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# Market Failure in the United States Health Insurance Market

**Characterization, externalities, and co-regulation.**



Photo by [Volodymyr](#)

The United States healthcare industry represents a critical component of the nation's economy and the well-being of its citizens. Central to this industry is the health insurance market, valued at USD 1.60 trillion in 2022 (Grand View Research, 2023). Health insurance mitigates the financial risk associated with healthcare costs by pooling resources and redistributing them across individuals and time, based on the occurrence of health-related events (HealthCare.gov, n.d.). The U.S. health insurance market is characterized by a mix of private and public insurance programs (NAIC, 2023). This complex ecosystem is influenced by numerous factors including policy regulations, market dynamics, and consumer behavior.

The health insurance market in the United States is particularly susceptible to market failures, phenomena where market outcomes are not Pareto efficient, meaning that resources could be reallocated in a way that would make at least one individual better off without making anyone else worse off (CoreEcon 2022). Three primary sources of market failure in this context are information asymmetry, concentration of market power, and externalities.

## **Key Features of the U.S. Health Insurance Market**

### **Market Structure**

The U.S. health insurance market encompasses private health insurance companies, government-sponsored programs, and exchanges

established under the Affordable Care Act (ACA (American Medical Association, 2021). Private insurers (for-profit and nonprofit organizations) offer coverage through employer-sponsored plans, the individual market, and managed care plans (HealthCare.gov, n.d.). Government programs: Medicare provides coverage for individuals aged 65 and above and certain younger people with disabilities; Medicaid targets low-income individuals and families (Chan et al., 2023). The ACA marketplaces, introduced a structured platform for purchasing health insurance, offering plans complying with standardized coverage levels and consumer protections.

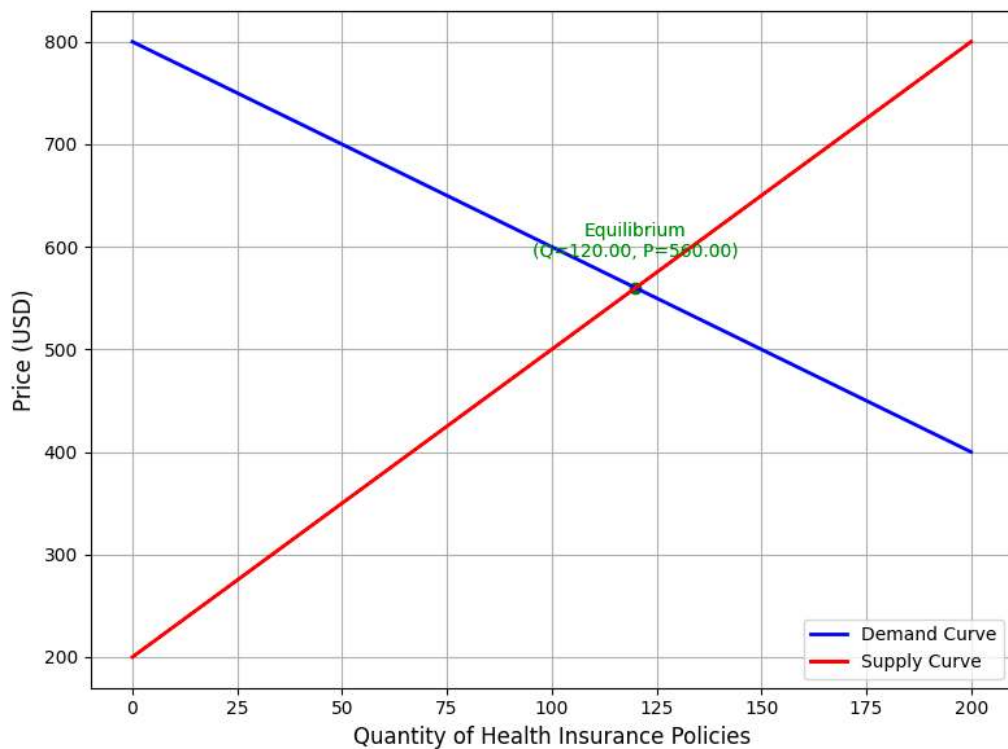
### **Demand and Supply Dynamics**

The demand for health insurance in the U.S. is influenced by various factors, including demographics, income, health status, and the legal mandate to obtain coverage. Demand tends to increase with aging populations due to higher expected healthcare needs and with rising incomes, as individuals and families prioritize health security. Health status, encompassing both current conditions and potential health risks, also significantly influences demand, as those with existing health issues or at high risk seek more comprehensive coverage (Kettlewell & Zhang, 2024).

On the supply side, the number of insurers and the variety of policy offerings are shaped by market competition, regulatory environments, and the insurers' risk management strategies (Yaskevich, 2022). Supply dynamics are further complicated by insurers' efforts to balance risk pools, manage healthcare provider networks, and innovate in coverage options to meet diverse consumer needs (Samuel et al., 2010).

### **Figure 1**

Demand and Supply in the Health Insurance Market



*Note.* The downward-sloping demand curve signifies the inverse relationship between the price and the quantity of health insurance demanded, influenced by demographics (older = more services need), income (richer = avails more services), and health status (high risk = more comprehensive coverage). Conversely, the upward-sloping supply curve reflects a direct relationship, where higher prices prompt insurers to offer more policies, shaped by market competition, regulatory environments, and risk management strategies. The equilibrium point, marking the balance between demand and supply, is strategically non-central, emphasizing the complex interplay of factors dynamics of demand and supply, noting how demographic shifts, income levels, and health statuses drive the demand for health insurance, while supply is intricately shaped by insurers' strategic responses to market competition and regulatory landscapes. This examination illuminated the multifaceted nature of the health insurance market, revealing the delicate balance policymakers and insurers must navigate to align consumer health needs with the market's capacity to supply beyond mere price adjustments. This equilibrium underscores the nuanced economic, demographic, and regulatory forces that uniquely affect the health insurance market, illustrating the intricate balance required to meet consumer needs while ensuring insurers' willingness to supply.

