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The Individual Medical Insurance Market: A Guide for Policymakers

Many recent proposals designed to reduce the number of uninsured would increase the reliance on the individual medical insurance market to provide coverage. As such, the American Academy of Actuaries' Individual Medical Market Task Force has developed this statement to provide policymakers with a clear understanding of how the current individual market works, the relative ease or difficulty a person may have acquiring coverage in this market, and the cost implications once he or she is covered.

Policymakers aiming to ensure that any "reformed" market is viable and sustainable over time should consider the information provided in this statement. A key to sustainability is managing the adverse selection in a voluntary market, which may require trade-offs between accessibility and affordability.

BACKGROUND

Insurance purchased in the individual market was the primary source of health coverage for about 5.4 percent of the nonelderly population, or 14 million people, in 2006.[1] The individual market is an important segment of the health insurance market. People who purchase coverage in the individual market include those who are self-employed, between jobs, or don't have access to either employer coverage or public coverage.

The individual market today is a mix of regional carriers and large national carriers plus independent or consolidated Blue Cross Blue Shield organizations. Within the past few decades, the number of insurance carriers has declined, due to carrier consolidations as well as some carriers leaving particular states due to changes in the regulatory climate. In recent years, some large carriers have been selectively entering the individual market; their considerable market share allows them advantages in provider-payment negotiations and economies of scale.

REGULATION

Like other forms of insurance, the individual market is regulated primarily by the states. Indeed, the individual market is considered to be the most heavily regulated health insurance market. States can regulate benefit-coverage requirements, underwriting and rating practices, and market conduct. While many benefit-coverage and insurance policy administrative provisions can be relatively consistent across the country due

[1] "Health Insurance Coverage in America: 2006 Data Update," Kaiser Family Foundation, October 2007.

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to standardized contractual language in all states, regulations of other aspects of individual market products, including specific mandated benefits, can vary significantly from state to state. As a result, multi-state insurance carriers must comply with multiple sets of regulations, which can increase compliance costs.

Some insurance companies use associations or discretionary trusts to offer what is essentially individual insurance. These vehicles are regulated as "group" or "franchise" insurance, as they insure multiple unrelated individuals under a single master contract. This may allow insurance companies to avoid the rate approval processes (and sometimes other regulatory oversight functions) required of traditional individual policies. Many states have clarified the regulatory oversight for these types of arrangements. For those that haven't, the lack of clear rating and regulatory oversight can lead to situations in which consumers have no place to turn for redress.

In addition to state regulations, certain federal regulations also apply to the individual market, in particular, the Health Insurance Portability and Accountability Act (HIPAA). This law provides security that had not previously existed in the individual market. Previously, insurers could cancel blocks of policies without penalty. Under HIPAA, insurers may not cancel or non-renew policies, except for non-payment of premium as long as the insurer remains in the individual market. HIPAA also contains provisions requiring that qualified individuals leaving employer coverage have access to coverage in the individual market on a guaranteed issue basis. HIPAA does not specifically regulate the premiums for such coverage. This means that individuals who cannot satisfy underwriting criteria are still offered coverage, but at premiums that may be twice or more the rates for individuals who do satisfy underwriting criteria. Most states, however, have means to control these rates, such as offering HIPAA-eligible people coverage through a high-risk pool or some other state-regulated mechanism.

ISSUE AND RATING CONSIDERATIONS

States use insurance issue and rating regulations in an attempt to strike the appropriate balance between access to insurance and premium affordability.

Underwriting Rules and Guaranteed Issue

Insurance in the individual market is issued on either a guaranteed-issue basis or through medical underwriting. In most states, insurers require applicants to qualify for coverage through a medical underwriting process. This enables insurers to classify similar risks together and assign an appropriate premium. The underwriting process removes from a risk pool those individuals for whom large claims may be expected in the near future. Underwriting decisions are made on a person-by-person basis, even within families applying for coverage together. Some individuals will be denied coverage and others may be able to obtain coverage but at a higher premium or with exclusions for certain pre-existing conditions.[2] Still, about three-quarters of underwritten applicants are accepted as standard risks.[3]

Importantly, the underwriting event is a one time process at the time of application. Individuals who pass underwriting and are issued a policy will not need to undergo any further underwriting in order to retain that policy, regardless of health status changes, as long as premiums are paid on time.

