An Undergraduate Honors Thesis:
How Will the Patient Protection and Affordable Care Act Affect the Market for Individually Purchased Health Insurance?

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Abstract

In contrast to employer-sponsored or public insurance, individually purchased health insurance is the market in which consumers purchase non-group, private insurance. The individual market for health insurance is about to undergo a significant transformation with the introduction of health insurance exchanges. Despite the importance of this issue, prior analysis of this particular market is somewhat limited. A description of consumers in this market will offer insight into who currently relies on this market for insurance. Furthermore, looking at the supply and demand of the current market will provide information on price and its’ determinants. Analysis of data from the 2009 Medical Expenditure Panel Survey will provide further insight into the consumer profile in the non-group market. This data set comes from the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality and is available for public use. Examining the current private non-group market for insurance will provide a better picture of what is necessary to improve it, and how the Patient Protection and Affordable Care Act may affect it in the future.
Introduction

The individual market for health insurance is about to undergo a significant transformation with the planned introduction of health insurance exchanges in 2014 under the Patient Protection and Affordable Care Act. Prior analysis of this particular market is somewhat limited as it has thus far been considered a marginal market and has not been examined as thoroughly as the system of employer provided health insurance. Examining the current private non-group market for health insurance will provide a better picture of what is necessary to improve it. More specifically, a description of consumers in this market, including their demographics and employment status, will offer insight into who currently relies on this market for insurance. Furthermore, looking at the supply and demand of the current market will provide information on price and its determinants.

Identifying the main issues in the current market for health insurance is useful in thinking through how the future market for individual health insurance may change due to the Patient Protection and Affordable Care Act. In terms of what the future holds for the non-group market for health insurance, we expect its size to grow, and for it to provide a more viable source of coverage for those employed by small employers, those who are self-employed, and those who are uninsured. In addition, there may be a possible increase in the number of early retirees, as well as a shift from employer-sponsored insurance toward state-run exchanges. Moreover, both supply and demand in the future market will increase following the creation of insurance exchanges.

An improved individual market in the future will also impact the manner in which consumers purchase insurance. Mainly, there will be state-run insurance exchanges and
subsidies provided based on poverty level indices. Subsidies will be aimed at facilitating the purchase of insurance by individuals. Although the future market will be federally regulated by the PPACA, variance among the states will still exist. Examining the percentage of people insured in certain states, as well as those states’ health insurance regulations, will illustrate how regulations affect access.

Analysis of data from the 2009 Medical Expenditure Panel Survey will provide further insight into the consumer profile in the non-group health insurance market. This data set comes from the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality and it is available for public use. This data includes consumer-reported information on insurance status, demographics, access to care, employment, health status, and quality of care.
Description of Current Market for Individually Purchased Insurance

Description of Consumers

A description of consumers in the individual insurance market is necessary in order to gain a better understanding of those who purchase individual, private health insurance. According to Michael A. Morrisey, only 6-7% of those people aged 65 and under living in the United States report having private, individual insurance (2007). Morrisey cites that much of the data on the individual market comes from a study done by Ziller and colleagues in 2004 by examining the Survey of Income and Program Participation from 1996-2000 from the U.S. Census Bureau. In this study, Ziller and colleagues were able to identify that more middle-aged people than any other age group report having this type of insurance. This was about 46%, including age ranges from about 45 – 64 years of age (Morrisey). It is concluded both by Morrisey and the Ziller and Colleague study, that the group of people with individual private insurance is quite “homogenous” in terms of age and employment status, and therefore, in spite of the shorter duration of time in comparison to other insurance, it is often stated that it is a rather stable market.

In terms of employment status, most individuals in the private market, about 75% according to Ziller and Colleagues, are employed. Of the remainder, about 22% are not in the workforce and approximately 3% are unemployed. This data comes from a 2004 study by Ziller and Colleagues. According to Morrisey, these consumers who are unemployed but purchasing insurance in the private individual market see it as “transitory coverage” in between jobs in
which they receive employer-sponsored insurance. For this reason, the duration of holding individual health insurance is mainly for six months or less according to Ziller et. al.

