Center for American Progress

The State of the Individual Market

The Problems Facing the Individual Health Insurance Market in the District of Columbia

Insurers limit care by offering those in the individual market weak benefits, and sometimes excluding benefits all together. Insurers will sometimes even cancel an insurance policy once a customer starts making costly claims. Study after study has documented that people with pre-existing conditions can find it nearly impossible to get the coverage they need, or face high costs in trying to purchase it.[1]

Weak benefits

One way insurance companies limit care is by offering coverage on the individual market that has a weaker benefit package than most employers provide.[2] Despite these smaller benefit packages, individual insurance policies also usually come with high cost sharing, such as deductibles that average $2,000 for PPO coverage.[3]

Limiting benefits: The District of Columbia requires insurance companies to include 19 benefits in all individual insurance plans, which is lower than the national average of 38.[4] This does not include basic benefits such as cancer medication, maternity services, and chemotherapy.

Weakening affordability: Insurers also charge higher rates to those who might need more care, such as older Americans or individuals with health conditions. There is no limit on how much insurers in the District of Columbia can charge individual policyholders for health insurance.[5]

Excluded benefits

Insurers also exclude coverage for medical conditions that individuals know they need. Insurers do this by defining pre-existing conditions as broadly as they can and then excluding those pre-existing conditions from coverage.

Broadly defining pre-existing conditions: The more broadly insurance companies can define pre-existing conditions, the more conditions they can exclude from coverage, and the less care they will have to pay for. In the District of Columbia, if you had a symptom of a medical condition, even if it went undiagnosed or untreated, it counts as a pre-existing condition.[6] That means that individuals can be found to have a pre-existing condition based on a symptom for which they never received care.

Counting recent and old pre-existing conditions: The more medical conditions that insurers can count as pre-existing—even if they no longer exist—the more they deny care. In the District of Columbia, there is NO LIMIT on how far back into your medical history insurers can look.[7] This means any medical condition you have ever had can be excluded from your coverage.

Limiting care for pre-existing conditions: Once insurers have identified an individual's pre-existing condition, they will limit coverage by selling people policies that specifically exclude coverage for those conditions. In the District of Columbia, insurers are allowed to permanently exclude pre-existing conditions from an individual's coverage.[8] This means that some people will never be able to purchase health insurance for their medical conditions on the individual market.

Canceling coverage

It is possible for insurance companies in the vast majority of states to cancel coverage once insurers discover that expensive claims are being made on the policy.[9] In a game of "gotcha," insurers can compare the original application to a policyholder's medical history to find any discrepancy—no matter how small, innocent, or irrelevant—in an effort to cancel coverage. This can happen even years after the policy was purchased and in the face of complex insurance applications. Individuals who have their coverage canceled or rescinded are often left with large medical bills and no insurance moving forward just when they need it the most.

Denying coverage for those who need it now or later: In the District of Columbia, insurers can deny coverage based on health status at the time of application, limiting care for anyone with less than perfect health. This means that those individuals who obtain coverage but are found to have omitted a pre-existing condition on their insurance applications can have their coverage canceled, rescinded (retroactively canceled), or limited through a pre-existing condition exclusion.

Investigating health status: Rescissions can occur when an insurance company fails to conduct sufficient medical underwriting to find pre-existing conditions at the time of application. By being thorough and answering all questions up front, insurers could eliminate rescinding coverage later. The District of Columbia does not require insurers to conduct medical underwriting at the time of application.[10]

Little external review of canceled coverage: Just one state, Connecticut, requires insurers to submit requests to rescind or cancel coverage to state regulators. Insurers in most states are allowed to handle rescissions internally. The District of Columbia gives individuals the right to a formal appeals process if they believe their coverage has been unfairly rescinded or cancelled.[11]

Coverage ineligibility

Insurance companies will use a range of reasons to limit health insurance on the individual market based on who wants to buy it.

Prescription drug use: Taking prescription medications makes millions of Americans ineligible for coverage on the individual market.[12] For example, insurance companies in California bar individuals from coverage if they take any of the eight of the 20 most popular prescription medications in the United States.[13] That includes the top selling drug in the country, Lipitor, which has been prescribed to more than 26 million Americans to treat cholesterol.[14]

Height and weight: Health insurance will cost more for the approximately one-third of adults who are medically obese[15] (a BMI of 30 or higher), if it is available at all. Those with a BMI of more than 35 will simply be denied.[16] But it isn't just the obese who can be turned down. Coverage can more expensive, or denied, for those deemed too short, too tall, or too thin.[17]

Age: Age discrimination is prevalent in the individual insurance market.[18] A person who is 60 to 64 and healthy is going to pay on average four times as much for health insurance than an 18 to 24 year old—$1,170 per year vs. $4,185 per year.[19] Of course, that is only for those who are offered coverage.[20] Those 60 to 64 are three times more likely to be turned down for individual coverage than those 18-24.[21]

Gender: Being a woman means paying more for health insurance.[22] Pregnancy has long been a reason insurance companies use to charge women higher rates for health insurance,[23] despite the fact many individual insurance policies don't even cover maternity benefits.[24]

Occupation: Insurers will use your occupation to decide if you can buy insurance. Roofing, window cleaning, lumber work, and asphalt laying are occupations that insurers will sometimes not cover.[25] Even hobbies such as scuba diving and skydiving can mean being denied coverage.[26] Volunteer firefighters, a common activity in rural areas, can be denied coverage even if their full-time occupation only involves office work.[27]

Endnotes

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