A handful of states prohibit insurers from medical underwriting and instead require guaranteed issue for all applicants, not just those eligible under HIPAA. In those states, all applicants must be issued coverage regardless of their health status or likelihood of large medical expenses. Compared to in-

[2] Certain individuals who are denied coverage at the time of application may have access to state high-risk pools. According to the National Association of State Comprehensive Health Insurance Plans, 35 states operated high-risk pools in 2007, covering about 200,000 individuals (available at www.naschip.com, accessed on July 23, 2008).
[3] America's Health Insurance Plans. 2007. "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits" (available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf).

surance pools comprised of individuals who pass medical underwriting, guaranteed issue provisions result in insurance pools with higher average expected claims and a higher share of insureds who are expected to have claims. Higher average premiums result. This arises not only because individuals at risk of high health spending cannot be denied coverage, but also because guaranteed issue provisions can reduce the incentives for individuals to purchase coverage when their expected medical spending is low. This is especially true when guaranteed-issue provisions are accompanied by community rating provisions, which is frequently the case. As will be discussed in more detail below, under community rating all insureds (or all in a certain demographic class under adjusted community rating) pay the same premium. Individuals who anticipate low medical needs may find it less costly to delay purchasing coverage until their medical needs rise.

Premium Setting

Similar to other types of insurance coverage, premiums for individual market business are set to provide for claims, administrative expenses, margins for adverse contingencies, profit/contribution to surplus, premium taxes and other applicable state fees, and federal taxes on earnings. How these components are included in setting premiums can vary by carrier, and competition can influence where premiums are set.

Typically, factors that are used to set premiums for an individual include the benefits selected, the selected provider network, age, gender, geographic location, and perhaps policy duration. Health status may also affect premiums, as can tobacco use.

Rating Structures and Restrictions

The most common state premium rating approach for the individual market is to permit premiums to vary not only by characteristics such as age and gender but also by the individual's health status at the time of issue. Even with this approach, however, there may be some limitations on premium variations. For instance, several states impose rating bands that limit the amount that premiums can vary according to health status.

Certain states have implemented more restrictive rating requirements, which generally limit the extent to which premiums are allowed to vary among all or certain risk characteristics. General approaches that states use to restrict rating variations include:

- ***Pure community rating.*** Under pure community rating regulations, every participant in a particular insurance plan pays the same premium. Premiums cannot vary by factors such as age, gender, and health status. However, premiums can vary by family size and usually by geographic region within the state. With pure community rating, the low-risk individuals subsidize the costs of the high-risk individuals, essentially lowering the premiums for high-risk enrollees and raising the premiums for the lower-risk enrollees. New York and Vermont are two states that require pure community rating in the individual market.
- ***Adjusted community rating.*** Under adjusted community regulations, premium rates are allowed to vary, often within limits, by certain characteristics, such as age and gender. However, premiums are not allowed to vary by health status. Maine and New Jersey are two states that require adjusted community rating in the individual market.

A goal of imposing rating restrictions is to reduce the premiums for those at risk for high health costs, thereby increasing the affordability of their coverage. The compression of risk-based rates between ages, in which the rates for older individuals (e.g., over age 50) are set lower than their risk level would imply while the rates for younger individuals (e.g., below age 35) are set higher than their risk level would imply, is an example. This needs to be done carefully, however, or the rates for younger individuals will be so high compared to the perceived value of the policy that they will be disinclined to purchase coverage. This can result in an age distribution skewed more heavily toward older higher-risk ages, resulting in higher premiums for all insured individuals. As premiums increase, more of the low-risk in-

dividuals (of all ages) leave the market, causing premiums to increase even further and threatening the market's sustainability.

Yearly Premium Increases

Premiums for plans in the individual medical insurance market typically increase every year (and sometimes more frequently), primarily due to increases in claims costs. Numerous factors affect how average claims costs for a particular plan and insurer can change from year to year, and how those changes in claims costs that are factored into a plan's premiums can vary from insurer to insurer. The result is a wide variation in claims costs and in the resulting premiums between plans within an insurer and between insurers.

- ***External factors driving medical-cost increases:*** These factors reflect increases in the per-unit costs of health services (e.g., the price for a given physician visit, hospital visit, or prescription drug) as well as increases in the utilization and intensity of medical services received. These external factors, which recently have been in the 8 to 10 percent range, are common to all health insurance markets.
- ***Cost-containment factors mitigating cost increases:*** Insurers use various techniques, such as utilization management and provider-payment negotiations, both of which may become more stringent as insurers try to offset the claim cost increases that arise due to external factors. Conversely, any reduction in the stringency of these capabilities will increase the growth in claims costs.
- ***Policy duration (for medically underwritten business)***: As discussed above, where allowed, medical underwriting is used in the individual market to assess an individual's relative risk for incurring near-term health costs and to assign a premium commensurate with that risk. Coverage for undisclosed pre-existing conditions is also limited for a specified period. The result is a pattern of increasing claims costs by year since issue, commonly referred to as policy duration. In the first two policy durations, claims costs are typically low. In later durations, individuals develop health conditions and incur more claims.

