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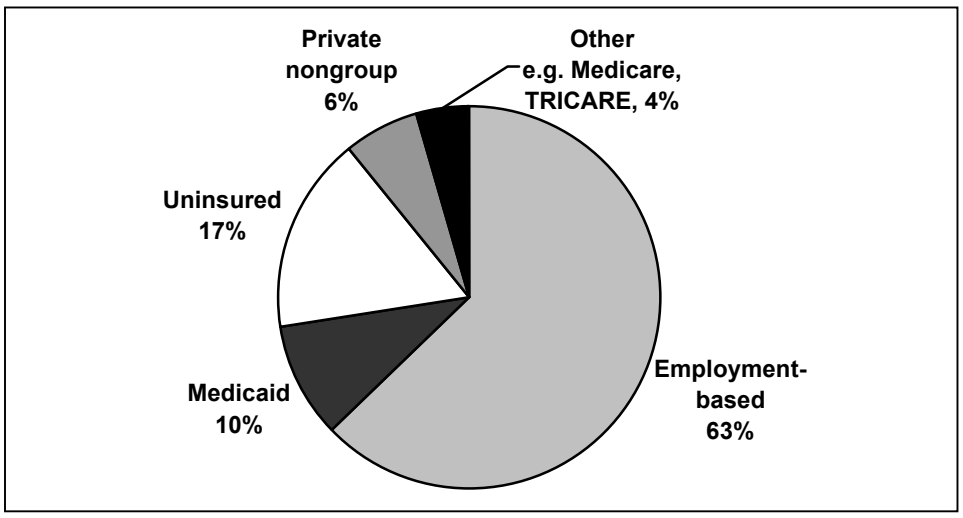
Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to testify today about the individual health insurance market and the role it might play in policies to expand health insurance coverage for the uninsured.

For the past five years, my colleagues at Georgetown and I have been studying private health insurance markets and their regulation by states and the federal government. One area of special focus has been the rules that protect access to coverage for people with pre-existing conditions. We have reviewed regulations governing the individual, small group, and large group markets in each state. This information is summarized in state-specific consumer guides that are available on the Internet at www.healthinsuranceinfo.net. In addition, we have undertaken many research projects and contracts on private health insurance-related issues – including a report on the early implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) – with support from national foundations, the U.S. Department of Health and Human Services, the Congressional Research Service, and others.

As a context for my remarks today, I would suggest that health insurance must meet three tests if it is to secure access to health care for people when they get sick: 1) coverage must be accessible; 2) it must be affordable; and 3) it must be adequate. Further, to be meaningful, coverage must meet all three tests not just at the outset, when people first seek coverage, but also over time, as they continue to need and buy coverage. For many consumers today, individual health insurance fails to meet one or more of these tests. As it is now structured, the individual health insurance market is a poor basis on which to plan future coverage expansions.

About 70 percent of Americans under the age of 65 have private insurance coverage. (See Figure 1) The vast majority of these covered people are insured by employer-sponsored group health plans. Another 14% of non-elderly Americans are covered under public programs, primarily Medicaid and S-CHIP. When people do not have employer-sponsored insurance or qualify for public programs, they turn to the individual health insurance market.

Figure 1. Health Insurance Coverage of Non-Elderly Americans



Source: March 2000 Supplement to the Current Population Survey.

In 2000, only about 6% of non-elderly Americans had individual health insurance. It is important to note, however, that many more people pass through this market at some point in their lives. Indeed, any of us might find ourselves in the individual health insurance market – when we first graduate from school and leave our parent's coverage; when we work for an employer that doesn't offer health benefits; when we take leave from our jobs or work part time; when we get divorced or widowed and are no longer eligible for our spouse's coverage; or when we retire before the age of 65. A recent survey by the Commonwealth Fund found that more than one in four adults had sought coverage in the individual health insurance market during the prior 3-year period.[1]

Individual health insurance is commonly considered in contrast to its counterpart, group health coverage. In particular, the perceived weaknesses of group health insurance lead many to assume that a system of individual coverage may make more sense. For example, many are concerned that workers and their families experience disruptions in coverage and may need to change doctors each time they change jobs. Wouldn't it be better for health insurance to attach to people so it could follow them wherever they go? Further, some are concerned that employers, not workers, select group health plans. Wouldn't people prefer to make this choice for themselves? Finally, group health plans enjoy extensive subsidies under our current tax system. Wouldn't it be more equitable for people to enjoy comparable tax subsidies in the individual insurance market?

Unfortunately, while the individual market might appear to offer important advantages over group health coverage, in practice, it rarely does. Access to individual health insurance coverage can be problematic for all but the healthiest consumers. For people who are older, sicker, or who live in expensive areas, individual insurance can be

unaffordable. Coverage under most individual policies is far less comprehensive than what is typically offered under group health plans. Finally, the stability of coverage can be problematic for consumers who need to hold a policy longer than a year or two.