Morrisey offers three roles of the individual insurance market with regards to consumers and their employment status. The first is to provide coverage to middle-aged people who are either self-employed or employed by small firms that do not offer coverage. This coverage ends when Medicare begins for these consumers at the age of 65. Second, its’ role is to provide “transitional coverage” in between full time jobs and those plans offered by employers. Finally, this market provides coverage for those who are unemployed, in spite of the short amount of time those consumers are insured (Morrisey).

Other descriptions of consumers in the individual market include increased familiarity with technology. The use of the Internet to obtain plan and premium info is increasing (Morrisey). Furthermore, Morrisey states that “some individuals, particularly, younger, healthier, people, can benefit from Internet searches for coverage.” A shorter amount of time spent comparing plans and the lower premiums they find on the Internet are two advantages of using technology to purchase insurance.

Another aspect of the market that must be considered in relation to consumers is the context. In the New England Journal of Medicine, an article titled “Health Insurance Exchanges – Key Link in a Better Value Chain,” Jon Kingsdale discusses characteristics of consumers in the private market. Kingsdale states “Individuals and small employers are also relatively weak buyers. They cannot afford to employ benefit specialists (used by large companies and unions), and they lack the scale to negotiate from a position of strength” (2010). Kingsdale emphasizes
that those in the private market have little to no power in comparison to those in the public or employer-sponsored market, who possess negotiating power from numbers. This is often cited as a contributing factor to higher premiums in the individual market compared to the group and public insurance markets.

Description of Firms

There are a small number of insurers in many states’ health insurance markets, measured by the Herfindahl-Hirschman Index, HHI (Kaiser Family Foundation). In an October 2011 document titled, “How Competitive are State Markets?” the Kaiser Family foundation cites using the HHI to examine the number of providers of insurers in a given area. The HHI ranges from 0 to 10,000, with a score of 0 meaning a perfectly competitive market and a score of 10,000 meaning a monopoly. According to this, the median HHI for the individual market was 3,761. This HHI indicates that in the majority of states, there is little competition in the individual insurance market, as a result of the low number of insurance providers. Since there are few providers, the ones that do exist have a lot of power and are able to dictate prices to consumers.

Problems with the Current Market for Individual Insurance

A major issue with the current private individual market is the high cost of obtaining insurance outside of a public program or employer, as well as the lack of transparency of information on plans and premiums offered in this market. A 2009 article in the New England Journal of Medicine, called “Health Insurance Exchanges – Making the Markets Work,” addresses this issue. The authors, Richard G. Frank, Ph.D. and Richard J. Zeckhauser, Ph.D.
state “consumers are rarely well-equipped to deal with markets offering large numbers of complex, expensive, hard-to-evaluate products, that as in the case of health insurance policies, may be critical to their well-being. Consumers facing complex, high-stakes choices are prone to predictable errors” (2009). Since making a decision about health insurance can be seen as a matter of life or death, the lack of transparency in this market is a major problem. Providers should display premiums and plan description in a clear manner, rather than making it difficult for the consumer to find or understand information.

There are extremely high administrative costs in the United States health insurance market (McKinsey Report). Due to the high administrative costs associated with administering health insurance, the nongroup market faces a unique problem compared to the public and employer markets. This is mainly attributed to the fragmented U.S. health care system. Since the private individual market is much smaller than the previous mentioned markets, the administration costs are spread out over fewer people, so there are fewer premiums; therefore the costs are higher for individuals.