  The extent to which these expected increases in claims costs translate to yearly premium increases depends in part on the insurer's pricing strategy. Some insurers will evenly spread these expected annual increases over all the premiums for the length of time an average policy will be in force, including the initial premium. This produces higher initial premiums, but lower premium increases over time. Other insurers will set lower initial premiums, but have higher premium increases to reflect more closely the pattern of these expected increases in each year. The degree to which carriers reflect the expected durational increases within each year's premiums varies considerably, and can depend on the state. Some states limit the durational effect on premiums by requiring that a larger portion of the later-year expected claims costs be included in initial and early-year premiums. Other states do not have such limits, and allow the balance between initial and renewal premiums to be adjusted by market forces.
- ***Policyholder lapses:*** In developing the initial premiums, as well as annual premium increases, insurers assume a certain percentage of policyholders will lapse, that is drop coverage. Some may secure employer-based coverage. Others, especially those at low risk for claims, may not be willing to pay the annual premium increases. They will either go without coverage or seek other coverage costing less. Lapse and re-purchase is more common if premiums increase substantially with duration. Individuals who are at lower risk for health claims may be able to purchase a new policy at a lower premium either from the current insurer or a different insurer. As a result, the average claims costs, and premiums, of those individuals retaining coverage will increase over time.
- ***Plan design effects:*** A plan's deductible levels can affect how its claims costs change over time. When total health spending increases but the deductible level is held constant, the deductible each

year represents a smaller share of the services used by the insured. Therefore, the plan's claims costs will increase more on a percentage basis than the increase in total spending. In addition, more individuals will have spending that exceeds the deductible amount. This increase in claims costs, and the associated increase in premiums, is referred to as deductible leveraging and the higher the deductible, the greater the leveraging effect will be, all other things being equal. To offset this increase, insureds who do not expect immediate health care needs may elect to increase their deductible levels in order to match their premium increase to, say, their wage increase. This practice is often referred to as a benefit buy-down.

It is important, however, to consider the effects of deductible changes in conjunction with policyholder choice and adverse selection. Individuals usually have knowledge about their expected health care expenses in the near term. They will use this knowledge to time a change in their deductible to maximize the benefits they receive. Because lower deductible plans pay a higher share of medical expenses, they tend to attract individuals who expect to incur claims in the near future. And higher deductible plans will tend to attract individuals who expect fewer claims in the near future. Some policyholders with low-deductible plans who expect low future health care needs will decide to increase their deductibles. This selection results in higher average claims costs for those remaining in the low-deductible plan. Moreover, the addition of the policyholders who are increasing their deductibles to the pool of individuals with higher deductibles could reduce the average cost of that pool. As a result, it is not uncommon for many insurers to increase premiums for low-deductible plans at or above the overall average premium increase rate while instituting the same or slightly lower premium increases for higher deductible plans. In other words, the impact of selection can offset the increases resulting from deductible leveraging of higher deductible plans.

In setting annual premiums, insurers consider the above factors. Since several of the factors operate together, the effects of a single factor on the overall trend in claims costs may be difficult to estimate. The goal is to develop the best estimate of the claims costs for the next year. Part of the process involves the correction of prior estimates; these corrections may increase or decrease the current estimate of the claims and the resulting rate increase. These help account for why premium increases can fluctuate over time and differ not only between insurers but also between plans within an insurer.

BENEFIT PACKAGES/COVERAGE

In the early days of the individual market, medical coverage offered only a limited benefit package, to keep premiums and rate increases low and to manage adverse selection. Coverage for hospitalization was limited to a fixed daily benefit payment, sometimes with a limit on the number of days per admission or per year and also a list of set-dollar fee payments for surgical procedures, with only those procedures on the list being covered. Many benefit packages did not cover office visits or prescription drugs. Over time, the benefit packages became more comprehensive in the amount and type of medical expenses covered, approximating those in the group market. Nevertheless, coverage in the individual market generally has higher out-of-pocket expense amounts than in the group market. Although lower-deductible policies are available, individuals typically choose policies with deductibles in the range of $1,000 to $1,500, with some choosing deductibles as high as $5,000 or $10,000.[4] Once the deductible is met, coverage is typically very comprehensive, unlike earlier limited benefit packages. For instance, a typical plan may require 20 percent coinsurance, but eliminates cost sharing altogether once an

[4] America's Health Insurance Plans. 2007. "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits" (available at http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf).

annual out-of-pocket threshold is reached.

In addition to higher deductible levels, medical coverage in the individual market commonly differs from typical group coverage in some areas, including:

- Normal maternity coverage (except for complications) is often excluded from benefit packages in the individual market, or offered with dollar limits and waiting periods of more than nine months before benefits are paid.
- Where allowed by a state, treatment for substance abuse, alcoholism, and mental conditions typically have annual and lifetime coverage caps.
- Pre-existing conditions for impairments unknown to the insurer at the time of application are excluded for the first one or two years following issue, as allowed by state. (Impairments known to the insurer are either covered, if minor, excluded permanently, or covered but with a premium surcharge.)

