



Play Fair with My Health Care Issue Brief

Empty Promise: Searching for Health Insurance in an Unfair Market

Introduction

Most Americans obtain health insurance through their workplace or the workplace of a loved one,¹ and most want to keep this coverage. When people try to purchase health insurance on their own, instead of through an employer or another type of organization, they are shopping in what is known as the “individual market.” The individual health insurance market is different from the employer market in several troubling ways:

- The employer market offers a greater variety of high-quality, comprehensive health insurance plans than the individual market. And, when such plans are available in the individual market, they are very expensive.
- In the employer market, “similarly situated” employees pay the same premiums, regardless of their age or health problems.² In the individual market, in most states, there are no limits to how much companies may vary premiums for individuals based on their age or health (a process called “underwriting”).³
- In the employer market, insurance companies cannot refuse to sell health insurance to small employers due to the health problems or age of their workers.⁴ In the individual market, all but five states allow companies to refuse to sell policies to individual applicants for these reasons.⁵

Despite these problems, some policy makers want Americans to leave their current employer-based coverage and instead purchase insurance on their own in the individual market. To help people obtain insurance in this market, these policy makers propose to provide tax credits to help consumers pay for premiums and the other out-of-pocket costs that come with such insurance. However, a tax credit will provide little or no help to most people who are buying health insurance unless they can use it to shop in a fair market.

Ironically, the same policy makers who want to move Americans out of employer-based coverage would unravel the consumer protections that currently exist in the states. These policy makers propose to allow insurance companies to sell their plans across state lines, which would enable insurers to elude the consumer protections that some states have established for the individual market. The result would be a “race to the bottom” as insurance companies move to sell insurance from the states with the fewest regulations, nullifying hard-won consumer protections in many states.

Without consumer protections, what happens to Americans who seek coverage in the individual insurance market?

■ **Insurance Policies in the Individual Market Don't Always Provide Quality Coverage**

If you shop for a policy in the individual market, you will find that many policies have more restrictions and less comprehensive coverage than the coverage that you are used to receiving through your employer. At first glance, policies available in the individual market may appear to be affordable. However, even if they have lower premiums, policies in the individual market often have higher deductibles and other out-of-pocket costs than employer-based coverage. Individual market policies are also more likely to impose problematic limits on common services such as maternity care, prescription drugs, and mental health care—or to not cover them at all.⁶

■ **Quality Insurance Policies Are Very Expensive in the Individual Market**

If you are able to find a policy in the individual market that is comparable to employer-based insurance—insurance that covers needed health services with reasonable cost-sharing—it's likely to cost you significantly more than the skimpy, "affordable" policies that are more commonly offered in this market.

■ **Quality Insurance Policies Often Cost Much More than Advertised**

If you are able to find a quality policy in the individual market that appears affordable, you should be aware that the premiums that are advertised are only a best-case scenario and not necessarily the price you will be offered. The *actual* price that the insurer will charge you is likely to be much higher. Since most states do not have laws that limit how much insurers can vary premiums based on an applicant's age or health, insurance companies often charge families higher premiums even for small health problems, such as a child's hay fever or a father's old college sports injury.⁷ Furthermore, in addition to premiums, you will also have to pay out-of-pocket costs such as copayments and deductibles, which are often higher for policies available in the individual market.

■ **A Health Insurance Policy May Not Be Available to You at All**

Even worse than finding a policy and discovering that it actually has a very high premium, you might not be offered *any policy* in the individual market. In all but five states, most insurance companies in the individual market are free to refuse to sell a policy to applicants because of health problems, health risks, or age.^{8,9}

Underwriting 101

“Underwriting” is the process that insurance companies use to determine how high a premium will be, what benefits they will cover or exclude, or whether they will offer a policy at all based on an applicant’s health problems or health risks.