Another issue in the private, individual market is adverse selection. Timothy Stoltzfus Jost defines adverse selection in a study entitled “Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues” for The Commonwealth Fund. Jost states that adverse selection is “the disproportionate purchase of health insurance by the least healthy individuals.” Furthermore, Jost lists adverse selection as a main issue in the individual market and one that must be addressed by the Affordable Care Act and health exchanges.
In “Health Insurance,” Morrisey discusses adverse selection in the individual market with regards to the similar characteristics shared by many consumers. In a 2003 study, Hadley and Reschovsky found that higher-risk individuals “may migrate to public or employer-sponsored coverage. Furthermore, this study looked at health status in relation to individual market premiums and concluded that it has quite an impact on premiums. Two examples from this study are the fact that those with a “minor” health problem paid a premium that was about 15% higher than those who were considered to be in “excellent” health. In addition, those with “major” health problems paid about 43-50% higher premiums than those with “excellent” health.

Supply and Demand of Current Market for Health Insurance

The supply and demand of the current market for individual health insurance differ greatly from the employer-sponsored insurance markets and the public insurance markets of Medicare and Medicaid. First of all, the small number of insurers in many states’ markets discussed earlier indicates that in the majority of states, there is little competition in the individual insurance market. Therefore, the supply for individual insurance is limited by the large market share many insurers have in each state.

In addition, since there is currently no cost sharing or subsidies in the individual market for insurance, the number of people demanding nongroup coverage is much lower than the demand for employer-sponsored or public insurance. Furthermore, the lack of choices in this market due to the low number of insurance providers discussed above affects consumer demand because it would increase significantly if more choices existed. Another factor that
affects consumer demand is the transparency and availability of information. In such a fragmented market with little buying power, it can be difficult and costly for individuals to find reliable information on insurance premiums and plan descriptions.

Technology has greatly impacted the supply and demand of healthcare and services. Websites such as ehealthinsurance.com and online-health-insurance.com, increase both the supply and demand of health insurance because they increase access for consumers and employers (Morrisey). By increasing access for consumers, technology increases the demand for health insurance. Using the Internet facilitates the search and comparison of plans for consumers, allowing them to potentially find lower prices and better plans. In contrast to the advantages created by technology, the lack of transparency and availability of information that exists in the individual market for health insurance decreases the demand for consumers. Since this information is often not readily available for consumers to access, they are less likely to purchase it. In addition, information on individual plans such as premiums, deductibles and services included can be difficult to interpret.
The Patient Protection and Affordable Care Act

Three Provisions Affecting the Individual Market

There are several changes created by Patient Protection and Affordable Care Act that affect the Individual market for insurance. According to the Kaiser Family Foundation, here are the three main changes that will affect those in the individual market for insurance. All of the following information comes from the Kaiser Family Foundation’s “Summary of New Health Reform Law” document. Note that I set aside for now the question of whether the Affordable Care Act will survive the legal challenges it currently faces.

First of all, the creation of an individual mandate will require that all U.S. citizens and residents have health insurance. This will require those who are uninsured, and would otherwise make up the consumer population in the private non-group market, to purchase insurance. The penalty for not having coverage is a tax penalty of $695 each year, up to three years, or 2.5% of income from a household. This penalty will take full effect in 2016 as it will be phased in with lower penalties each year prior to 2016. After 2016, the penalty will increase each year in accordance with the cost of living. As for exceptions from the individual mandate for insurance, the PPACA lists financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, those with incomes lower than tax filing threshold, and incarcerated individuals.

Second of all, the expansion of Medicaid to cover all American citizens under the age of 65 with incomes up to 133% Federal Poverty Level will increase the number of Americans insured. This expansion will guarantee that these citizens will receive a benchmark benefit
package that has the same benefits as those offered in the exchanges. Third of all, the creation of health insurance exchanges and tax subsidies to pay for insurance within these exchanges will increase coverage for many U.S. citizens currently uninsured. This may also reduce the cost for those citizens already paying for plans in the individual market. There will be premium credits offered for families with incomes of FPL between 133% - 400%. With regards to subsidies and poverty level, the PPACA will require that individuals verify income and citizenship status in order to determine eligibility for subsidies offered.