#### **Nature of Market Failure in the Health Insurance Market**

##### **Information Asymmetry**

Information asymmetry is a pervasive issue in the health insurance market, manifesting primarily through adverse selection and moral hazard (Mwachofi & Al-Assaf, n.d.; Gerfin, 2019; Johnson, 2021).

Adverse selection occurs when individuals more likely to require care are more inclined to purchase health insurance or opt for higher levels of coverage. Information disparity between consumers (who have better knowledge of their health) and insurers (who cannot discriminate between low/high-risk individuals without incurring substantial costs) leads to a market where premiums rise to cover the expected higher costs. This can drive healthier individuals out of the market.

Moral hazard refers to when insured individuals engage in riskier behaviors or consume healthcare services more extensively compared to if they bore the full cost. Such individuals might be less incentivized to maintain a healthy lifestyle, leading to inefficient overutilization of healthcare.

### **Concentration of Market Power**

According to a comprehensive study by the American Medical Association (2021), the majority of U.S. health insurance markets are highly concentrated, with an increase in average market concentration from 2014 to 2022. In 48% of metropolitan statistical area-level markets, a single insurer had a market share of at least 50%. This concentration can lead to monopolistic or oligopolistic market structures, where the dominant insurers have significant control over pricing, the scope of coverage, and the availability of services (Nussbaum, 2017). The lack of competitive pressure may diminish incentives for insurers to innovate, adversely affecting the overall quality and accessibility of healthcare (Bisceglia et al., 2021).

### **Externalities**

Externalities in the health insurance market, particularly positive externalities associated with public health outcomes, are often inadequately addressed by private insurers. Healthcare services, especially preventive care and vaccinations, generate benefits that extend beyond the individual consumer to society at large, such as reduced disease transmission rates and improved public health (Hempstead, 2017). However, because these broader societal benefits

are not captured by private insurers in their pricing/coverage decisions, they tend to underprovide these services (Starc & Town, 2019).

### **Impacts of Market Failure**

#### **Individuals**

Information asymmetry can lead individuals to select inappropriate insurance plans, either underinsured or overinsured. This directly impacts their financial stability and access to healthcare services. Individuals with low-income or chronic health conditions face the brunt of these market failures (Johnson, 2021). High costs and complex insurance products limit their access to comprehensive care, resulting in delayed treatments, increased emergency room visits, and poorer health outcomes (Brodwin, 2021).

#### **Groups**

Low-income families often struggle with the high cost of premiums and may forgo insurance, leading to a lack of preventive care and higher instances of untreated chronic conditions (Aron-Dine, 2019). The elderly, covered primarily by Medicare, may find gaps in coverage, especially for long-term care and prescription drugs, affecting their health and financial well-being (Fiedler, 2021). People with pre-existing conditions may still encounter difficulties in finding affordable, comprehensive coverage.

#### **The National Economy**

Inefficient allocation of resources leads to higher healthcare expenditures without corresponding improvements in health outcomes. Poor health limits individuals' ability to work. It also increases national healthcare expenditures, diverting funds from other critical areas of the economy (McGough et al., 2023; Turner et al., 2023).

Employment is also affected, as businesses face higher insurance costs for employees. This could limit job growth and wage increases (Rhyon & Miller, n.d.). The healthcare sector's focus on treating illnesses rather than preventive care contributes to a cycle of high medical spending with suboptimal health improvements.

#### **International Comparison**

Countries with single-payer systems, such as Canada, provide coverage

to all citizens (Axenehp, 2019). While the system has its challenges, like potential wait times for services, they offer lessons in achieving more equitable health outcomes (Carroll, 2023).

### **A Solution—Co-Regulation**

While ACA's provisions aim to reduce information asymmetry through standardized plan information and the creation of exchanges; limit the concentration of market power via antitrust laws and market entry regulations; and mitigate externalities through the expansion of Medicaid, inequality remains rampant (Centers for Medicare & Medicaid Services, 2020; American Hospital Association, 2023).

In the telecommunications industry, the Federal Communications Commission's (FCC) co-regulation has significantly improved market transparency and consumer satisfaction (Senate and House of Representatives of the United States of America in Congress, 1932). A proposal for the U.S. health insurance market could involve the establishment of a Health Insurance Transparency and Engagement Committee (HITEC). This committee would be a body comprising representatives from health insurance, consumer advocacy groups, healthcare providers, and government regulators.

### **A Digital Platform for Plans Comparison**

A concrete initiative under HITEC could be the creation of a standardized digital platform where consumers can easily compare insurance plans based on coverage, price, ratings, and patient outcomes. This platform facilitates better consumer decisions and incentivizes insurers to compete on value and quality.

However, the effectiveness of HITEC would hinge on several factors:

1. **Consumer Engagement.** The success of the standardized digital platform depends on active consumer engagement. The platform should be user-friendly and widely marketed for widespread adoption.
2. **Industry Compliance.** Insurers' willingness to provide data is vital. The proposal must include mechanisms for enforcing compliance, like penalties for non-disclosure or misleading information.
3. **Adaptability.** Like governments wrestling with AI today, HITEC's standards must be adaptable to reflect market changes, ensuring continued usefulness.

By addressing the sources of market failure in the U.S. insurance market, a more equitable healthcare system is possible.

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