Underwriting Can Lead to Sizeable Variations in Premium Prices

The factors that insurance companies use in underwriting are not limited to health problems. In most states, insurance companies can also drastically increase prices for their policies based on an applicant’s age, gender, occupation, and geographic location. Insurance companies might also consider an applicant’s height and weight, hobbies, driving record—even credit history.¹⁰

Thirty-three states and the District of Columbia have no restrictions on how much insurers may vary an applicant’s premium based on these and any other factors that insurers consider in the underwriting process.¹¹ In many states, insurers multiply the added risk of a person’s age by the added risk of the person’s health by each other risk factor. One study found that, when only age and health status are taken into account, one person’s premium may be priced nine times higher than another person’s.¹² When occupation, geographic location, hobbies, and other factors are also considered, the variations in premiums can be enormous.

Coverage Exclusions Can Last for One Year—or Forever

Insurance companies try to minimize their financial risk by excluding coverage for pre-existing medical conditions. They do this by eliminating specific benefits, either temporarily or permanently, that are related to an applicant’s pre-existing condition. For example, a person with asthma may be offered only a policy that excludes all health services related to the respiratory system. In some states, insurance companies can deem a condition “pre-existing” even if the applicant never received a diagnosis or care for it, if the insurance company believes that most people would have sought care in a similar situation. In 19 states and the District of Columbia, insurers can look back at least five years into an applicant’s medical history to find so-called pre-existing conditions. In 12 of these states and the District of Columbia, insurers can look back without any limits on the timeframe—throughout a person’s entire life, if they want—to find “pre-existing conditions.” If insurers do find pre-existing conditions, 21 states and the District of Columbia allow insurers to exclude coverage of those conditions for more than one year. And, in 37 states and the District of Columbia, insurers can attach “elimination riders” to individuals’ policies, which are clauses that permanently exclude coverage for specific conditions.¹³

In Most States, Insurers Can Refuse to Sell You a Policy Altogether

Very few states have laws known as “guaranteed issue,” which require insurance companies to sell all policies to all applicants regardless of health status. In 45 states and the District of Columbia, most or all insurers are free to completely reject applicants because of medical problems.¹⁴ In most states, insurers can set their own rules about who to accept and can reject applicants whether their health problems are minor or serious.

Discussion

Some policy makers have proposed giving federal income tax credits to people to encourage them to purchase health insurance in the individual market instead of getting coverage through their jobs, as most people do now. In order for these tax credits to be useful, they must provide enough financial help so that Americans – particularly those with lower incomes – can afford the premiums, deductibles, copayments, and other out-of-pocket costs that come with health insurance. It is also critical that consumers be able to use the tax credits to purchase insurance in a marketplace that treats them fairly. In a fair health insurance market, insurance companies would not be able to raise premiums as much as they want, offer only policies that exclude key benefits, or outright refuse to sell policies based on the health of applicants.

Overall, the individual market is not fair to consumers, and it has little to offer the many people who are seeking quality, affordable coverage. There are no national standards that protect Americans against many kinds of insurance company abuses, and most states lack appropriate regulations to protect consumers from high costs or denials of coverage in the individual market. Proposals that include tax credits aimed at helping Americans purchase coverage in the individual market are meaningless if they do not address these serious inadequacies. Unfortunately, recent proposals that seek to move people out of job-based coverage and into the individual market do not include sufficient consumer protections or otherwise address the many problems in today's individual market. What's more, they actually weaken the good consumer protections that some states have enacted.

Below we present a more in-depth discussion of some of the most serious problems in the individual health insurance market.

Premiums Are Too High

For most low-income Americans, as well as many in the middle class, the annual premium for a high-quality policy in the individual market is simply too expensive. In a survey of Americans who attempted to purchase policies in the individual market, nearly 60 percent found it “very difficult” or “impossible” to find a policy that they could afford. Among lower-income respondents, the problem was worse – 70 percent of respondents with incomes under 200 percent of the federal poverty level (\$20,800 for an individual in 2008) said it was very difficult or impossible to find an affordable policy.¹⁵

Finding an affordable policy is made even more difficult by the fact that the advertised premiums for policies in the individual market are likely to be the lowest possible premiums, not the premiums that are typically offered. These advertised premiums are merely the starting point, or base price. Insurers build on these base prices, increasing

them as information emerges in the underwriting process. Therefore, few families or individuals would actually receive offers of coverage at the prices that are advertised.

