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U.S. House of Representatives
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on

Health Reform in the 21st Century
Insurance Market Reforms

Mr. Chairman, Members of the Committee:

Thank you for inviting Consumers Union to testify on insurance market reforms and in particular, problems in the individual insurance market. Consumers Union is the independent, non-profit publisher of *Consumer Reports.*[1]

We not only evaluate consumer products like cars and toasters, we rate various health care providers and insurance products, and we apply comparative effectiveness research to save consumers millions and millions of dollars by purchasing the safest, most effective brand and generic drugs.[2] Our May 2009 issue features an article on "hazardous health plans," and points out that many policies are "junk insurance" with coverage gaps that leave you in big trouble.

The Problem of the Individual Insurance Market

The individual insurance market is Exhibit A for why America needs health reform. It is the epitome of everything wrong with the system (and when you think about it, the very term "individual insurance" is really an oxymoron):

--if it provides good coverage, it is too expensive for many who need it most;

--pre-existing condition exclusions and medical underwriting mean it often doesn't cover the costs consumers are most likely to incur;

--many policies have gaps in coverage, that consumers often don't understand;

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[1] Consumers Union, the nonprofit publisher of *Consumer Reports*, is an expert, independent organization whose mission is to work for a fair, just, and safe marketplace for all consumers and to empower consumers to protect themselves. To achieve this mission, we test, inform, and protect. To maintain our independence and impartiality, Consumers Union accepts no outside advertising, no free test samples, and has no agenda other than the interests of consumers. Consumers Union supports itself through the sale of our information products and services, individual contributions, and a few noncommercial grants.

[2] See www.ConsumerReportsHealth.org/BBD

--all too often it is a hassle to collect on a policy, and

--all too often, if you use it, you lose it, because of future huge increases in premiums.

Real Examples of Problems with the Individual Insurance Market

Appendix 1 to my statement documents these points.

Last summer, Consumers Union collected over 5,000 'stories' and traveled around the country documenting why our nation needs fundamental health care reform. Appendix 1 is a tiny sample of those stories, focusing on the particular problems of high cost, inadequate benefits, pre-existing condition exclusions, and administrative hassles in the individual insurance market.

If you only look at one, as a Medicare Committee, look at the first one: Tom from Hutchinson, Minnesota, who delays--at considerable pain and extra cost—hip surgery until he is on Medicare. An amazing number of these stories include people saying, "I'll just have to tough it out until I'm eligible for Medicare." If you enact legislation insuring all Americans, CBO ought to give you some savings in Medicare!

Why the Individual Insurance Market is so Flawed

For decades, individual insurance has been what economists call a 'residual' market—something to buy only when you have run out of other options. The problem is that the high cost of treatment in the U.S., which has the world's most expensive health-care system, puts truly affordable, comprehensive coverage out of the reach of people who don't have either deep pockets or a generous employer. Insurers tend to provide this choice: comprehensive coverage with a high monthly premium or skimpy coverage at a low monthly premium within the reach of middle- and low-income consumers. Particularly in this recession, more and more consumers are forced to choose the skimpy coverage/low premium policies.

It is understandable why the insurance market, particularly the individual insurance market, behaves the way it does. Most big insurers are for-profit or quasi-for-profit and have a fiduciary duty to their stockholders to return a profit. Historically, the least healthy 10 percent of the population consumes about 64 percent of the health dollar. The healthiest 50 percent of the population uses only 3 percent.[3] You don't need an MBA to figure out that the best way to make your shareholders happy is to avoid those sickest ten percent or charge them a very very high premium to cover their expected high costs. Add this basic economic fact to uneven and weak regulation of insurers, and consumers who need health insurance are constantly vulnerable.

Solutions

[3] AHRQ, Issue #19, June 2006.

