



“Do I put myself in the poorhouse, or do I drop my insurance?”

Maggie Frazier, Cumming, Ga., who has rheumatoid arthritis

CR INVESTIGATES HEALTH CARE

On their own

Far from a remedy, insurance for individuals is a world of pain

Imagine that shopping for a new car worked like this: If you really didn't need the auto and lived two blocks from work, any dealer would sell you a car for a song. If the commute was 50 miles, much too far to walk, no one would sell you a car at any price.

You wouldn't get to see a full contract until you plunked down your cash. Your monthly car payment would go up 20 to 30 percent every year, and, by the way, the steering wheel might be extra.

The auto industry doesn't work like that, of course, but the market for people who buy their own health insurance does.

"I have been living with a dark cloud over me, thinking I am one illness away from poverty," says Kathie Baughman, 57, a self-employed title searcher, of Howard, Pa. She couldn't get insurance because

she takes medication for high blood pressure and once had a lab test that detected slightly high blood sugar.

Our yearlong investigation of health insurance shows that consumers stuck in this market often have traumatic experiences. Here's what we found:

- Consumers who bought health insurance on their own had higher costs and more limited coverage than people who had insurance through an employer, according to a nationally representative survey by the Consumer Reports National Research Center. Individual buyers were more likely to have complaints: 71 percent vs. 53 percent.
- People who consider themselves in fine health can be declined insurance because of previous treatment, even for conditions such as hay fever and acid reflux.
- Enormous differences exist in state

regulation of individual insurance plans. A person who could easily buy insurance in one state could be shut out of the market in another.

• In our survey, 76 percent of people without insurance said they couldn't afford an individual plan. Indeed, only about 7 percent of adults have individual insurance. Yet any adult who hopes to retire early, loses a job, is self-employed, or has an adult child leaving a group plan could face the prospect of trying to buy such a policy.

When CONSUMER REPORTS invited readers in September to share their insurance stories online, hundreds responded. More than half were trying to cope with the high costs and poor coverage of individual insurance.

Such insurance "is not an efficient way to cover people," says Sara Collins, an assistant vice president of the Commonwealth

THIRD IN A SERIES ON AMERICA'S HEALTH-CARE CRISIS

Fund, a nonprofit research organization in New York. "It's very expensive. It's inequitable. When you're most in need, it seems you lose access to it."

The insurance industry disagrees. "The availability and accessibility for those seeking coverage is very widespread," says Mohit M. Ghose, senior vice president of public affairs at America's Health Insurance Plans, the industry's trade group. He cited a 2007 survey of member companies showing that just 11 percent of individual applicants were turned down for health reasons.

But Collins says most people never get to the point of applying. A Commonwealth Fund national survey in 2005 found that 89 percent of people who looked into buying individual insurance had not bought it because it was too costly, they were turned down for health reasons, or it provided inadequate benefits.

Reforming the health insurance system and reducing the ranks of 47 million uninsured Americans have emerged as major issues in this year's presidential race, with some candidates proposing to use tax breaks and the individual insurance market to solve the problem. But the stories of many consumers who struggle with high costs and a lack of access because of medical conditions underscore the hurdles that must be cleared.

SELF-EMPLOYED AND FRUSTRATED

When Bruce Stephens, 55, decided to leave his corporate job to open a senior in-home-care franchise business in Tucson in 2007, it never occurred to him to worry about health insurance. He had had a liver transplant at age 44 because of a congenital metabolic condition but says, "I was fortunate enough to get a very good match and have never had any problems. I just passed my annual physical with flying colors, and my liver is in such good shape that the transplant clinic only needs to see me every five years. I didn't think it would be a big deal."

Like many people leaving corporate jobs with generous health insurance, Stephens continues to receive coverage because of the federal COBRA law, which

6 tips for buying individual insurance

1 KNOW YOUR STATE LAWS

Whether you can get health insurance, and how much you'll have to pay for it, depends largely on your state's laws and regulations. Some states allow medical underwriting, a practice in which insurers can reject people with illnesses, exclude specific conditions from coverage, and charge people with health issues much higher premiums. Other states outlaw medical underwriting. You can research your state's rules at www.healthinsuranceinfo.net, maintained by the Georgetown University Health Policy Institute.

2 BE CAREFUL LEAVING A PLAN

Even in states that allow medical underwriting, the federal Health Insurance Portability and Accountability Act (HIPAA) provides some protection if you are switching from job-based group coverage to the individual market even if you have a medical condition that would make it impossible to pass medical underwriting. To exercise your HIPAA rights, you first have to exhaust all job-based coverage available to you, including COBRA, which allows you to continue in your employer's plan for 18 months by paying the full cost plus 2 percent. Then you have to apply for individual coverage within 63 days after your old coverage ends. Every state has to make sure there is at least one policy available to you that has to accept you regardless of your health status and without waiting periods for pre-existing conditions.

