



Too Sick for Health Care

How Insurers Limit and Deny Care in the Individual Health Insurance Market

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Introduction

All of the roughly 170 million Americans with private health insurance share concerns about skyrocketing costs and shrinking benefits. But there are even greater challenges for the roughly one in four Americans who either purchase their insurance on the individual market or have considered doing so.¹ The individual market is confusing, complex, and typically costs more for less coverage—if coverage is available at all.

Conservatives claim that comprehensive health care reform will lead to government control and rationing of care. Yet private insurers already effectively limit and deny the health care that their policyholders can access, especially those who have to find coverage in the individual market. And make no mistake—the insurance companies are well aware that just 20 percent of patients are responsible for 80 percent of health care costs in the United States.² That's why insurers try to limit the coverage of this 20 percent, especially in the individual insurance market.

The recent testimony of former insurance company executive Wendell Potter before the Senate Commerce Committee offers insight into the practices that protect insurers' economic interests at the expense of their policyholders' best interests.³ In an effort to limit their costs, Potter explained the techniques that insurers use to try to drop sick individuals from coverage. One approach is “purging,” where the monthly costs for some individuals are significantly increased in the hopes that the individual will choose to drop coverage.

Health reform will bring an end to insurers' practices that limit care and bring stability to families' insurance coverage. To their credit, the health care insurance industry has stated that they would accept changes to improve the stability of coverage under certain circumstances.⁴ But the industry actively opposes the creation of a public health insurance plan as part of an insurance exchange that will enable employers and individuals to purchase insurance as a group under market reforms that prohibit screening for pre-existing conditions and other conditions that insurers like to use to deny coverage. These reforms will

finally make insurance affordable and available for all while creating a marketplace that has a choice of plans that will have to compete with one another.⁵

In addition, to make the market more efficient and fair, specific changes will be made in the health care marketplace that will make insurance easy to obtain, easy to keep, affordable, and a meaningful source of protection when people need care. For too long, our system of market rules has allowed insurance companies to deny and limit health care. It's time to fix the problem to bring down health care costs in the United States so they are fair and affordable for everyone.

There are four basic problems with our current health care system that allow insurers to limit our access to health care: insurance policies are too expensive, too easily manipulated in order to limit or deny coverage, too hard to keep, and too weak to be effective. Comprehensive health care reform offers four solutions that will improve the system by making insurance affordable, available to everyone, easy to maintain, and adequate for all medical situations. Let's consider each of these problems and solutions in turn.

Problem

Health insurance is too expensive

Health insurance premium costs put coverage out of reach for too many American families, and many more have problems paying their medical bills because they are underinsured.⁶ The fact is, more and more Americans fail to get the care they need based on their inability to pay.

Over the past decade, health insurance premiums have risen 119 percent nationally,⁷ while wages (adjusted for inflation) have remained relatively flat.⁸ Today, the average family premium for employer-sponsored health insurance exceeds \$13,000, while total average medical costs can account for as much as 16.2 percent of income for low-income families.⁹ High premium costs contribute to the number of uninsured Americans.

While premiums have been growing so too have out-of-pocket costs, or those costs not covered by insurance such as deductibles and copays. High out-of-pocket costs have contributed to the total estimated 25 million underinsured Americans—those with insurance but not enough to protect them from financial risk.¹⁰ Paying for the rising cost of health care is a particularly severe problem for people without coverage through their employers. Those individuals who have to buy their insurance on the individual insurance market face:

- **High premium costs.** Insurers in 31 states have no limit at all on what they can charge for individual insurance.¹¹ This leaves families vulnerable to not being able to afford their coverage over time, or to spikes in insurance costs from one year to the next.

