



**STATEMENT OF  
SABRINA CORLETTE, RESEARCH PROFESSOR AND PROJECT DIRECTOR  
GEORGETOWN UNIVERSITY  
CENTER ON HEALTH INSURANCE REFORMS**

**HEARING ON  
A NEW, OPEN MARKETPLACE: THE EFFECT OF GUARANTEED ISSUE AND NEW  
RATING RULES  
SENATE HEALTH, EDUCATION, LABOR AND PENSIONS COMMITTEE**

**APRIL 11, 2013**

Good morning, Mr. Chairman, Ranking Member Alexander, Members of the Committee. I am Sabrina Corlette, a Research Professor and Project Director at Georgetown University's Center on Health Insurance Reforms. I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA).

I thank you for the opportunity to testify before you today, for the leadership of this Committee in drafting key provisions of the Patient Protection and Affordable Care Act (ACA), and for the ongoing oversight you have conducted to assess its implementation. This hearing today is a timely one, as we are now slightly less than 6 months away from open enrollment into health plans that will meet sweeping new standards for access, affordability, and adequacy.

In my testimony, I will focus on how the nongroup health insurance market works today for consumers, and how it will change upon implementation of the ACA's market reforms, some of the most significant of which go into effect on January 1, 2014. The ACA has a particular focus on the nongroup market because of its well-documented systemic problems, which include:

- 1) Lack of access to coverage because of health status discrimination
- 2) Inadequate coverage
- 3) Unaffordable coverage
- 4) Lack of transparency and accountability

Today, approximately 48 million non-elderly Americans are uninsured, and approximately 19 million non-elderly Americans have insurance coverage in the nongroup market, meaning they do not have coverage through their employer or public programs such as Medicare and Medicaid.<sup>1</sup> Anyone can find themselves at any time in the position of being uninsured, or in the nongroup market. Those who buy insurance on their own can be self-employed entrepreneurs, farmers and ranchers, early retirees, part-time workers, widows, and young people "aging off" their parents' plans. This market tends to be the option people turn to as a last resort when they do not have an employer offer or insurance and are ineligible for public coverage.

What does the health insurance marketplace today look like for these individuals and families, particularly those who might be in less than perfect health?

### Access Issues

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<sup>1</sup> U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2011," September 2012.

In today's marketplace, one of the ways health insurers manage costs is to make use of aggressive underwriting practices to deny coverage to individuals with pre-existing conditions.<sup>2</sup> A seminal Georgetown study from 2001 found that even people with minor health conditions, such as hay fever, may be turned down for coverage, and more recent studies have found that these practices have only increased over time.<sup>3,4</sup> Health insurers maintain underwriting guidelines that can list as many as 400 medical conditions as reasons to trigger a permanent denial of coverage.<sup>5</sup> At Georgetown, we hear stories every day of people struggling to access coverage in the nongroup market. For example, we were recently contacted by a young man who was turned down for coverage not because of his own health status – he is a healthy 30-year-old running his own successful consulting business. Rather, he was turned down because his wife is expecting a baby. Even though her prenatal care is covered through her own, student health plan, the insurer turned him down because of the risk that they might have to pay for care for the newborn.

There's also the story of John Craig, a 46-year-old software consultant in Orem, Utah, who plays racquetball twice a week, doesn't smoke or drink and isn't overweight. When he tried to buy an individual insurance policy, however, he was denied. The insurance company cited sinus infections and depression, even though he hadn't experienced symptoms of either condition for years.<sup>6</sup>

According to a GAO study, average denial rates in the individual market are 19 percent, but they can vary dramatically market-to-market and insurer-to-insurer.<sup>7</sup> For example, GAO found that across six major health insurers in one state, denial rates ranged from 6 to 40 percent. Unfortunately, access is probably even more difficult for people with health conditions than these data suggest, because of a common industry practice known as "street underwriting, in which an insurance company agent asks a consumer questions about their health history and steers them away from the plan before they fill out or submit an application.

Under the ACA, these denials will no longer be permitted. Under the ACA's guaranteed issue and renewal provisions, with limited exceptions health insurers must accept applicants, and continue to renew their policies, regardless of their health condition, health history, or that of a family member.

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<sup>2</sup> U.S. House of Representatives, Committee on Energy and Commerce, "Memorandum: Coverage Denials for Pre-Existing Conditions in the Individual Market," October 12, 2010.

<sup>3</sup> Karen Pollitz, "How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?" Kaiser Family Foundation, June 2001.

<sup>4</sup> *Supra*, n. 2.

<sup>5</sup> *Id.*

<sup>6</sup> Sarah Lueck, "Seeking Insurance, Individuals Face Many Obstacles," *Wall Street Journal*, May 31, 2005.