3 RESEARCH THE MARKET A good place to start gathering information is eHealthInsurance.com, a reputable Web site that links to hundreds of individual plans nationwide. Use it to get a range of policies available in your state and to compare prices and benefit levels. But the quoted prices are available only to people who pass medical underwriting; in most states if you have any kind of health condition, you can be turned

down or charged much more. You can also contact companies directly. Your state's insurance department Web site might have a list of companies licensed to sell health insurance in the state; some list licensed agents.

4 GET ADEQUATE BENEFITS Make sure that any policy you buy covers everything that is "medically necessary" for any health problem, including emotional disorders. That includes doctor visits, outpatient and inpatient treatments, all hospital expenses, drugs, preventive care, rehabilitation care, prenatal care, and screening tests. Karen Pollitz of the Georgetown University Health Policy Institute says, "If you buy a policy that won't pay your expenses if you get sick, why did you bother?"

5 LOOK BEYOND THE PREMIUM

The real costs of an insurance plan include the monthly premium, the annual deductible, and the copays for office visits and prescription drugs. Make sure you understand which copays and coinsurance payments apply to the deductible and the out-of-pocket limit. You also need to know whether the policy has a lifetime cap on benefits. Unlimited is best, but experts we consulted say \$2 million is a bare minimum. We have created tools you can use to compare features of different plans. For more information, go to www.ConsumerReports.org/health.

6 KEEP LOOKING You might be eligible for insurance designed for people who can't pass medical underwriting, though you can't count on hearing about that from a broker or private insurer. Thirty-four states maintain high-risk pools for that purpose; others designate selected Blue Cross-Blue Shield plans as "insurers of last resort." But they might be expensive. State-specific information is available at www.healthinsuranceinfo.net.

I can't find anyone who wants to cover me.

Bruce Stephens, Tucson, who had a liver transplant 10 years ago



allows him to stay on his former employer's plan for 18 months, paying the entire premium himself. Stephens recently went shopping for insurance to cover him when COBRA runs out. "I went to agents and individual companies, who found insurance for my wife and son, who's 21, but I can't find anybody who wants to cover me," he says. A few companies offered insurance only if they could exclude his blood tests and anti-rejection drugs related to his transplant. He's still looking.

Consumers discover that though individual policies are sold by companies with familiar names like Anthem and Aetna, the individual market is unlike the group market they are used to.

Group insurance is usually the best deal around for both insurers and insured. Employers typically pay a hefty share of the premium, usually around 70 to 85 percent, in exchange for a tax break. Job-based plans tend to be fairly comprehensive, and the subsidized premiums, though they've risen sharply in the past seven years, remain low enough that most employees sign up. That means group plans collect enough premiums from the majority of people who are relatively healthy to pay the medical expenses of the few who are not.

"The fact that they're employed is the glue that holds people in the group market," says David Shea, a health-insurance actuary in Virginia and spokesman for the American Academy of Actuaries. People who buy individual health insurance pay the entire premium themselves.

"People can voluntarily stay out of the market completely," says Linda Blumberg, Ph.D., principal research associate at the Urban Institute, a Washington, D.C., think tank. "We want to spread the risk as broadly as possible, and the private market is just too small."

Shea offered a simplified example of why that is so:

"Person A is 25 years old, exercises regularly, isn't overweight, and doesn't smoke. Her health-care costs average \$50 a month. Person B is 50 years old, smokes a pack a day, doesn't exercise, and is 60 pounds overweight. His health care costs \$250 a month. If an insurance company charges a premium that covers the aver-

learn that he was uninsurable.

"I've been diagnosed with diabetes but I'm perfectly healthy," he says. "I follow a strict diet. I'm not overweight and I walk 20 miles a week. I check my glucose levels regularly. I take oral medication, and my diabetes is completely under control."

His problems result from the practice called medical underwriting. It's illegal nationwide for insurers to discriminate against people in group plans on the basis of their health. But in all but a handful of states, medical underwriting for individual plans is allowed. Here's how it works:

If you want an individual policy, you must fill out a detailed health-history questionnaire and might be asked to submit the results of a recent physical exam or have blood or urine tests. The insurance company might look up your prescription records in the databases of pharmacy benefit management companies.

If the company doesn't like what it sees, in many states, it can flatly turn you down, quote you a much higher premium, or offer you insurance that covers everything except the health conditions it doesn't like. Applicants for individual health insurance quickly learn that although they consider themselves healthy, insurers may not.

