Congressional Health Care Reform Education Project
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Private Health Insurance: Individual Insurance and Related Topics

House Summary

Gary Claxton, vice president and director of the Health Care Marketplace Project at the Henry J. Kaiser Family Foundation, explained differences between the individual, or nongroup, health insurance market and employer-sponsored coverage. In the nongroup market, people purchase coverage directly from an insurer – on their own or through a discretionary association. In either case, the person must qualify individually for the insurance and can be rejected for reasons such as pre-existing conditions (unlike with employer-sponsored coverage).

Mr. Claxton noted that premiums can actually be lower in the nongroup market, but for reduced benefits (compared with employer coverage) and with higher deductibles and copayments. Premiums in the nongroup market vary according to a person's age, location, health and other factors. Coverage can be written in the nongroup market to exclude certain conditions or parts of the body, e.g. maternity care could be ruled out for a woman of childbearing age. Or such condition-specific coverage could be offered as an extra-cost rider.

Some other differences include:

Tax treatment – Premiums paid on an employee's behalf are not counted as taxable income for the employee. Premiums paid by an individual for nongroup coverage are tax deductible only if total out-of-pocket health expenses (including the premiums) exceed 7.5 percent of income.

Administrative costs – Many people are enrolled at one time in the employer-sponsored market. So administrative costs are less than with nongroup policies, which are sold one at a time. Many people keep nongroup policies for a relative short period (more than half of these policies are dropped before two years are up). Thus, insurers must recoup their marketing and sales costs "up front."

Discussing policy issues, Mr. Claxton noted that the premiums and out-of-pocket expenses for those covered by nongroup policies can have a noteworthy impact on low- and moderate-income families. The average wage of those not offered coverage at work is $12 per hour, he said, compared to $30 per hour for those who are offered job-related coverage.

Nancy Turnbull, senior lecturer on health policy and associate dean for education programs at Harvard, described the workings of the Massachusetts health insurance Connector, on whose board she sits. She explained that the Connector is a body that helps people shop for, and buy, individual health coverage. It negotiates rates on behalf of consumers and provides "one-stop shopping," making it easier for consumers to compare policies. But the Connector doesn't buy insurance for consumers, nor does it assume any of the risk of covering people, she said.

Among the advantage of buying coverage through the Connector:

- Those who are employed but who aren't eligible for their employer's health coverage can buy coverage with pre-tax dollars through Section 125 flexible spending arrangements.
- Part-time workers with more than one employer can pool employer contributions toward the cost of their insurance.

One reason the Connector works so well in Massachusetts, Dr. Turnbull said, is that the state already had in place several insurance reforms. These include guaranteed issue and guaranteed renewal of policies, and limits on rating practices and rate variations.

If the Connector idea were to be expanded nationally, here are some of the questions to be addressed, she said:

- Would there be one national connector, a national connector with regional branches, freestanding regional connectors, or state-based connectors?
- Would small employers be able to buy coverage for their employees through the connector? What about large employers?
- Would the connector be seen as competition by private insurers?
- Would the connector be government financed, self-sustaining, or some combination of the two?

Deborah Chollet, senior fellow at Mathematica Policy Research, provided an overview and update on state high risk insurance pools. These pools, she said, are the insurers of last resort for those who apply for individual coverage and are only offered coverage with a permanent exclusion for a condition or part of the body, or are quoted a high premium due to their health status, or are denied outright because of their health status. People can also be eligible because they have had group coverage and have the right to enroll in a risk pool under the Health Insurance Portability and Accountability Act or the Trade Adjustment Assistance Act. (The situations that make a person eligible for a high risk pool vary by state.) Thirty-two states presently have high risk pools that accept new enrollees, she said.

The pools were set up largely at the request of health insurers, as a way of helping keep premiums affordable for healthy individuals. And removing high-cost individuals from the national health insurance pool does in fact reduce costs for others, Dr. Chollet pointed out. The average per-person expenditure for health care nationally would go down from $2,500 to $1,909 if the most expensive one percent of individuals were taken out of the general insurance pool, she noted.

Premiums charged to high risk pool individuals are 125 percent to 200 percent of the standard rates in the nongroup market. Premiums can be increased before a year of coverage has been reached. If a person is eligible for other coverage but doesn't take it for any reason, the person can't enroll in the high risk pool. A pre-existing condition can mean that an enrollee must pay for the coverage, but not file any claims for care related to the pre-existing condition for three to 12 months. These factors and others mean that relatively few people, around 2 percent of nongroup enrollees in most states, are in high risk pools.

High risk pools could work better, Dr. Chollet said, if: premiums were close to the standard rate; exclusions because of pre-existing conditions were shorter; a person who had had any other coverage were automatically eligible for the high risk pool; prescription drugs, maternity care and mental health services could not be excluded; there were no requirements that a person must take any other available coverage; and minimum length of residency weren't required, among other improvements.

During the Q&A session, the issue of "rescissions" was discussed. A rescission means that after a person has been enrolled for health coverage, that coverage is canceled and the claim that triggered the rescission will not be paid. Rescissions can be made if the person did not tell the whole truth about pre-existing conditions on his or her insurance application. But rescissions can also happen if the person didn't know he or she had a pre-existing condition, but did have symptoms noted on a medical record that could suggest a problem. Any pre-existing condition can prompt a rescission, not just a condition related to the claim that caused the insurer to look more deeply into the person's medical record.