<sup>7</sup> General Accounting Office, "Private Health Insurance: Data on Application and Coverage Denials," March 2011.

The ACA also prohibits the practice of rescissions. Prior to the enactment of this provision, which went into effect in September of 2010, insurers in many states would investigate individual policyholders who make claims in their first year of coverage. If the company found evidence that their health condition was a pre-existing one, and not fully disclosed during the initial medical underwriting process, the company could deny the relevant claims, and in some cases cancel or rescind the coverage.<sup>8</sup> Thanks in large part to this Committee's leadership, this practice is now illegal, except in a clear case of fraud by the policyholder. And since this provision was made effective in 2010, Georgetown research has found that insurers have generally come into compliance without much incident.<sup>9</sup>

### Affordability Issues

Health insurance is an expensive product, and it is particularly expensive for people trying to buy it on the individual market. Unlike those with employer-sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance must pay their full premium.

For those in less than perfect health, those premiums can cause them to forego coverage completely. One national survey found that 61% of people seeking individual coverage but failing to ultimately buy a policy cited the high cost of premiums as the reason.<sup>10</sup> Health insurers manage costs by segmenting their enrollees into different groups and charging them different prices based on their health status or other risk factors.<sup>11</sup> In practice, this means that people can be charged more because of a pre-existing condition (and even if, like John Craig, they've been symptom-free for years), because of their age, gender, family size, geographic location, the work they do, and even their lifestyle. A Georgetown study of rating practices in unregulated markets found rate variation of more than nine-fold for the same policy based on age and health status.<sup>12</sup> People in their early 60s can be charged as much as six times the premium of people in their early twenties, based on age alone. I had one gentleman call my office last year, in his early 60s. He told me he couldn't find a policy for less than \$1300 per month. Unfortunately, at the time all that I could tell him was that things would get better in 2014.

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<sup>8</sup> Girion, L., "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, November 9, 2007.

<sup>9</sup> Katie Keith, Kevin W. Lucia, and Sabrina Corlette, "Implementing the Affordable Care Act: State Action on Early Market Reforms," The Commonwealth Fund, March 2012; Kevin W. Lucia, Sabrina Corlette and Katie Keith, "Monitoring Implementation of the Affordable Care Act in 10 States: Early Market Refoms," The Urban Institute, September 2012.

<sup>10</sup> Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, "Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families," The Commonwealth Fund, July 2009.

<sup>11</sup> Melinda B. Buntin, M. Susan Marquis, and Jill M. Yegian, "The Role of the Individual Insurance Market and Prospects for Change," *Health Affairs*, November 2004.

<sup>12</sup> *Supra*, n. 3.

And they will get better. Beginning January 1, 2014, insurers will no longer be able to charge someone more because of their health status, the work they do, or their gender. And they will be limited in the amount they can differentially charge because of someone's age or use of tobacco products.

And of course, through the new health insurance exchanges, low- and moderate-income individuals will be eligible for premium tax credits that will help make coverage more affordable. An Urban Institute analysis estimates that over 8 million people will take advantage of the tax credit, with an average per-recipient tax credit of \$4553.<sup>13</sup>

### Adequacy Issues

Currently, the insurance coverage available to individuals buying on their own falls considerably short of the comprehensive health coverage that you, as Members of Congress, and I, as a Georgetown professor, have come to expect. In addition to paying more in premiums, people buying individual policies face much higher deductibles and other forms of cost-sharing, limited benefits, and spend a much larger share of their income on health insurance and health care than those of us with employer-sponsored coverage.<sup>14</sup> A recent Commonwealth Fund survey found that 60 percent of people with health problems found it very difficult or impossible to find a plan with the coverage they needed, compared to about 1/3 of respondents without a health problem.<sup>15</sup>

Indeed, the number of "underinsured" individuals has risen dramatically over the last decade, to an estimated 29 million adults in 2010.<sup>16</sup> These are people with health insurance, but with high out-of-pocket health expenses relative to their income. Underinsurance is particularly prevalent in the nongroup market. In fact, a recent University of Chicago study found that over half of all nongroup plans currently in the market do not meet the minimum standards for coverage set by the ACA.<sup>17</sup> Coverage in the nongroup market today can be woefully inadequate for many reasons, including:

*Pre-existing condition exclusions or riders.* In many states, insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses on their

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<sup>13</sup> Fredric Blavin, Matthew Buettgens, and Jeremy Roth, "State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain," the Urban Institute, January 2012.

<sup>14</sup> Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, "Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families," The Commonwealth Fund, July 2009.