Health Net, for instance, lists "diabetes, once diagnosed, all treatments" on its list of "declinable conditions." Diabetes is one of a lengthy list of conditions that will

INDIVIDUAL PLANS

76%
of uninsured couldn't
afford to buy a plan

age cost of these two people, it's going to be \$150 a month. So which person is going to enroll? Person B, because Person A's costs are much lower than the premium charged. And that's where the market starts to fall apart." Insurers call that phenomenon "adverse selection," and they use strategies to minimize risk. It may make sense from the insurer's point of view, but it creates difficulties for people in less than perfect health trying to get or hold on to individual health policies.

DISQUALIFIED FOR DIABETES

When Michael Miano, 61, of Abingdon, Va., first sought to buy individual insurance in 2003 after leaving a federal regulatory position and exhausting his COBRA benefits, he was distressed to

automatically get you into state high-risk pools, special insurance products maintained by 34 states for people who can't get insurance on the open market.

"It sounds harsh, but insurance is an actuarial science that looks at the likelihood of something happening and what the cost will be," says Janet Trautwein, chief executive officer of the National Association of Health Underwriters. "When a diabetic does have complications, they are unbelievably expensive, and that's why a diabetic is always turned down, even if they're running marathons."

But conditions that most lay people would consider less serious than diabetes will also get you turned down. PacifiCare may decline anyone who takes prescription medications for high blood pressure, acid reflux, asthma, migraines, arthritis, or depression. Aetna won't insure anyone who's had a hip or knee replacement.

ARTHRITIS AND HAY FEVER EXCLUDED

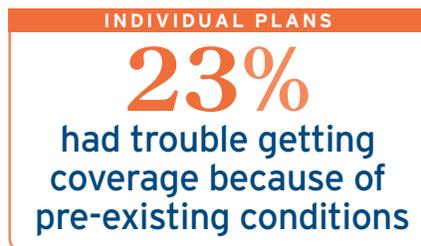
Insurers can be inconsistent. In 2001 the Kaiser Family Foundation, a nonprofit group that studies health policy, commissioned a study that created seven hypothetical insurance customers with a range of health conditions. They were as diverse as a young woman with seasonal hay fever requiring allergy shots and an occasional antihistamine medication, and an HIV-positive man. The researchers asked 19 insurers in eight states to put those profiles through their real underwriting process, for a total of 60 applications per customer.

Every insurer turned down the HIV-positive man, and all of the other "applicants" were medically underwritten at least some of the time, including the young woman with hay fever. Insurers rejected five of her applications. In 46 cases, they agreed to cover her only at a higher cost or by excluding coverage for her hay fever (or in three cases, her entire upper respiratory system).

A hypothetical 62-year-old, overweight, smoking, hypertensive retired salesman got rejected outright 33 out of the 60 times and accepted at "standard" rates only twice. The remaining offers either cost more, reduced benefits, or excluded cov-

erage of his entire circulatory system.

Maggie Frazier, 59, of Cumming, Ga., is facing just such a problem. She has rheumatoid arthritis, but her symptoms are in remission as long as she takes a drug called Enbrel, which costs \$1,731 a month. Her current \$1,120-a-month plan is being dissolved because of dwindling participation. She says that she cannot secure new coverage except with an ex-



clusion for the rheumatoid arthritis and any illness associated with it, but she also can't afford the \$2,200 monthly bill for replacement insurance plus the Enbrel. "Do I put myself in the poorhouse," Frazier says, "or do I drop my insurance, pay for Enbrel myself, and hope nothing else happens to me for the next six years until I can go on Medicare? You see where my rock is. I'm at the hard place."

As the Kaiser underwriting study documented, people like Frazier, with existing health problems, may be able to get insurance only if it doesn't cover those

very problems. In 37 states, insurers can exclude pre-existing conditions permanently, and most of the others permit insurers to exclude pre-existing conditions for some length of time after enrollment, typically six months to two years.

"Companies will put an exclusion on a condition for three years, but the three-year period won't start until you stop getting treated for the condition, such as going three years without needing a prescription for allergies," says Jay Norris, an insurance broker from Broomfield, Colo.

"In some states, you don't even have to know you had the condition," says Gary Claxton, director of the Health Care Marketplace Project at the Kaiser Family Foundation. "Something as simple as dizziness noted on a chart, or an innocent visit to a chiropractor, may be enough."

THE \$4,284 MONTHLY PREMIUM

If you go to the eHealthInsurance.com Web site, which links to hundreds of insurance plans across the country, you will find many policies offered at seemingly affordable prices. A recent search found policies available for a 25-year-old man in Evergreen, Colo., for as little as \$45 a month. But unless you are also 25 years old and in perfect health don't bet on getting such a policy.