If families do purchase policies in the individual market despite their high cost, they may be putting themselves at significant financial risk. People in families that spend a higher percentage of their income on health care are more likely to struggle with medical debt.¹⁶ The consequences of medical debt can be catastrophic: Families can have their wages garnished and lose their homes due to legal action,¹⁷ forcing them into bankruptcy. About half of all personal bankruptcy cases in the United States are due, at least in part, to medical reasons. Among those whose illnesses led to bankruptcy, more than three in four actually had insurance when they got sick.¹⁸

In addition to being financially risky, taking on health costs that eat up too much of a family's earnings may also jeopardize the family's health. Insured adults who report having medical debt are four times more likely than insured adults without medical debt to postpone medical care due to costs, and they are more than twice as likely to forgo a needed prescription.¹⁹ So, individuals and families who have to spend more than their budgets can handle to obtain health coverage may still not receive the care that they need even though they are insured.

Aren't policies available in the individual market affordable?

Some studies claim to show how affordable policies available in the individual market are. Here's what proponents of the individual market don't tell you about these studies:

- Studies that claim to show the affordability of policies available in the individual market often include only the insurance policies that consumers actually ended up purchasing. This means that those studies include only policies for the people who got the best deals—people who are healthy and unlikely to need medical care. These studies fail to include the policies that are offered to all of the people who apply for coverage but who don't purchase a policy because the cost is too high or because the coverage is inadequate.
- Some studies fail to describe the quality of the insurance policies that they include. They don't report details on the size of deductibles, copayments, or other cost-sharing, or they don't provide information on which benefits are covered and which are excluded.

Insurers Can Refuse to Sell You a Policy Altogether

Only five states have laws that require what is called "guaranteed issue." In these states, insurance companies must offer all of their policies to all applicants looking to purchase coverage. In the vast majority of states, insurance companies can—and do—reject applicants based on their medical conditions, past and current.

According to Stephen L. Wyss, the managing director of Affinity Group Underwriters in Glen Allen, Virginia, “Trying to buy an individual policy is tough. About 40 percent of people in the 55-64 age group that we try to place are getting turned down because of pre-existing conditions. Almost everybody has some kind of health problem.”²⁰ Wyss’s statement is supported by a study in one state that showed that, in total, insurance companies denied about 19 percent of all people who applied for policies in the individual market or offered them insurance policies that excluded some needed treatment. For some insurance companies, the denial rate was about 40 percent.²¹

In a groundbreaking study, the Kaiser Family Foundation examined the availability of health insurance coverage in the individual market. For its study, Kaiser was able to secure the cooperation of actual insurance brokers to consider hypothetical applicants in several states. The applicants were rejected for coverage 37 percent of the time, and only 10 percent of the remaining offers of health insurance were “clean”—that is, at the standard premium with no limitations on covered benefits. One hypothetical applicant with only a mild case of hay fever (a condition experienced by 36 million Americans) was rejected for coverage 8 percent of the time. A hypothetical applicant who was an overweight smoker with high blood pressure was rejected 55 percent of the time.²² The study concluded that when a person has any health conditions—even relatively minor problems—the availability, cost, and terms of coverage in the individual market change significantly.

Some states attempt to help individuals who are denied coverage in the individual market by offering them subsidized coverage through a “high-risk pool.” High-risk pools offer coverage to people who are unable to buy an insurance policy anywhere else because of their health problems, also called “uninsurables.” High-risk pools can make it possible for people with health problems to obtain health insurance, but they are too expensive for most Americans. Premiums for high-risk pools can be as much as twice as high as standard premiums, which are already high. Furthermore, most high-risk pool plans have very high deductibles, which require consumers to spend significant amounts of money out-of-pocket before the plans begin paying for health services. Also, these plans usually impose waiting periods of at least six months before they will cover services for pre-existing conditions, and they often have insufficient lifetime coverage caps.²³ For all of these reasons, high-risk pools and similar mechanisms for covering “uninsurables” may provide relief to some Americans, but they are no substitute for an insurance marketplace that has adequate consumer protections and that treats everyone fairly.