<sup>15</sup> *Supra* n. 10.

<sup>16</sup> Cathy Schoen, Michelle M. Doty, Ruth H. Robertson, and Sara R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70%," *Health Affairs*, September 2011.

<sup>17</sup> Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover, and Ethan Levy-Forsythe, "More than Half of Individual Health Plans Offer Coverage that Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs*, June 2012.

application for a nongroup policy. This is an amendment to the policy contract called an “elimination rider.” In addition, once coverage begins, if a consumer makes claims under the policy, he or she can be investigated to see whether the health problem was pre-existing. In many states, it’s not necessary for a health condition to have been diagnosed before the consumer bought the policy for it to be considered “pre-existing.” And insurers can look back for up to 5 years into a person’s health care history to determine whether the current condition was pre-existing. This is sometimes called “post-claims underwriting.” For example, in Alabama, a consumer applying for nongroup coverage might have a known pre-existing condition permanently excluded from his policy. In addition, if he makes a claim for health care services during the first two years of his coverage, the health insurer can look back at his medical history dating back 5 years to look for evidence that the current health problem existed before he bought the policy. If such evidence is found, the insurer can refuse to pay for care associated with the condition.

Under the ACA, these pre-existing condition exclusions were prohibited for individuals under the age of 19 in 2010, and will be prohibited for all individuals beginning in January of 2014. This means people will be able to access the care they need from their first day of coverage.

*Limited Benefits.* Insurers selling health insurance in the nongroup market often sell “stripped down” policies that do not cover benefits such as maternity care, prescription drugs, mental health, and substance abuse treatment services. For example, twenty percent of adults with individually purchased insurance lack coverage for prescription medicines, but only 5 percent of those with employer coverage do.<sup>18</sup>

To improve the value of coverage, the ACA sets minimum standards that insurers must cover. This “essential health benefits” package requirement is designed to ensure that consumers have comprehensive coverage that meets their health needs and protects them from financial hardship. The essential health benefits are expected to be included in the coverage of up to 68 million Americans by 2016 and will include – at a minimum – 10 categories of benefits: ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.<sup>19</sup>

*Lifetime and Annual limits.* Prior to enactment of the ACA, it’s estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits

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<sup>18</sup> *Supra*, n. 10.

<sup>19</sup> Sabrina Corlette, Kevin W. Lucia, and Max Levin, “Implementing the Affordable Care Act: Choosing an Essential Health Benefits Plan,” The Commonwealth Fund, March 2013.

every year. And 18 million people are in plans with annual limits on their benefits. These limits can be a matter of life and death. For example, Georgetown faculty recently documented the story of Martin Addie, a gentleman with severe hemophilia.<sup>20</sup> His body produces less than 1% of the clotting factor he needs, so he must administer clotting factor every other day to prevent bleeding. This costs approximately \$60,000 per month. Prior to the ACA, he had blown through lifetime limits with three different health plans, causing incredible stress and worry – and putting his health at significant risk. Thankfully, the ACA brought in a ban on lifetime limits, and put immediate restrictions on annual dollar limits (banning them completely in 2014).

*High Out-of-Pocket Costs.* Nongroup policies often come with high deductibles – \$10,000 or more is not uncommon - and high cost-sharing. In fact, deductibles can be about three times what they are in employer-based plans.<sup>21</sup> As a result, many have very low actuarial values, below the minimum standard in the ACA of 60% for a “Bronze” level plan.<sup>22</sup> One study in California found that nongroup policies pay for just 55% of the expenses for covered services, compared to 83 percent for small group health plans.<sup>23</sup> Thus, these policies have fewer covered services AND cover a smaller share of the costs associated with the services they do cover. It is not surprising that approximately 57 million Americans live in families struggling with medical debt and 75 percent of those families had health insurance.<sup>24</sup>

For the first time, the ACA sets new standards to ensure that insurance coverage does what it should: provide real financial protection to individuals and families. The law sets coverage tiers, with Platinum plans being the most generous (enrollees will pay, on average, 10% of the out-of-pocket costs) and Bronze plans being the least generous, with enrollees paying, on average, 40% of the out-of-pocket costs. In addition, the ACA sets new limits on the total amount of out-of-pocket spending consumers must incur, based on their income.

And, for individuals earning up to 250% of the federal poverty level, the ACA provides cost-sharing subsidies that will reduce the cost-sharing amounts and annual out-of-pocket limits. These subsidies have the effect of increasing the overall actuarial value of coverage, on a sliding scale basis, so that people between 100-150% of poverty will be responsible for only 6% of their out-of-pocket costs, rising to 22% for people at 250% of poverty.