Continued on next page.

closeup

	INDIVIDUAL PLAN	EMPLOYER PLAN
Overall complaints with coverage	71%	53%
Insurance covered most costs	55	81
Premium is too high	52	29
Postponed needed medical care because of costs	45	31
Deductible is too high	41	28
Does not adequately cover costs of doctor visits	26	16

Source: Consumer Reports National Research Center survey of nationally representative sample of 2,905 adults 18 to 64.

"It's true that the advertised prices for many individual policies in many states are eye-poppingly low," says Karen Pollitz, a research professor who heads projects on individual health insurance at the Georgetown University Health Policy Institute. "The policies often cover very little: \$5,000 deductibles, four doctor visits a year, no drugs."

Our survey found that the median out-of-pocket medical expenses for the past 12 months were \$2,264 for those with individual insurance vs. \$973 for people with employer-based plans.

And anyone with a pre-existing condition who has individual insurance must pay whatever rate the company charges. Although it is illegal in all states to kick people out of insurance plans if they become ill, in most states insurance companies are allowed to increase rates as much as they need to cover the plan's medical costs, plus a reasonable profit.

Companies also control their risk by using a maneuver known as closing a block or book of business. They stop accepting new customers in a plan, which kicks off a process known as a "death spiral."

Even if everyone in an insurance plan starts out relatively healthy, as time goes

on, people get sick, and the cost to insure them rises. Once the pool is closed, costs for the remaining members rise inexorably. Healthier members find cheaper plans, but sicker ones are effectively forced out because they can't afford coverage.

INDIVIDUAL PLANS
16%
**had been uninsured
sometime in the
past 12 months**

Once that process gets going, premiums can rise at a breathtaking rate. Jesse Paul, 59, an Indianapolis lawyer, paid \$25.50 a month for his individual, \$100-deductible Prudential major medical policy when he took it out in 1980. Premiums rose steadily for years but at a pace that Paul deemed "rational in terms of medical costs." In 2003 the premium shot up from about \$1,200 to about \$1,900 a month at renewal.

When Paul complained to the state insurance department, he learned that the policy had been closed to new entrants for years, that he was one of only 400 to 600

customers left in the state, and that the premium increase was permissible under Indiana law. Paul reached his breaking point when he got his latest renewal notice in August; the monthly premium was now \$4,284. He quickly found out he was uninsurable on the private market because he took medications for high blood pressure, high cholesterol, and allergies. He is now insured by the Indiana high-risk pool for a premium of \$650 a month.

FIXING THE MARKET

Massachusetts is starting the most ambitious state effort yet to secure health insurance for all residents. It requires everyone to get health insurance if affordable coverage is available, either through their jobs or individually. People earning modest incomes can buy subsidized plans, but people with an income more than three times the poverty level, \$61,956 for a family of four, must buy policies at market rate. While 127,000 residents, many of them previously uninsured, have bought the subsidized insurance, market-rate insurance is still costly.

Reform proposals by most of the major presidential candidates count on the private individual market to expand coverage. Several candidates propose tax incentives for people to buy individual insurance. Consumers Union, the nonprofit publisher of CONSUMER REPORTS, opposes that approach because it does nothing to fix underlying problems, such as medical underwriting, and the tax breaks wouldn't be enough to make insurance affordable for people with lower incomes.

Other candidates propose to expand coverage by bringing more people into the risk pool. Techniques include requiring everyone to have health insurance, allowing individuals to buy into large public or private risk pools, requiring insurers to cover everyone regardless of health history, and subsidizing premiums for lower-income consumers. Consumers Union believes that those are more promising approaches, so long as they are coupled with vigorous efforts to control costs, eliminate waste, and encourage better coordination of care for chronic conditions.

Be wary of 'affordable' plans

Someone who can't obtain comprehensive individual health insurance might be tempted to purchase one of the many lower-cost "affordable" plans, frequently marketed through associations.

But experts say stay away because the premiums aren't worth their limited coverage. For instance, a plan called AWA Gold, sold online through the American Workers Association, includes just three office visits per year. It covers a maximum of 30 hospital days per year, at \$750 per day, a fraction of what a hospital stay really costs.

Susan Kelly, a 47-year-old Houston real-estate agent, said she had an individual "catastrophic hospital expense

plan" through the National Association for the Self-Employed for about \$650 a month. In 2004 she got a diagnosis of breast cancer. "The insurance covered my surgery and the three days I was in the hospital, and that was it," she says. It didn't cover tests, biopsy, or chemotherapy. She is paying off a \$100,000 debt.

Here's what to check in a plan:

- Make sure it mentions all types of coverage, including hospitalization, in-patient and outpatient surgery, office visits, mental health care, physical therapy, and prescription drugs.
- Avoid plans that set fixed dollar or number limits on visits, such as four visits per year or \$500 per hospital day.
- Look for disclaimers such as "This is not major medical coverage." Avoid a plan that calls itself "limited benefit" insurance.