Accessibility of Coverage – Medical Underwriting

In most states, the individual health insurance market is characterized by "medical underwriting." This is a process insurers use to evaluate the health and risk status of an applicant in order to decide whether to issue coverage and at what price. Last year, my colleagues and I undertook a study of the individual health insurance market to test the accessibility of coverage for consumers who are in less than perfect health.[2] We surveyed individual health insurers in eight markets. The survey presented seven hypothetical applicants – with health problems ranging from hay fever to HIV – and asked insurers whether they would sell these applicants coverage and, if so, under what terms and at what price. In total, each of our hypothetical consumers "applied" for 60 policies.

The results of their applications are attached at the back of this statement. A summary of responses received by our first hypothetical applicant, "Alice," follows:

Alice is 24 years old and a waitress. Like many restaurant workers, she doesn't have health benefits through her job, so Alice must buy individual health insurance. Alice is in good health, but she does suffer from seasonal hay fever. To avoid sneezing on her customers, she takes a prescription drug called Allegra during pollen season and is getting allergy shots to lessen her symptoms.

In 60 applications for coverage, Alice received the following responses:

- 3 times, Alice received a "clean offer," which means the insurer offered to sell her the policy she requested at the "standard rate," or premium offered to the healthiest applicants.
- 5 times, Alice was denied coverage.
- 52 times, Alice received a "substandard offer." This means she was offered less coverage than the policy she requested, or coverage at a premium higher than the standard rate, or both. In many of these substandard offers, the insurer would apply a "rider," or amendment to her policy excluding coverage for her allergies. However, other offers increased her annual deductible from $500 to $2,500. Sometimes, Alice was offered a policy with no prescription drug card. Three times, Alice was offered a policy that excluded coverage for her upper respiratory system.

At the other end of the health spectrum, our hypothetical applicant, "Greg," who is HIV-positive, was rejected on all 60 of his applications for coverage.

Taken as a group, the 7 hypothetical insurance consumers made 420 applications for coverage. Only 43 applications (10%) resulted in clean offers. They were rejected 154 times or 37% of the time. Among the applications that were accepted, the vast majority of offers (223 of 266) imposed benefit restrictions, premium surcharges, or both.

In short, our study found that consumers who are in less-than-perfect health clearly face significant barriers to obtaining health insurance coverage in the individual insurance market. Even applicants with mild health problems, or with a history of health problems that had been resolved years earlier, faced such barriers.

Adequacy of Coverage

Even for consumers who are in perfect health, coverage under individual health insurance policies tends to be far less comprehensive than that typically provided under group health plans. Among the 60 policies our hypothetical consumers applied for, we noted the following limitations in particular:

Maternity coverage - Nearly half (27) of the 60 policies studied did not cover maternity services. Another 27 policies offered maternity coverage only for an additional (often considerable) premium. Optional maternity riders usually required a waiting period (of 9 months to 3 years) before benefits would be fully covered. One company imposed an additional cap of $4,000 on covered benefits under the maternity rider. Only 6 policies included maternity benefits as part of the standard benefit package.

Mental health and substance abuse - Coverage for mental health and substance abuse treatment also was very limited. Six policies had no coverage for these services; 28 policies covered some mental health care, but no substance abuse treatment. None of the policies covered mental/nervous treatment as other health services, although in 6 policies there was parity in coverage under certain circumstances – usually for specified severe mental or nervous conditions. Instead, policies imposed various limits – usually in combination – on mental health coverage.

Low lifetime and annual caps were used most often to limit coverage for mental health care. Twenty-seven policies imposed lifetime caps, usually of $10,000. By comparison, lifetime caps for other health services ranged from $1 million to $6 million under all of the policies studied. Thirty-three policies imposed annual caps on mental health coverage (often in addition to lifetime caps), usually of $3,500 or less.

Many policies also limited covered inpatient days (30 days was the typical limit) and outpatient visits (usually at 25 or fewer.) Nine policies also limited coverage for drugs to treat mental or nervous disorders.

Prescription drugs - Most policies included coverage for outpatient prescription drugs. Four capped drug coverage – one at $1,500 a year and three others at $1,000/year. Only one policy included no drug coverage. As we found, however, access to prescription drug coverage under most policies is dependent on medical underwriting. Companies often imposed separate (and higher) deductibles or other coverage limitations on drugs for consumers with pre-existing medical conditions.

Coverage limits for HIV/AIDS - Eight policies we reviewed capped lifetime coverage for HIV- and AIDS-related care at $25,000 or less.

Premium Variation – Rating on Age, Geography, and Health Status

Another characteristic of the individual health insurance market is the lack of a benchmark premium. The cost of insurance varies widely and is entirely dependent on who and what is covered. Three common practices that contribute to premium variation are age rating, geographic rating, and health status rating.