We hope that this year Congress will enact reform legislation to ensure that a comprehensive package of benefits is always available and affordable for every American. That legislation will mean a number of big changes, including insurance reform: no pre-existing conditions and no waiting periods

Assuming you enact that kind of reform, it will probably include some form of initial and annual open enrollment period in some type of 'marketplace' or 'connector' where private and--we hope--a public plan could compete for consumers.

It is in that marketplace of enrollment that we ask you to provide critical consumer protection and assistance.

Why Consumers Need Help Shopping for Insurance

The honest, sad truth is that many of us are terrible shoppers when it comes to insurance. The proof is all around you. While provider network and local pharmacy and reputation are all factors, the fact is that many us spend more money than we have to on insurance products that are similar or even inferior to other products in the marketplace.

> --In FEHBP, hundreds of thousands of educated Federal workers spend much more than they should on plans that have no actuarial value over lower-cost plans.[4]
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> --In the somewhat structured Medigap market where there is a choice of plans A-L, some people spend up to 16 times the cost of an identical policy.[5]
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> --In Medicare Part D, only 9 percent of seniors at most are making the best economic choice (based on their past use of drugs being likely to continue into a new plan year), and most are spending $360-$520 or more than the lowest cost plan available.[6]
>
> --In Part C, Medicare has reported that 27% of plans have less than 10 enrollees, thus providing nothing but clutter and confusion to the shopping place.[7]

The Institute of Medicine reports that 30 percent of us are health illiterate. That is about 90 million people who have a terrible time understanding 6th grade or 8th grade level descriptions of health terms. Only 12 percent of us, using a table, can calculate an employee's share of health insurance costs for a year.[8] Yet consumers are expected to understand "actuarial value," "co-insurance" versus "co-payment," etc., ad nauseum.

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[4] Washington Consumers' Checkbook Guide to Health Plans, 2008 edition, p. 5.
[5] See also, TheStreet.com Ratings: Medigap Plans Vary in Price, 9/15/06.
[6] Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009.
[7] SeniorJournal.com, March 29, 2009.
[8] HHS Office of Disease Prevention and Health Promotion

If Congress wants an efficient, effective marketplace that can help hold down costs, you need to provide a structure to that marketplace.

Consumers Union recommends including the following in any legislation you enact:

Empower Consumers in a New Health Insurance Marketplace

■ A new Office of Consumer Health Insurance Education and Information that will:

√ Provide general and comparative information about insurance issues and policies using consumer-friendly formats.

> We need a Medicare Compare-type website (with some improvements) applied to all health insurance sectors where policies can be compared on price and quality. Extending this comparison site to all insurance would help stop the waste in the Medigap market where seniors are talked into buying a standard policy that may be up to 1600 percent of the cost of the low-cost plan in their state.

√ Require standardization of insurance definitions and forms so consumers can easily compare policies on an "apples-to-apples' basis.

> **This is key**. Hospitalization should mean hospitalization. Drug coverage should mean drug coverage, etc. In our May magazine article, we describe a policy in which the fine-print excluded the first day of hospitalization—usually or often the most expensive day when lab and surgical suite costs are incurred.
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> NAIC could be charged with developing these definitions, backed up by the Secretary if they fail to act.

√ Require insurers to clearly state (in standardized formats) what's covered and what's not in every policy offering, and to estimate out-of-pocket costs under a set of typical treatment scenarios.

> The Washington Consumers' Checkbook's "Guide to Health Plans for Federal Employees (FEHBP)" does a nice job showing what consumers can expect, but even in FEHB policies they find it impossible to provide clear data on all plans.[9]

√ Maintain an insurance information and complaint hotline, and compile federal and state data on insurance complaints and report this data publicly.

> The States would continue to regulate and supervise insurers operating in their state, but with the continual merger and growing concentration of insurers, consumers need a simple place where complaints can be lodged and data collected, analyzed, and reported nationally concerning the quality of service offered by insurers. This type of central complaint office may have allowed quicker detection of the UnitedHealth-Ingenix abuse of underpaying 'out-of-network' claims.