What about People Who Don’t Stay Perfectly Healthy?

If Americans who are young and healthy are able to find quality coverage in the individual market, what happens when they become sick and need to use that coverage? It isn’t safe to assume that health insurance companies in the individual market evaluate a person’s

medical history only when he or she first applies for coverage. More and more companies are reevaluating policyholders' medical status at the end of each year of coverage when they try to renew their policies. If a person has developed a serious or chronic condition, or even just filed more than a few claims, his or her insurance company may try to find a way to raise premiums, increase deductibles and other out-of-pocket costs, or restrict coverage.

Most states do not limit the amount by which insurance companies may raise an individual's premium at the time of renewal.²⁴ However, even in states that do have laws that limit price increases at renewal, insurance companies might be able to circumvent them by, for example, taking a policy off the market and forcing everyone who had the policy to apply for a new policy. The bottom line is that, without the bargaining power of a large group such as an employer, individual consumers are helpless when negotiating with large insurance companies that engage in this practice.

Conclusion

Health coverage in the individual market is unrealistically expensive for most consumers. Prices in this market will likely remain prohibitively high even with the help of a tax credit, as there are no national consumer protections that hold individual market insurers accountable, and most states do not limit how much insurers may increase premiums based on applicants' health—or even prohibit insurers from rejecting applications outright.²⁵ And proposals to allow insurers to sell policies across state lines would only exacerbate the situation, making it even harder for consumers to find quality, affordable health insurance policies in the individual market.

If health insurance companies are allowed to drastically vary their prices based on applicants' health or refuse to sell policies to some applicants altogether, even tax credits that appear generous are not a viable solution for helping consumers obtain quality, affordable coverage. Only if tax credits are paired with improved consumer protections that require insurers to sell coverage to all who apply, and to sell coverage at reasonable prices that consumers can afford, will they be able to help Americans obtain health insurance. Health insurance tax credits without such consumer protections are nothing but an empty promise.

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Endnotes

¹ Carmen De-Navas Walt, Bernadette D. Proctor, Jessica Smith, *Income, Poverty and Health Insurance Coverage in the United States: 2006* (Washington: U.S. Census Bureau, August 2007).

² The Health Insurance Portability and Accountability Act (HIPAA) prohibits discrimination in premiums charged to employees and their dependents based on health status. In other words, within an employer's plan, premiums must be the same for groups of "similarly situated" employees. Groups of employees may be considered "similarly situated," for example, if they are all full-time workers, or if they have the same job classification, or if they have all worked at the same business for at least a certain amount of time. Employees in one group may be charged a different premium than employees in another group. However, an individual employee cannot be singled out based on his or her health status and charged a higher premium than someone else in the same group.

³ Health Policy Institute, Georgetown University, *Individual Market Guaranteed Issue, Not Applicable to HIPAA Eligible Individuals, 2007* (Menlo Park, CA: Kaiser Family Foundation, December 2007), available online at www.statehealthfacts.org, accessed on March 24, 2008.

⁴ *Health Insurance Portability and Accountability Act of 1996* (Public Law 104-191, 104th Congress), Title 1-Health Care Access, Portability, and Renewability, Sec. 2711, Guaranteed Availability of Coverage for Employers in the Group Market, 42 USC 300 gg-11. Large employers are not legally protected from denials by insurance companies, but due to their large number of employees, they generally do not experience difficulty finding insurance policies because of employee health problems or age.

⁵ Health Policy Institute, Georgetown University, *Individual Market Guaranteed Issue, Not Applicable to HIPAA Eligible Individuals, 2007* (Menlo Park, CA: Kaiser Family Foundation, December 2007), available online at www.statehealthfacts.org, accessed on March 24, 2008.

