of a comparative advantage to individuals than to groups, since conditions in the individual market are worse than in the group market, but cooperatives for individuals inherently cannot achieve the efficiencies enjoyed by large employer groups. This is because most efficiencies result from the fact that large employers make wholesale or collective decisions for all of their employees. Although this limits choice, it also greatly simplifies the information processing and transaction costs of selecting insurance, which is a complex transaction. Purchasing cooperatives for individuals unbundle group purchasing and require insurance to be sold individually, in a retail fashion.

The great hope is that the Internet will replace personal and individualized advice from

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insurance agents, as is happening for airplane tickets and travel agents. This may work for some people, but not for most people I know, for whom the stakes are too important, the options too confusing, and the consequences of a mistake too frightening. Accordingly, most successful purchasing cooperatives continue to use insurance agents, who require a commission; these commissions are the major component of overhead expense that cooperatives hoped to avoid.

Other issues that need to be resolved in setting up cooperatives include conflicts of interest in their administration, whether they should have standardized or minimum benefits, whether they may work with only one insurer or must offer plans from competing carriers, and whether cooperatives should compete with each other or have exclusive franchises for defined territories. Each of these issues entails competing pros and cons. One simplifying solution often offered is to allow individuals to buy into existing purchasing pools such as health benefit programs for government workers. This, too, is not as easy as it appears. Experience under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, which permits persons who lose their jobs to purchase coverage from their employer's plan at group rates, suggests that allowing people to opt in to existing groups may raise costs to the group due to adverse selection. Claims costs for COBRA eligibles generally run about 50 percent higher than for the rest of the group.¹² Subsidizing individuals who buy into groups will reduce the amount of adverse selection by encouraging a greater portion of eligible purchasers to join, but subsidies may not eliminate this problem. This fear will likely cause existing groups to resist agreeing to accept outsiders unless the outsiders are put into a separate risk pool.

The final problem with purchasing cooperatives is that each one usually constitutes a separate risk pool rather than having each insurer setting its prices uniformly across all pools or market segments it deals with. If each risk pool were not separate, the pool could not reflect in its rates the bargaining leverage and

group efficiencies it is able to achieve. Separating risk pools, however, tends to create an unstable dynamic in which purchasers seek out the pool with the lowest overall risk profile. Because of the reluctance of higher-risk people to change, this can lead to a strategy in which insurers or association sponsors close off older pools and open new ones, to segment the worse risks and offer better rates to fresh business. This is done to exploit a phenomenon known as the "durational effect," according to which, all things being equal, newer pools are lower risk than older ones. This strategy has the biggest payoff when the new business can be medically underwritten and higher risks overtly excluded, but it also pays off even when there is no medical underwriting, because of the natural selection effect just mentioned (reluctance of sick people to change).

In employer groups, none of this is a problem because workers are wedded to their groups. Where group membership is completely fluid, however, opting among alternative experience-rated groups can result in a volatile and unstable market.¹³ None of the potential fixes for this problem are uncontroversial. They include restricting eligibility for group membership, restricting the number of available groups or the formation of new ones, or requiring more binding and much longer term commitments to the group one selects.

Concluding Comments

Rather than a magic wand, a better metaphor for fixing problems in the individual market is a kaleidoscope, since the problems that must be solved are refracted through a complex array of economic and regulatory structures. Therefore, crafting a set of rules and institutions that will allow the individual market to function as an acceptable alternative to the group market requires sophistication, intricacy, and difficult trade-offs.¹⁴ What is not acceptable is to hand people subsidies and send them to the unstructured and relatively unregulated individual market, nor will it work to give people unhindered choice between two radically different market seg-

ments. Instead, an entirely new market segment needs to be created, one that is specially tailored for these purposes and carefully spliced between the existing group and individual markets. It remains to be seen whether this can be done successfully, and whether the benefits are worth the regulatory costs and the compromises of other health policy objectives.

NOTES

1. Many of these studies, conducted by me and others, are collected at a Web site that I maintain, "Wake Forest University, Health Insurance Market Reform Study," www.phs.wfubmc.edu/insure (15 July 2002).
2. K. Pollitz, R. Sorian, and K. Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, June 2001); and E. Simantov et al., "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs* (July/Aug 2001): 139.
3. M.V. Pauly et al., "Individual versus Job-Based Health Insurance: Weighing the Pros and Cons," *Health Affairs* (Nov/Dec 1999): 31.
4. D.J. Chollet and A.M. Kirk, *Understanding Individual Health Insurance Markets* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, March 1998).
5. See J. Gabel et al., "Individual Insurance: How Much Financial Protection Does It Provide?" 17 April 2002, www.healthaffairs.org/Web/Exclusives/Gabel_Web_Excl_041702.htm (12 August 2002).
6. M.A. Hall, "The Structure and Enforcement of Health Insurance Rating Reforms," *Inquiry* 37, no. 4 (2001): 376-388.
7. M.A. Hall, "An Evaluation of New York's Reform Law," *Journal of Health Politics, Policy and Law* 25, no. 1 (2000): 71-99; M.A. Hall, "An Evaluation of Vermont's Reform Law," *Journal of Health Politics, Policy and Law* 25, no. 1 (2000): 101-131; and K. Swartz and D. Garnick, "Lessons from New Jersey," *Journal of Health Politics, Policy and Law* 25, no. 1 (2000): 45-70.
8. M.A. Hall, "The Geography of Health Insurance Regulation," *Health Affairs* (Mar/Apr 2000): 173-184.
9. Hall, "An Evaluation of Vermont's Reform Law."
10. D. Altman, D.M. Cutler, and R.J. Zeckhauser, "Adverse Selection and Adverse Retention," *AEA Papers and Proceedings* 88, no. 2 (1998): 122-126.
11. E. Wicks and M.A. Hall, "Purchasing Cooperatives for Small Employers: Performance and Prospects," *Milbank Quarterly* 78, no. 4 (2000): 511-546.
12. U.S. General Accounting Office, *Private Health Insurance: Declining Employer Coverage May Affect Access for 55- to 64-Year-Olds*, Pub. no. GAO/HEHS-98-133 (Washington: GAO, 1998).
13. M.A. Hall, E. Wicks, and J. Lawlor, "Health-Marts, HIPCs, MEWAs, and AHPs: A Guide for the Perplexed," *Health Affairs* (Jan/Feb 2001): 142-153.
14. For an admirable effort that creatively addresses all of the difficult issues, see T. Miller, "Improving Access to Health Care without Comprehensive Health Insurance Coverage," in *Covering America: Real Remedies for the Uninsured*, vol. 2, ed. E.K. Wicks and J.A. Meyer (Washington: Economic and Social Research Institute, 2002).