A consumer in his early 60s typically will be charged three to four times more than a consumer in his early 20s for the same policy.[3] We observed a similar degree of premium variation in the age-rated policies we reviewed for our study.

Health insurance rates also vary geographically. Premiums in two rural towns we studies – Corning, Iowa and Winamac, Indiana – tended to be roughly 20% lower than

rates charged for the same policy in larger cities. In Miami, however, premiums were about twice as high as rates charged in other urban areas, including Chicago.

In addition, as noted earlier, individual health insurers can and do impose premium surcharges on consumers considered to be higher risks. These "rate-ups" can be as high as 100% or more.

The combined impact of age, geography, and health status means that the premiums for individual health insurance coverage vary dramatically. For example, one national carrier in our study offered the same policy to Alice (a 24-year-old with hay fever) in Corning, Iowa for $1,471 per year, and to Frank (a 62-year old overweight smoker with high blood pressure) in Miami for just over $30,000 per year – more than a 20-fold difference in price.

Stability of Coverage Over Time

Finally, getting health insurance that is adequate and affordable in the individual market is not the only challenge facing consumers. Staying covered can also be difficult.

Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires most health insurance to be "guaranteed renewable," in the individual market this protection is incomplete. HIPAA permits exceptions to guaranteed renewability – notably, when an insurance carrier withdraws from a market. One national commercial insurer, Conseco, recently announced its withdrawal from 20 states, leaving up to 120,000 customers to find new health insurance.[4] Conseco policies began expiring in February of this year.

Furthermore, HIPAA's guaranteed renewability protections do not address renewal price increases. Consider the recent experience of two real-life consumers:

> Rhonda and John live in Michigan and have a small business with no other employees. Rhonda and John were paying $526 per month for health insurance in the individual market. They've been covered under this policy for 3 years. Recently, Rhonda and John received their renewal notice, only to find their monthly premium would almost double to $1,026. Both Rhonda and John are healthy and have not had any claims until last year. In his own words, "Last year we paid $7,000 in premiums and our insurer paid $2,200 in claims for us." Their policy paid for minor knee surgery for Rhonda and a doctor's visit for John, who had a reaction to eating a bad clam. In addition, John celebrated his 60th birthday last year. Rhonda is 52. The couple cannot afford to pay $12,000 for health insurance.

Other circumstances, beyond renewal problems, may also arise causing consumers to change their health insurance. People move to new communities. Their doctors change health plan networks. Their children grow up and need to buy their own coverage. HIPAA requires that some coverage be offered to individuals on a "guaranteed issue" basis when they first leave group coverage, but not thereafter. HIPAA offers no portability protections to help people change from one individual health insurance policy to another. Unless state laws add protections in these areas, consumers who are able to buy individual health insurance may be locked into that plan. Or, when they do need to

make a change – as Rhonda and John and all of Conseco's former customers must now do – they may have trouble maintaining coverage. Transitions can be treacherous for people who do not remain young and healthy forever.

Implications for Tax Credit Proposals

The President and others have proposed to extend refundable tax credits of up to $1,000 per person and $3,000 per family to purchase individual health insurance. While a flat credit of this amount could improve the affordability of coverage in some cases – such as for Alice, a 24-year-old with a relatively mild health condition – it may not offer a sufficient subsidy for other consumers whose age, place of residence, or health status makes health insurance especially expensive. Furthermore, a tax credit would not address the other two tests of coverage – access and adequacy. It would not help Alice purchase coverage from the insurers who turned her down. Nor would it fill the gaps in policies that exclude coverage for her upper respiratory system, maternity care, or other needed services. Finally, a tax credit, alone, would not guarantee that coverage will remain available and affordable over time.

Additional measures must accompany a tax credit if we want recipients to be able to spend it on stable coverage that meets the three-pronged test of access, affordability, and adequacy. Either we must reform the individual market to improve its accessibility, adequacy, and affordability, or the proposed subsidy should be applied to other group or public program coverage that meets these important tests.

[1] Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman, "Security Matters: How Instability In Health Insurance Puts U.S. Workers At Risk," The Commonwealth Fund, New York, New York, December 2001.
[2] Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" a report for the Henry J. Kaiser Family Foundation, Menlo Park, California, June 2001.
[3] Elizabeth Simantov, et. al., "Market Failure? Individual Insurance Markets for Older Americans," Health Affairs, July/August 2001. See also Deborah Chollet and Adele Kirk, "Understanding Individual Health Insurance Markets," a report for the Henry J. Kaiser Family Foundation, Menlo Park, California, March 1998.
[4] "Conseco Bails Out of Major Medical," The Indianapolis Star, February 17, 2002. See also "Insurance Watch – Conseco: Company Phases Out Half of Health Insurance Unit," American Health Line, August 10, 2001.