Because they pay the full premium, without any subsidies from employers, consumers in the individual market are more sensitive to premiums. As premiums have continued to climb, the individual market has reacted to this price sensitivity by reintroducing limited benefit plans. These plans, which are purchased as either the primary source of coverage or as supplemental coverage, are a small but growing share of the market. These products are modeled on some of the earlier benefit packages and do not provide comprehensive coverage or catastrophic protection. The underlying philosophy is that some coverage is better than no coverage. Some of these products provide limited outpatient benefits only, whereas others provide inpatient benefits that are limited to a fixed-dollar amount per day and/or are capped at a specific number of days per year. The desire for lower premiums is driving the demand for these types of benefits. Some states prohibit these types of policies and some require that policies with limited benefits properly disclose that to consumers.

ADMINISTRATIVE COSTS AND OTHER CHARGES

Administrative costs and other charges include those used to cover the costs of marketing and selling the insurance and the managing of the policy after it is sold. Because administrative costs, risk/profit charges, and state fees are higher in the individual market, a lower share of premiums goes to pay benefits in the individual market compared to that in employer-sponsored group insurance.

Loss ratios, which are the measure of premiums that go to health claims, provide information on the share of premiums that go to administrative costs and other expenses. Typical loss ratios in the individual market, which is the share of premiums that go toward paying claims, average about 65 to 70 percent. That means on average 30 to 35 percent of the premium is used toward administrative expenses, risk charges, premium taxes, and profit/contribution to surplus. In comparison, loss ratios average about 75 to 85 percent for employer-sponsored group coverage and can be as high as 95 percent for very large self-funded plans.

Comparing the loss ratios for employer-sponsored group insurance to those in the individual market can be misleading, however. Large employers have human resource departments that support employees and dependents with benefit questions. In the individual market, these are handled by the agent/insurance company. The costs of the human resource departments are not reflected in the administrative costs for the large employers, but the analogous costs for individual contracts are reflected in the premium.

Distribution costs, which cover the costs of advertising, member acquisition, and commissions to agents and brokers, can make up a large share of administrative costs, particularly in the individual market. Individual health coverage has traditionally been sold through salaried employees of the carrier, or more typically, through independent commissioned agents. Commissions can either be level over the life of the policy, say 5 to 10 percent of the premium, or can be tiered

with higher commissions in the first year, as high as 20 to 30 percent in the first year, 5 to 10 percent for the next few years, and then as low as 0 to 2 percent thereafter. Even with the advent of insurance sales over the Internet, insurers need to provide licensed agents on staff in their administrative offices to respond to applicant questions relating to benefit options on the application.

In addition to distribution costs, insurers also incur administrative costs for billing and enrollment, underwriting, claims adjudication, customer service, information technology support, and regulatory compliance.

PUBLIC POLICY IMPLICATIONS

In an attempt to reduce the number of uninsured, many recent federal health reform proposals would expand or restructure the individual market. For instance, some proposals would extend the favorable income tax treatment of health insurance to the individual market, or otherwise make the tax incentives for health insurance more consistent between the individual and group markets. Other proposals would allow for the purchase of insurance across state lines or allow for cross-state insurance pooling. And others would merge the individual and small group markets.

Whether such attempts would succeed depends, in part, on how changes to the rules and regulations governing the individual market are structured. It is important to strike the appropriate balance between access to coverage and premium affordability. This is especially important in a voluntary market, where a key to sustainability is managing adverse selection.

Currently, states have chosen varying regulatory strategies with respect to the individual market, with disparate effects on access and affordability. To increase access to health insurance for higher risk individuals, some states have imposed guaranteed issue and community rating requirements. Because these provisions can exacerbate adverse selection, however, higher average premiums result. Other states allow insurers to underwrite and to incorporate health status factors into the premium rates charged to individuals. These provisions can help keep average premiums lower by managing adverse selection risk. On the other hand, they can also decrease access to insurance for higher-risk individuals.

Increasing overall participation in health insurance plans, in particular among those with average or lower-than-average claims costs for their risk class, would be one of the most effective ways to minimize adverse selection. In that way, there would be enough healthy participants over which to spread the costs of those with high health costs. Aside from mandating coverage—which wouldn't necessarily guarantee 100 percent participation—potential options to help minimize adverse selection include providing premium subsidies or penalizing delayed insurance purchase through higher premiums (as it is with Medicare Parts B and D) and/or lower benefits. Implementing risk-adjustment mechanisms could also be used to mitigate the impact of adverse selection on a particular insurer.

Nevertheless, efforts to reduce the number of uninsured through any insurance reforms may be in vain if the growth in health care costs is not addressed. Doing more to control the growth in health spending is essential to a more sustainable health insurance system.

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