- **High out-of-pocket costs.** Health insurance on the individual market also tends to come with high out-of-pocket cost sharing. Deductibles, for example, average about \$2,000 per person for so-called Preferred Provider Organization plans, the managed care health insurance networks many Americans receive care through.¹² Being underinsured—facing very high out-of-pocket costs—is often little better than being uninsured in terms of having access to health care services.¹³ Higher deductibles and other cost-sharing requirements make it less likely that individuals will seek out health care—even if they need it.¹⁴

Solution

Health reform will make insurance affordable

Health care reform will help families to buy comprehensive health insurance at an affordable rate and strengthen employer-based insurance. In addition, health reform can mandate maximum out-of-pocket costs for private insurance. Under the plans being discussed by progressives, health care reform will:

- **Control the cost of health care by promoting competition and increasing efficiency.** With a new health insurance exchange in place, consumers will receive better information about health insurance plans. This means insurers will have to compete for policyholders by bringing down costs while offering quality coverage.¹⁵ And with a public health insurance plan on offer, consumers will have a benchmark for quality insurance at a competitive price, which will also drive competition by offering a quality insurance product but without the higher administrative costs and profits of private insurers. With individuals able to freely choose from a range of plans, competition will drive improvement in plan offerings. Health reform also will lower costs by redesigning care payment systems that will, for example, increase the incentives to providers to offer chronic care and preventive services.

Health insurance premiums and out-of-pocket costs

A health insurance premium is the cost of a health insurance policy and it is generally paid on a monthly basis. Out-of-pocket costs are paid by policyholders when they seek health care with their insurance. There are several types of out-of-pocket cost-sharing arrangements:

- **Deductibles.** Many types of insurance have deductibles, such as home or automobile coverage. In many health insurance plans, policyholders must pay 100 percent of the cost of certain services subject to the deductible before the insurer begins paying a share of the costs. For example, an individual with a \$1,000 deductible that applies to doctor's visits would pay the full cost of every doctor's visit until they had paid the full \$1,000.
- **Copayments.** One of the most common types of cost sharing, a copayment is a set amount a policyholder must pay for certain services such as visiting a doctor or filling a prescription drug. For example, a policyholder may pay \$10 per visit to a primary care physician.
- **Coinsurance.** Instead of a flat fee for a service, some health insurance plans require policyholders to pay a percentage of the cost of certain services. The percent of costs policyholders are required to pay may vary by whether their provider is in the insurer's network or not. For example, an individual may be required to pay 30 percent of hospital costs in network, but 40 percent of hospital costs out of network.

- **Offer subsidies for health insurance premiums.** Tax credits or subsidies to help low- and middle-income families will make health insurance affordable for all Americans.
- **Cap out-of-pocket costs.** This will ensure costs do not prevent families from seeking needed care, and will protect Americans from excessive medical debt and medical bankruptcies if they get really sick.
- **Support small business.** Small businesses and the self-employed today pay more for health insurance and get less coverage than those who work for large businesses with employer-sponsored health care plans. A health insurance exchange will help small businesses by improving their purchasing power with financial help in the form of government subsidies to offset premium costs. The health exchange also will improve the purchasing power of the self employed and individuals who do not have employer-sponsored coverage by enabling them to buy into a health insurance pool, which will attract discounts from health care providers similar to those now enjoyed by big employer-sponsored plans. One recent report estimates that health care reform could save small business up to \$855 billion in costs.¹⁶

Problem

Insurance companies use a range of reasons to charge some people more for health insurance or deny it altogether

Health insurance is supposed to protect us when we get sick. Yet study after study documents that people with pre-existing conditions find it nearly impossible to get the coverage they need.¹⁷ One survey shows that 89 percent of the people who tried to purchase coverage on the individual market ultimately did not, either because it was unavailable or it was unaffordable.¹⁸ In the vast majority of states, insurers can refuse to sell coverage to individuals based on their health status, and insurers face few restrictions on the rates that they can charge.¹⁹

Then there's the application process. Insurers want to limit their exposure to customers that could need medical care—and cost the insurer money. So insurers use long and confusing insurance applications to look at all aspects of an applicant's life and medical history to identify factors that could make them more costly. Insurers then charge higher premiums for those with real or perceived risk factors. Insurers look specifically for:

- **Health status and chronic illness.** It is common practice for health insurers to use the application process to determine an individual's health status to decide both how much coverage to offer and at what cost. In one survey, half of those in fair or poor health found it very difficult or impossible to find the coverage they needed. And for those offered coverage, poor health status is used as a reason to charge higher premiums or limit coverage.²⁰

- **Prescription drug use.** Taking prescription medications makes millions of Americans ineligible for coverage on the individual market.²¹ Case in point: Insurance companies in California bar individuals from coverage if they take any of 8 of the 20 most popular prescription medications sold in the United States.²² That list includes the top-selling drug in the country, Lipitor, which has been prescribed to more than 26 million Americans to treat cholesterol.²³
- **Height and weight.** For the approximately one-third of adults who are medically obese²⁴—defined by a body mass index of 30 or higher; a recommended BMI ranges from 19 to 25—health insurance will cost more if it is available at all. Those with a BMI of more than 35 are simply denied coverage.²⁵ But it isn't just the obese who can be turned down. Coverage can be more expensive, or denied, for those deemed too short, too tall, or too skinny.²⁶
- **Age.** Age discrimination is prevalent in the individual market.²⁷ On average, someone 60 to 64 years old and healthy is going to pay significantly more for health insurance than an 18- to 24-year-old.²⁸ Of course, that is only for those who are offered coverage.²⁹ Of those ages 60 to 64, 29 percent are turned down for individual coverage compared to just 4 percent of those ages 18 to 24.³⁰
- **Gender.** Women are more likely to have to seek coverage on the individual market than men as they are less likely to qualify for employer-sponsored coverage.³¹ However, being a woman means paying more for health insurance.³² Pregnancy has long been a reason insurance companies use to charge women higher rates for health insurance,³³ even though many individual insurance policies don't even cover maternity benefits.³⁴
- **Occupation.** Insurers will use your occupation to decide if you can buy insurance. Roofing, window cleaning, lumber work, and asphalt work are occupations that insurers will sometimes not cover.³⁵ Volunteer firefighters, a common occupation in rural areas, can be denied coverage even if their full-time occupation only involves office work.³⁶
- **Hobbies.** Even hobbies such as scuba diving and skydiving can mean being denied coverage.³⁷

If individuals are offered coverage after clearing all of these hurdles, the next challenge they face is the scarce information on how to compare benefit packages.³⁸ Given the number of ways insurers can vary benefit packages to limit coverage—from not including some services to high cost sharing to low-benefit limits—successful applications find it hard to truly understand what coverage they are purchasing. One study showed that 75 percent of policyholders didn't understand the policy they purchased, and more than 50 percent didn't know if their policy limited out-of-pocket spending.³⁹

Solution

Health reform will make insurance more available

Comprehensive health care reform will make it much easier for families to find insurance, compare benefit packages, and then purchase the one that works best for them. Under the plans being discussed by progressives, health care reform will:

- **Make insurance available to everyone.** Insurers will be required to offer insurance to all individuals and employers who apply for coverage, and will no longer be able to deny coverage to people with pre-existing conditions, or price coverage out of reach for people with health problems.
- **Make insurance understandable.** Minimum benefit standards and a guarantee that all policies will offer meaningful insurance will create tools for helping families sort through insurance plans and understand their benefits and out-of-pocket costs.⁴⁰

Problem

Health insurance is hard to keep

When individuals lose their health coverage just when they need it the most, care is being rationed. In the vast majority of states it is possible for insurance companies to cancel individual market coverage once it is found that expensive claims are being made on the policy.⁴¹ Such claims often trigger post-claims underwriting, insurance jargon for insurers investigating a policyholder's already-completed application and medical history to find evidence of preexisting conditions.⁴² Even if errors or omissions on an application were unintentional, in many states they can be grounds to cancel coverage going forward, rescind or retroactively cancel coverage, or limit coverage to exclude the preexisting condition.