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[9]Op. cit., p. 68.

√ Institute and operate quality rating programs of all insurance products and services.

This would be similar to the Medicare Part D website, with its '5 star' system.

√ Manage a greatly expanded State Health Insurance Assistance Program that would provide technical and financial support (through federal grants) to community-based non-profit organizations providing one-on-one insurance counseling to all consumers, not just the Medicare population.

These programs need to be greatly expanded if you want the marketplace/ connector to work. The SHIPs should be further professionalized, with increased training and testing of the quality of their responses to the public. Instead of roughly a $1 per Medicare beneficiary for the SHIPs, the new program should be funded at roughly the level that employers provide for insurance counseling. We understand that can range from $5 to $10 or more per employee.

■ An insurance "exchange" or "connector," offering a choice of plans, that will:

√ Like Medigap, include an optimal number of plan choices – not too few and not too many.

√ Limit excessive variations in benefit design so that plans compete more on price and quality.

Consumers want choice of doctor and hospital. We do not believe that they are excited by an unlimited choice of middlemen insurers.[10] Fewer offerings of meaningful insurance choices would be appreciated. There are empirical studies showing that there is such a thing as too much choice, and dozens and dozens of choices can paralyze decision-making.[11] The insurance market can be so bewildering and overwhelming that people avoid it. We think that is a major reason so many people having picked a Part D plan, do not review their plan and make rational, advantageous economic changes during the open enrollment period.

It is shocking that CMS allowed roughly 1400 Part C plans with less than 10 members to continue to clutter the marketplace. What a waste of time and money for all concerned. Reform legislation should set some guidance on preventing the proliferation of many plans with tiny differences that just serve to confuse a consumer's ability to shop on price and quality.

We hope you will enact a core package which all Americans will always have. If people want to buy additional coverage, there would be identical packages of extra coverage (as in the Medigap program) that many different companies could offer for sale. Consumers

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[10] "Nearly three-fourths (73 percent) of people ages 65 and older felt that the Medicare Prescription drug benefit was too complicated, along with 91 percent of pharmacists and 92 percent of doctors. When asked if they agreed with the statement: "Medicare should select a handful of plans that meet certain standards so seniors have an easier time choosing," 60 percent of seniors answered in the affirmative." Jonathan Gruber, "Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?" (prepared for the Henry J. Kaiser Foundation) March, 2009. Page 2.

[11] Mechanic, David. Commentary, Health Affairs, "Consumer Choice Among Health Insurance Options," Health Affairs, Spring, 1989, p. 138.

would have to be shown the pricing and quality ratings of those different packages before purchase. (Chairman Stark's AmeriCare bill includes much of this concept.[12])

We believe standard benefit packages (and definitions) are the key to facilitating meaningful competition.[13]

√ Require information on price and quality to be presented in consumer-friendly formats.

Medicare law requires a pharmacist to tell consumers if there is a lower-priced generic available in their plan. A similar concept in the insurance market might be scored by CBO as driving savings. That is, before you enroll in a plan, you must be told if there is an insurer with equal or better quality ratings offering the same standard structured package.

√ Require plans to provide year-long benefit, price, and provider network stability.

In Medicare Part D, we saw plans advertise certain costs during the autumn open enrollment period, and then by February or March increase prices on various drugs so much that the consumer's effort to pick the most economical plan for their drugs was totally defeated. This type of price change—where the consumer has to sign up for the year and the insurer can change prices anytime—is a type of bait and switch that should be outlawed.

√ Protect against marketing abuses and punish insurers that mislead consumers.

We urge stronger penalties against sales abuses. Any reform bill must include the best possible risk adjustment so as to reduce insurers' constant efforts to avoid the least healthy individuals (e.g., rewarding sales forces for signing up healthy individuals). This would have the added benefit of encouraging development of best practices for efficient treatment of these complex cases – which is a key part of controlling costs over time.

√ Ensure that consumer co-payments for out-of-network care are based on honest, audited data.

