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Our Own Worst Enemies

Explaining Premium Increases in the Individual Health Insurance Market

Health care costs in the individual (i.e., non-group) market have been rising rapidly compared to the consumer price index (CPI), and the increases have, in turn, put upward pressure on health insurance premiums. Similar trends have occurred in the small and large group markets for many of the same reasons, but to a lesser extent.

Employers, consumers and especially legislators want to know why the problem has occurred and, more important, how to resolve it. What they need to understand is that all three parties, but especially legislators and the policies they adopt, are responsible for the increases.

What Is Driving Up Costs in the Individual Market? Four key factors are putting upward pressure on health insurance premiums, and an additional five *could* be significant under certain circumstances, but overall are likely to have a minimal effect on premiums. The magnitude of impact from these factors varies considerably from state to state, depending on state laws and regulations — just as the price of a new car varies significantly depending on the options the buyer chooses. Some states have virtually destroyed the individual market for health insurance, while in other states policies are available and affordable.

Key Factor: Cost Shifting. One of the primary factors affecting the cost of premiums in the individual market is cost shifting. When one person or group negotiates lower prices for the cost of care, others may pay more, just as squeezing one end of a balloon does not make it smaller, it just forces the other end to expand. Small squeezes result in imperceptible expansions; big squeezes mean big expansions. Government health insurance programs (Medicare and Medicaid), managed care companies and large employer programs have the numbers to negotiate very low prices for care.

The individual market, by contrast, has little collective power to negotiate big discounts, which means that provider charges are high in the individual market relative to the other markets. The cumulative effect of cost shifting has been to increase the cost of premiums between 15 and 50 percent, depending on the geographic region and the risk assumed by the insurers. [See the table.]

Factors Driving Up Premiums in the Individual Health Insurance Market

Factor	Estimated Range of Increase
Cost Shifting	15-50%
Mandated Benefits	5-45%
Underwriting & Rating Restrictions	0-100%+
Comprehensive vs. Basic Benefit Packages	0-30%
Tax Equity	Affordability Effect Only
The Uninsured	Minimal Effect
Small Group Market Reform	Minimal Effect
Administrative Costs	An Increase Relative to Group
Litigation	5% or Less
Composite	**20% - 225%**

Key Factor: Mandated Benefits. Both the federal and state legislatures mandate health insurance to cover certain benefits such as chiropractic services, mental health care, or drug and alcohol abuse counseling. Many of these mandates require people to buy coverage they do not want or need. Mandate proponents claim that requiring insurance to cover additional services will lower health care costs (e.g., chiropractic care reduces costs because chiropractors generally charge less than medical doctors). However, mandates encourage people to increase their utilization beyond what they might otherwise use, since they bear only a small part of the cost.

Such mandates have proliferated over the years. Although the impact varies by state, mandates have increased the cost of health insurance in the individual market between 5 and 45 percent, with many states experiencing cumulative increases in the range of 20 to 30 percent.

Key Factor: Underwriting and Rating Restrictions. Some states have limited insurers' ability to underwrite or vary premiums according to risk. For example, New York and New Jersey require all insurers to accept everyone applying for health insurance (guaranteed issue) in the individual market. In addition, insurers either must

charge everyone the same rate regardless of their health status (community rating) or permit only slight price variations.

As a result, healthy people drop out of the pool because they know they can return if they get sick. As the pool gets smaller and sicker, health insurance premiums soar. [See CAHI Issues & Answers No. 104, "What Were These States Thinking?"]

States such as Wisconsin and Illinois have not passed such restrictions, so premiums for their residents have not been adversely affected. They also have provided a less-expensive alternative for those who are uninsurable: high-risk pools. Thus the range of impact varies from 0 to 100 percent or more, depending on whether a state has implemented such "reforms."

Key Factor: Comprehensive vs. Basic Benefit Packages. Individuals who want and purchase comprehensive policies tend to have above average utilization — both because they need more care and because they are insulated from the cost of that care — while those with very basic policies or high deductibles tend to have below-average utilization.

Employees want and employers have provided comprehensive coverage because the workers get a tax break for employer-provided coverage and employers often pay most or all of the premiums. The result has been very high utilization and little focus on costs, which has been a significant factor in driving up health care spending in the group market.

While the I-want-everything-covered mentality has carried over in the individual market to some extent, rising premium costs over the years have led people in the individual market to reduce their coverage by going to higher deductibles or other options.

The additional utilization of services in the individual market, although less than the group market, has led to an increase in premium costs of between 0 and 30 percent, with the leaner plans producing virtually no extra utilization and the richest plans producing 30 percent higher utilization.

Minor Factor: Tax Equity. Under current tax law, workers getting employer-provided health insurance get a tax exclusion (i.e., they pay no taxes on the money an employer spends on the coverage). This year the self-employed will get a 70 percent deduction. However, those who work for employers who do not provide health insurance must buy their insurance with after-tax dollars.

The financial incentives encourage workers with employer-provided coverage to be overinsured, using insurance for services they could easily pay for out of pocket. By contrast, many workers without employer-provided coverage struggle to pay for even a basic policy.

Minor Factor: The Uninsured. Only about one-fourth of the 39 million Americans without health insurance are chronically uninsured, which means they will remain uninsured for more than 12 months. The rest tend to move in and out of health coverage every four to six months, primarily because they or a spouse are changing jobs. Experience suggests that when these individuals are uninsured, their average utilization is between 50 and 70 percent of those who are continuously insured. However, when these same individuals become insured, their utilization rises to 180 and 200 percent of the continuously insured group.

Minor Factor: Small Group Market Reform. As the small group market has collapsed in a number of states due to growing regulations and escalating costs, people have sometimes moved to the individual market. There is no clear evidence that the average costs for the group that moved are substantially different than those already in the individual market. However, HIPAA-eligible individuals moving from small or large groups to the individual market have led to higher costs and trends in the latter.

Minor Factor: Administrative Costs. The individual market has higher administrative costs than group markets because of underwriting and commissions. Total administrative costs typically range from 25 to 30 percent in the individual market, average 20 percent in the small group market, and dwindle to 10 to 15 percent in the large group market.

Minor Factor: Litigation. Although the impact of litigation on premiums in the individual market is increasing, it is still relatively small. The premium increases are a result of defensive medicine — in which doctors overtreat patients to protect themselves from malpractice claims — and from the costs doctors and hospitals incur in defending themselves and paying awards. However, such costs are still, on average, less than 5 percent of total costs.

Conclusion. The first four factors discussed above clearly have affected cost-increasing trends in the individual health insurance market and explain why premium increases substantially exceed increases in the CPI. As the table shows, the cumulative effect of all the factors has pushed premiums up by at least 20 percent, and in some states as much as 225 percent. The upward trend could be moderated or even reversed if consumers, employers and legislators embraced lower-cost basic coverage or high-deductible polices and stopped trying to micromanage the system. If not, Americans have only themselves to blame for the high cost of health care.

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