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<sup>20</sup> JoAnn Volk, “Martin Addie: ACA Ban on Lifetime Limits has Ended his Coverage Circus,” CHIRblog, November 14, 2012.

<sup>21</sup> Roland McDevitt, Jon Gabel, Ryan Lore, et al., “Group Insurance: A Better Deal for Most People than Individual Plans,” *Health Affairs*, January 2010.

<sup>22</sup> *Supra*, n. 17.

<sup>23</sup> Jon Gabel, Jeremy Pickreign, Roland McDevitt, et al, “Trends in the Golden State: Small-group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet,” *Health Affairs Web Exclusive*, July/August 2007.

<sup>24</sup> Peter J. Cunningham, “Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003-2007,” Center for Studying Health System Change, Tracking Report No. 21, September 2008.

## Transparency and Accountability Issues

Lastly, transparency and accountability are critical to a well-functioning insurance marketplace. Shopping for health insurance is a complex and confusing task for consumers, most of whom do not understand important components of the products being sold to them or how it works. As one study noted, most consumers rate reading their health insurance policy as a less appealing activity than preparing their income taxes or going to the gym.<sup>25</sup>

Prior to the ACA, individuals attempting to buy coverage in the nongroup market faced confusing choices, with little transparency regarding pricing or what their policy would actually cover – and what it would not. For example, one woman contacted a colleague of mine when she was attempting to switch to a higher deductible plan last December. The insurer told her that they could not quote her a monthly premium until she actually enrolled in the plan. And when questions arise about these confusing choices and the lack of transparency, consumers have few places to go to get unbiased, impartial advice on the plan that would best suit them and their family.

The ACA ushers in a number of critical changes to improve consumers' ability to shop for and compare plans in a manner that allows them to make informed choices and select a plan that best meets their needs.

One of the most talked about are the state-based health insurance exchanges (now called "marketplaces") that will help consumers make apples-to-apples comparisons among health plan options, and allow them to shop with confidence, knowing that all of the participating plans have met minimum quality standards.

Less talked about, but in polling one of the most popular provisions of the ACA, are the new "Summaries of Benefits and Coverage," (SBC) which insurers are now required to provide to individuals and employees seeking coverage. These standardized, easy to read summaries of the benefits, cost-sharing, limitations and exclusions in a plan can help consumers understand their coverage and make better choices. Recent consumer testing by Consumer Reports has found that consumers rated the SBC as more helpful than other sources of plan information, such as employer guides and health insurers' brochures.<sup>26</sup>

The ACA also includes new expectations for accountability for insurers. The law improves state rate review practices, and authorizes the federal government to review unreasonable rate increases if a state is unwilling or unable to do so. Insurers proposing new premium rate

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<sup>25</sup> ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008.

<sup>26</sup> Lynn Quincy, "Early Experience With a New Consumer Benefit: The Summary of Benefits and Coverage," Consumers Union, February 27, 2013.

increases must provide detailed and public justification for those increases. Insurers must also comply with new medical loss ratio (MLR) standards, meaning they must spend at least 80% of nongroup premiums on health care and improving health care quality. If insurers' MLRs go below 80%, they must issue rebate checks to enrollees. The MLR was in effect for 2011, and in 2012 nearly 12.8 million Americans received rebates totaling more than \$1.1 billion.<sup>27</sup>

### Conclusion

The evidence is clear and unequivocal: the current nongroup market does not work for the people who need it most. Anyone with just about any health condition could face difficulty obtaining coverage in the individual market. What we have today is a system of "haves" and "have nots." And remember – even if you happen to be a "have," such as those young and healthy individuals who can access this market – you cannot have peace of mind. Just because you are young and healthy today does not mean you will remain so. It is an unfortunate fact of life that all of us will get older and most of us will have some health problems at some point in our lives. Yet today's nongroup market can't even provide people with the most basic obligation of insurance, which is to protect people from bad, unexpected events. And remember those of us who are happy with our employer-based coverage cannot be guaranteed it will last forever. A bad economy – a bad election – and any one of us could be subject to the nongroup market and all of the risks that come with that.

Congress, led by this Committee, recognized the fundamental injustice of the current health insurance marketplace. In the ACA it enacted sweeping reforms that will improve Americans' access to adequate, more affordable health insurance coverage that allows them to get the care they need and protect them financially. This kind of change will be transformative and disruptive, particularly for those who have benefited from the inequities of the current system. But it is the right thing to do.

Thank you, Mr. Chairman, Ranking Member Alexander, Members of the Committee, for the opportunity to speak before you today. I look forward to your questions.

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<sup>27</sup> Healthcare.gov, "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers," June 21, 2012.