<table>
<thead>
<tr>
<th>Percentage of Federal Poverty Level (FPL)</th>
<th>Premium contribution &amp; Percentage of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 133% FPL</td>
<td>2% of income</td>
</tr>
<tr>
<td>133 – 150% FPL</td>
<td>3-4% of income</td>
</tr>
<tr>
<td>150 – 200% FPL</td>
<td>4-6.3% of income</td>
</tr>
<tr>
<td>200 – 250% FPL</td>
<td>6.3-8.05% of income</td>
</tr>
<tr>
<td>250 – 300% FPL</td>
<td>8.05-9.5% of income</td>
</tr>
<tr>
<td>300 – 400% FPL</td>
<td>9.5% of income</td>
</tr>
</tbody>
</table>

Note: Table showing premium credits available for eligible individuals and families to purchase insurance through exchanges. Kaiser Family Foundation, 2011.

The creation of state based health exchanges, known as “American Health Benefit Exchanges” and “Small Business Health Options Program” Exchanges will dramatically increase access for U.S. citizens currently without insurance or paying for insurance in the private market. The exchanges are required to offer at least two multi-state plans in each exchange that will serve as a type of public option for consumers. At least one must be from a non-profit entity, and they both must be licensed in each state and meet certain qualifications. According to the Kaiser Family Foundation, the exchanges must be administered by a state agency or a non-for-profit entity and must offer insurance to individuals and employers with up to 100 employees. Furthermore, as long as the exchange is for a specified geographic area, states are
permitted to create regional exchanges. This may reduce administrative costs to administer insurance through exchanges because these costs would be spread out over more people. Also, an advantage of state exchanges is that each state, or region, is able to cater to its own citizens’ needs for health insurance based on the current supply and demand in the market. The creation of state-based health exchanges will significantly change the manner in which individuals are able to purchase health insurance.

Supreme Court Issues

Currently, there are two main provisions of the ACA that are being considered in the United States Supreme Court. The first is the constitutionality of the individual mandate and the second is the expansion of Medicaid. Twenty-six states, led by Florida, are arguing that these two provisions in the Affordable Care Act are not constitutional since they violate the Commerce Clause, the Necessary and Proper Clause, and Taxing power. Essentially, the States believe Congress and the Federal government are over regulating among the states and taking away the power granted by the Constitution to each state. The outcomes of these cases in the Supreme Court will affect whether the individual mandate and the expansion of Medicaid will in fact occur. If they are found to be unconstitutional, the entire Affordable Care Act may be undermined since the Act heavily relies on these two provisions to provide health insurance to individuals (Kaiser Family Foundation).
Data and Method

Analysis of data from the 2009 Medical Expenditure Panel Survey will provide further insight into the consumer profile in the non-group health insurance market. This data set comes from the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality and is available for public use. This data includes consumer-reported information on insurance status, income, demographics, access to care, employment, health status, and quality of care. It is the most complete data set on insurance coverage and the cost and use of health care.

In order to interpret this data to compare the population with individual health insurance to those with employer insurance and with no insurance, certain variables required isolation. Statistical analysis using Stata software was used to isolate those who reported being covered by non-group Insurance, employer Insurance, and no insurance. Then variables were chosen to describe and compare the above groups based on age, education, health status, utilization, and income. Finally, Stata was used to calculate the mean of each variable for each group. After identifying the mean of each variable for each group, they were compared and further data analysis was performed based on the results.
Results