⁶ Nancy Turnbull and Nancy Kane, *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market* (New York: The Commonwealth Fund, February 2005).

⁷ Karen Pollitz, Richard Sorian, and Kathy Thomas, *How Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (Washington: Kaiser Family Foundation, June 2001).

⁸ Federal law protects applicants from insurance company refusals if they have left a job and exhausted their COBRA benefits and they then purchase a particular insurance plan without a significant gap in coverage.

⁹ Health Policy Institute, Georgetown University, *Individual Market Guaranteed Issue, Not Applicable to HIPAA Eligible Individuals, 2007*, op. cit. In addition, although Idaho is not among the five states that have guaranteed issue laws for all insurers and insurance products, insurers in Idaho must offer a reinsured product to any applicants for whom they deny coverage.

¹⁰ Texas Office of Public Insurance Counsel, *2007 Individual Health Insurance Underwriting Guidelines* (Austin: Texas Office of Public Insurance Counsel, 2007), available online at http://www.opic.state.tx.us/docs/442_2007_health_ug.pdf, accessed on July 29, 2008.

¹¹ Health Policy Institute, Georgetown University, *Individual Market Rate Restrictions, Not Applicable to HIPAA Eligible Individuals, 2007*, op. cit.

¹² Karen Pollitz, Richard Sorian, and Kathy Thomas, op. cit.

¹³ Health Policy Institute, Georgetown University, *Individual Market Portability Rules, Not Applicable to HIPAA Eligible Individuals, 2007* (Menlo Park, CA: Kaiser Family Foundation, December 2007), available online at www.statehealthfacts.org, accessed on March 24, 2008.

¹⁴ Health Policy Institute, Georgetown University, *Individual Market Guaranteed Issue, Not Applicable to HIPAA Eligible Individuals, 2007*, op. cit.

¹⁵ Sarah Collins, Jennifer Kriss, Karen Davis, Michelle Doty, and Alyssa Holmgren, *Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families* (New York: The Commonwealth Fund, September 2006).

¹⁶ Cathy Schoen, Michelle M. Doty, Sara R. Collins, and Alyssa L. Holmgren, "Insured but Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005): W5-289-W5-302.

¹⁷ Robert Seifert and Mark Rukavina, "Bankruptcy Is the Tip of the Medical-Debt Iceberg," *Health Affairs* Web Exclusive (February 28, 2006): W89-W92.

¹⁸ David Himmelstein, Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* Web Exclusive (February 2, 2005): W5-63-W5-73.

¹⁹ Catherine Hoffman, Diane Rowland, and Elizabeth Hamel, *Medical Debt and Access to Health Care* (Washington: Kaiser Commission on Medicaid and the Uninsured, September 2005).

²⁰ Fred Brock, "Before Medicare, Sticker Shock and Rejection," *The New York Times* (New York: April 21, 2008).

²¹ Maryland Insurance Administration, *Individual Health Benefit Plan Applications and Declinations, YTD March 31, 2007* (Baltimore: Maryland Insurance Administration, March 31, 2007).

²² Karen Pollitz, Richard Sorian, and Kathy Thomas, op. cit.

²³ National Association of State Comprehensive Health Insurance Plans, *Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis* (Denver: Leif Associates, Inc., August 2007).

²⁴ National Association of Health Underwriters, *Summary of State Individual Health Insurance Policy Renewal Laws* (Arlington, VA: National Association of Health Underwriters, 2003), available online at www.nahu.org/legislative/charts/State_Individual%20Health_Policy_Renewal.doc, accessed on March 28, 2008; Personal Communication with Jessica Waltman, Vice President of Policy and State Affairs, National Association of Health Underwriters, July 21, 2008.

²⁵ Health Policy Institute, Georgetown University, *Individual Market Rate Restrictions, Not Applicable to HIPAA Eligible Individuals, 2007*, op. cit.