The recent report by the NY Attorney General is a shocking indictment of the nation's major insurers: "The current industry model for reimbursing out-of-network care is fraudulent."[14] The Attorney General calls for an independent, verifiable system of determining usual and customary charges so that consumers and doctors are not gamed

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[12] HR 193, Sec. 2266(c)(2) SIMPLIFICATION OF BENEFITS-
`(A) IN GENERAL- Each AmeriCare supplemental policy shall only offer benefits consistent with the standards, promulgated by the Secretary, that provide--
`(i) limitations on the groups or packages of benefits, including a core group of basic benefits and not to exceed 9 other different benefit packages, that may be offered under an AmeriCare supplemental policy;
`(ii) that a person may not issue an AmeriCare supplemental policy without offering such a policy with only the core-group of basic benefits and without providing an outline of coverage in a standard form approved by the Secretary;
`(iii) uniform language and definitions to be used with respect to such benefits; and
`(iv) uniform format to be used in the policy with respect to such benefits.
`(B) INNOVATION- The Secretary may approve the offering of new or innovative and cost-effective benefit packages in addition to those provided under subparagraph (A).

[13] Center on Budget and Policy Priorities, "Rules of the Road: How an Insurance Exchange Can Pool Risk and Protect Enrollees," by Sarah Lueck, March 31, 2009.

[14]" Health Care Report: The Consumer Reimbursement System is Code Blue," State of NY, Office of the Attorney General, January 13, 2009.

> out of millions of dollars a year in out-of-network payments. In addition, such usual and customary data should be transparent—available on a website—so consumers have some advance idea of what their out-of-network costs are likely to be.

√ Make consumers fully aware of their rights to register complaints about health plan service, coverage denials, and balance-billing and co-pay problems, and to appeal coverage denials.

> We urge you to require the standardization and simplification of grievance and appeals processes, so that it is easier for consumers to get what they are paying for.
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> Many are worrying that comparative effectiveness research may lead to limits of what is covered. We believe CER will help us all get the best and safest care. It makes sense to give preference to those items which objective, hard science says are the best. But if a drug, device, or service does not work for an individual, then that individual must be able to try another drug, device, or service. The key to this is ensuring that the nation's insurers have honest, usable appeals processes in place. This legislative effort is where we should be putting our energy to address the otherwise legitimate concern of many people about CER
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Conclusion

We thank you again for this opportunity to testify. The American health care system can be fixed, but consumers need tools to help drive the system toward quality and cost savings. The reforms we have suggested are keys to this goal.

Appendix I

Examples of why America needs comprehensive health care reform

This is a small sample of the 5000-plus stories we have collected. The sample concentrates on cost, pre-existing condition exclusion, and poor coverage problems in the individual market, along with examples of what it means to be uninsured because one cannot afford a policy. All of these individuals are willing to be contacted upon request for further discussion.

"Insurance" with inadequate benefits and coverage

Tom from Hutchinson, MN

Tom and his wife own their own pottery studio and have paid for their own health insurance over the years. About five years ago, Tom developed a debilitating hip condition. The pain got so bad that his doctor recommended that he undergo hip replacement surgery. Under his insurance policy, Tom would have had to pay $10,000 for the surgery, which he could not afford. He ended up putting off his surgery for three years until he qualified for Medicare. Two days after he turned 65, Tom had his surgery and his costs under Medicare were just one-third of what he would have paid under his individual insurance plan. Delaying the procedure had its own cost: his muscles atrophied considerably and it took him longer to recover from his surgery.

Gina from St. Joseph, MO

Gina and her husband own their own delivery company and have purchased an individual health insurance policy for their family. Gina recently had a miscarriage and decided not to seek medical treatment because they have a high $3,500 deductible and she couldn't afford to see the doctor. When Gina gave birth to her son a few years ago, the insurance company refused to pay for her C-section because they maintained it was elective (even though her son was born breeched). She had to fight with the insurance company to get them to pay for these medical costs. In the meantime, the insurance company sent their bill to collections. The insurance company eventually paid six months after Gina had paid her full deductible.