All three of these steps ration care for those who need medical attention. Rescissions go further by sticking former policyholders with the bill for services they sought believing they had coverage. At a recent congressional hearing, it was revealed that just three insurers rescinded at least 20,000 individuals between 2003 and 2007.⁴³ In one case, a nurse had her coverage rescinded when she developed breast cancer—after failing to disclose that she had seen a dermatologist for acne.⁴⁴ When insurance industry executives were asked if they would end the practice of rescissions, the answer was “no.”⁴⁵

Individuals and families also are at risk of losing insurance during life transitions that limit their access to coverage. Losing a job, going through a divorce, or graduating from college can automatically make some individuals or families ineligible for employer-sponsored coverage. While federal law offers some protections for individuals and families who are moving from one job to another, or from group insurance to the individual market, how those protections are enforced varies by state. Families uncertain of their options, or those

without the resources to pay often very high premiums, are at risk of becoming uninsured.

Solution

Health reform will make insurance easy to keep

Comprehensive health care reform will ensure individuals always have access to coverage no matter their health status. Health care reform will:

- **Make insurance always available.** The new insurance exchange will make it possible for everyone to have access to health insurance and give applicants more details about the kinds of coverage they can purchase. If policyholders pay their premiums, insurers will be required to keep their side of the bargain to pay for covered benefits. Insurers will be required to accept all applicants and maintain coverage for all policyholders no matter their health status.
- **Help families transition between insurance plans.** The new insurance exchange can promote auto enrollment to ensure seamless health insurance coverage. Also, the new exchange will conduct outreach and consumer education so that families understand their options, including new subsidies that can make coverage more affordable.

Problem

Health insurance benefits are weak

Health insurance that does not cover the services individuals and families need, at cost-sharing levels they can afford, is a way of rationing care. Thirty-four percent of people seeking coverage on the individual market reported having trouble finding coverage that met their needs. And almost half have trouble when they have a pre-existing condition.⁴⁶ Insurance companies limit their risk by limiting benefits. Specifically, insurers:

- **Exclude basic benefits.** Insurance companies ration care by offering coverage on the individual market that covers fewer services than coverage available through employer-sponsored plans.⁴⁷ Today, every state mandates a different set of medical services be included in every health insurance policy, but there is no national minimum for what services health insurance must cover. The result: depending on the state, families with coverage on the individual market may not have access to needed services such as chemotherapy or even well-child visits, which are so critical for basic preventative care.
- **Cap lifetime benefits.** Insurance companies can limit the total amount a policy will pay out for policyholders over the course of their lives. While these lifetime limits are

in the millions of dollars, if individuals with serious illnesses reach those limits they essentially no longer have health coverage. Over 90 percent of Preferred Provider Organization policies on the individual market have lifetime limits, putting individuals at risk for costs.⁴⁸

- **Exclude preexisting medical conditions.** Insurers try to limit benefits by selling people policies that specifically exclude care for the medical conditions they already have. In nine states, insurers are allowed to permanently exclude preexisting conditions from coverage.⁴⁹ Just four states limit the waiting period insurers can impose to less than a year.⁵⁰ In 32 states and the District of Columbia, having a symptom of a medical condition, even if it went undiagnosed or untreated, counts as a pre-existing condition.⁵¹ All of these exclusions mean there are cases where an individual is found to have a pre-existing condition when they didn't even know they had one.⁵² To determine if there is a preexisting condition, 25 states and the District of Columbia say that insurance companies can review your medical history going back further than a year. Thirteen have no limit on how far back they can look.⁵³

Solution

Health reform will make coverage adequate

Health reform will include the basic medical services that families need, such as the services listed in the health reform bill being drafted in the house, which include:

- Hospitalization.
- Prescription drugs.
- Maternity benefits.
- Well-child care.⁵⁴

This comprehensive coverage will ensure all families can purchase insurance that covers the benefits they need and deserve. No one plans to get sick, or knows what kind of medical care they may one day need. Comprehensive health care reform will ensure that no one has to find out when they get sick that a necessary treatment has been excluded from their coverage.

Conclusion

Comprehensive health care reform will ensure all American know they can purchase health coverage that will meet their needs today and in the future. Our health care system will no longer allow insurance companies to ration care based on who is healthy enough not to need it, or wealthy enough to pay for it.

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