Below is a table showing the mean of each variable with respect to those covered by non-group insurance, employer insurance, and no insurance.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Non-Group Insurance</th>
<th>Employer Insurance</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>45.21 yrs</td>
<td>36.01 yrs</td>
<td>34.43 yrs</td>
</tr>
<tr>
<td>Perceived Health Status</td>
<td>2.08</td>
<td>2.06</td>
<td>2.32</td>
</tr>
<tr>
<td># Office Based Provider Visits</td>
<td>5.86</td>
<td>4.64</td>
<td>1.5</td>
</tr>
<tr>
<td># Emergency Room Visits</td>
<td>.129</td>
<td>.141</td>
<td>.145</td>
</tr>
<tr>
<td># Prescription Med Refills</td>
<td>12.55</td>
<td>8.14</td>
<td>3.33</td>
</tr>
<tr>
<td># Hospital Discharges</td>
<td>.096</td>
<td>.069</td>
<td>.037</td>
</tr>
<tr>
<td>Family’s Total Income</td>
<td>$62,008.67</td>
<td>$80,022.89</td>
<td>$39,253.0</td>
</tr>
<tr>
<td>Number of Years in School</td>
<td>12.57 years</td>
<td>11.94 years</td>
<td>10.57 years</td>
</tr>
<tr>
<td>Positive Cancer Diagnosis</td>
<td>16.11%</td>
<td>7.47%</td>
<td>2.19%</td>
</tr>
</tbody>
</table>

The following conclusions were drawn after the data analysis. For education, those covered by non-group insurance went to school on average 2 years longer than those who are uninsured. For health status, the percentage of those covered by non-group insurance with a positive cancer diagnosis was 16% compared to only 2% for the uninsured, meaning those who with non-group insurance may have purchased insurance due to illness. With regards to health care utilization, those with non-group insurance use more care than those who are uninsured or have employer insurance. This was shown especially with the high number of average prescription medication refills and office-based visits for those with individual insurance. Finally, those with employer insurance had the highest income, followed by those with non-group insurance. The uninsured had the lowest average income.
In terms of age, those covered by non-group insurance are on average older than those covered by employer insurance or not covered at all. Since the mean age for those with individual insurance was around 45 years and the mean age for those in the other two groups was around 35 years, further analysis was necessary to examine this difference. The following figures display the distribution of age among each group.

The Distribution of Age in Group with Non-Group Insurance.

The Distribution of Age in the Group with Employer Insurance.
The Distribution of Age in the Uninsured.

The figures above are consistent with industry data discussed earlier in the description of consumers in the current market. Within the group with non-group health insurance, there was quite a uniform age, however the distribution was higher among those aged 60 and above. Within the group with employer insurance, the distribution of age was high for those under 20, presumably covered by parents’ insurance. In addition, it showed a very low distribution of employer insurance among those aged 60 and older since that is when retirement occurs. Finally, within the uninsured group, the distribution of age was highest among those between 20 years and 40 years, suggesting a younger population lives without insurance.
About half of those covered by non-group insurance aged 17-23 were full time students. Only around a quarter of those uninsured aged 17-23 were full time students. The graph below shows the distribution of full time students compared to part-time or non-students in each group. This suggests that the group purchasing individual insurance and those with employer insurance may be more similar to each other than to the uninsured. It also suggests those who decide to purchase insurance may be slightly more educated than those without insurance.

Graph of Proportion of Students to Non-Students in Each Group.
Conclusion

An estimated 17% of the population under the age of 65 will benefit from the ACA provisions (Kaiser Family Foundation). The groups purchasing individual insurance and the uninsured will now be combined, assuming that the individual mandate is binding in the future. Therefore, the demographics of the combined group will be a combination of those currently purchasing insurance, older and not as healthy, with those who are uninsured, younger and healthier. This will result in a more stable group altogether. Furthermore, there will be more choice for consumers of the individual insurance market, easier access, and an increase in demand due to the Individual mandate. There will also be an increase in supply of plans because the exchanges will facilitate access into the market for suppliers. More competition in exchanges should lower plan premiums for the non-group insurance market. While these seem like positive implications for the market for individual health insurance, the future of this market depends on the impending Supreme Court decision about the constitutionality of the individual mandate and Medicaid expansion.
References