Attachment

"How Accessible Is Individual Health Insurance for Consumers In Less-Than-Perfect-Health?" Summary of Survey Results

In this study, seven hypothetical consumers made 60 applications for individual health insurance in eight markets across the nation (Arlington Heights, Illinois; Austin Texas; Corning, Iowa; Fresno, California; Miami, Florida; Richmond, Virginia; Tucson, Arizona; and Winamac, Indiana). In each market, the applicants applied for insurers' most frequently-sold policy and specified a $500 annual deductible. Insurers responded to these hypothetical applications by either accepting the applicant for standard coverage at a standard rate for a healthy person (i.e., a "clean offer"), rejecting the applicant, offering coverage with special restrictions on covered benefits (e.g., to exclude benefits through a "rider"), or offering coverage at a higher-than-standard premium (i.e., a "rate-up" or surcharge). Some responses combined special benefit restrictions with a rate-up. The results for each of the consumers were as follows:

Alice, a 24-year-old waitress with hay fever. Alice had her application rejected 5 times, or 8% of the time. She received 3 clean offers of coverage. The vast majority of offers (46 of 55) she received had limitations on benefits based on her health condition. Alice was offered policies with exclusion riders that would eliminate coverage for her hay fever or, in three cases, for her entire upper respiratory system. Other offers modified coverage under the policy by increasing the annual deductible from $500 to $2,500, or increasing the cost sharing (e.g., deductibles or coinsurance) for prescription drugs. Ten offers applied a premium surcharge, or rate-up, ranging from 20-40% (including four that restricted benefits as well). The average annual premium quoted to Alice was $1,656, although the prices on her offers ranged from $408 to $4,596 per year.

Bob, a 36-year-old consultant who injured his knee in college and had it surgically repaired 10 years ago. Bob was turned down 7 times, or 12% of the time. He received 15 clean offers of coverage and was one of only two of the applicants who received at least one clean offer in each market where he applied. In 34 instances, carriers sought to limit Bob's coverage in some way. Most often, Bob was offered a policy that excluded coverage for his knee. He also had five offers with premium surcharges ranging from 25% to 40% (including one with benefit restrictions as well). The average annual premium quoted to Bob was $1,764, although the prices on his offers ranged from $588 to $5,112 per year.

The Crane Family (Cathy and Carl, both aged 36, daughter Cindy, 10, and son Colin, 12, who has asthma and recurring ear infections). The Crane family was offered coverage 60 times, but in nine cases the offer excluded Colin from the policy. The entire Crane family received 3 clean offers of coverage. The vast majority of offers to cover the entire family came with limitations. Some attached riders excluding coverage for Colin's asthma, other respiratory disorders, his ears, or even his entire respiratory system. The Cranes were also offered policies that imposed higher cost sharing on prescription drugs and other services, or that increased the annual deductible to $2,500. Seventeen offers imposed premium rate-ups ranging from 20% to 50% (including 12 that also imposed benefit restrictions). The average annual premium quoted the Cranes was $5,460, although the prices on their offers ranged from $1,692 to $15,444 per year.

Denise, a 48-year-old actress and seven-year breast cancer survivor. Denise was rejected 26 times, or 43% of the time, and received 11 clean offers of coverage. However, she was also the only other applicant to receive one clean offer in each market where she applied. Of the 34 offers of coverage Denise received, 18 had limits on benefits covered. Most often the policies had riders excluding coverage for her treated breast, her implant, or cancer of any type. Eighteen offers imposed a premium surcharge, ranging from 40% to 100% (including 13 that were accompanied by some other benefit restriction). The average annual premium for Denise was $3,912. The cost of coverage on her offers ranged from $1,464 to $16,344 per year.

Emily, a 56-year-old widow who is "situationally depressed." Emily was rejected 14 times, or 23% of the time, while receiving 9 clean offers. Of the 46 offers she received, 23 limited benefits in some fashion, such as excluding coverage for depression or for any mental/nervous disorder and increasing cost sharing for prescription drugs. Thirty of Emily's offers imposed a premium surcharge, ranging from 20% to 50% (including 16 that also imposed some other special coverage limit or restriction). The average annual premium for Emily was $4,056. Her offers ranged in price from $1,920 to $10,992 per year.

Frank, a 62-year-old retired salesman who smokes, is overweight, and has high blood pressure. Frank was rejected 33 times (55%) and received 2 clean offers. Of his 27 offers of coverage, three included riders excluding coverage of his circulatory system.

A total of 25 offers imposed a premium surcharge, ranging from 16% to 110% (including three that also limited benefits). The average annual premium offered to Frank was $9,936, with a range from $2,928 to $30,048.

Greg, a 36-year-old writer who is HIV-positive. Insurers in the individual market generally consider HIV to be an "uninsurable" condition. As a result, Greg was rejected for coverage all 60 times.