Kristin from Beaverton, OR

"I am a single mom who has been out of work for almost a year. I started working 2 months ago and was diagnosed with Interstitial Cystitis last week. I went to fill my prescription of "Elmiron" and to my horror found out that AFTER my insurance discount, I will still have to pay $283/mo. for my medication. I also take buproprion and effexor xr. This means that I will be paying $420/mo for medication alone. I already pay almost $400 for my insurance. I live on $1000/mo after paying my mortgage (which I currently can't do anything about due to the market) payment. Now I will live on $200???? Yet, because I took a contract position until the end of the year, I make too much money for

any assistance programs. I am very frustrated with the system and I'm tired of being taken advantage of for insurance and medication that I need. Maybe I would be better off not working and getting assistance. This is a serious problem with our society! Sometimes not working and depending on assistance is the ONLY way to get our medications...what else can I do?"

Molly from Nashville, TN

After being diagnosed with uterine cancer last year, Molly had to undergo three surgeries and six months of chemotherapy and was unable to work for about eight months. Her insurance policy covered catastrophic medical expenses, but she still had about $25,000 in out-of-pocket medical expenses for the care she received. Her friends were able to help her pay many of her bills, but she was left with about $12,000 in unpaid medical debt and a damaged credit record. "The stress of my illness was enough for me to deal with, but then seeing all the bills I had to pay was just too much for me to handle," Molly says.

Tina from Pittsburgh, PA

When Tina was pregnant a couple of years ago she found out that her individual health insurance policy did not cover any of her maternity expenses. She developed preclampsia and diabetes during her pregnancy and none of the care she required for these conditions was covered. Tina faced the prospect of having to pay nearly $50,000 in pregnancy-related expenses out of pocket. Fortunately, a local journalist took up her cause and contacted the insurance company. Her insurer agreed to cover her expenses through her baby's one-month appointment. Her policy was then cancelled but now her husband has a new job that provides coverage for her family.

Sandra from Portland, ME

Sandra is disabled with chronic fatigue syndrome and needs a scooter to get around. At first, her insurance company decided to only provide partial payment for her scooter and then later said it would only pay for a manual wheelchair. Sandra had to provide further documentation from her doctor that she couldn't use a wheelchair. The appeals process with her insurance company took more than one year. Sandra continues to incur major out-of-pocket medical expenses, including $25,000 last year.

Catherine from San Francisco, CA

"Four years ago I was diagnosed with breast cancer. As a 31 year old freelance documentary producer, I barely had enough money to pay my bills and eat, let alone afford the private health insurance that allowed me access the to quality, but high-cost health care that I believe saved my life. I signed up for insurance because I was afraid I'd get hurt snowboarding, not managing a long-term illness. Private health insurance covered the basics, but I still paid over $50,000 for all the care I received. I'm still paying it off. Sometimes I wonder how bad off I would be if I hadn't gotten it in the first place."

Sarah from Los Angeles, CA

"In 2001, I paid $135 per month for individual health insurance coverage. Co-pays were $20.00 per visit and $5.00 for Rx. Now, I pay $603.00 per month, $40.00 co-pay per visit and $10. per RX, and a $4000 per year deductible. I have no chronic health problems. Three years ago I suffered a bout of severe sciatica (I had never experienced this before) which sent me to the ER for 12 hours. My insurance company refused to cover the ambulance bill and refused 50% of the ER fees. My out of pocket expenses for that one episode came to over $2,500.00. This after paying $549.00 per month (at that time) for coverage. Consequently, I never got the full PT that I probably needed and as a result have some permanent nerve damage in my leg."

High cost of individual market insurance

Melinda from Lakewood, OH

“I'm a 46 year old self-employed woman. I have not had health insurance since 2002 or 2003. As a company of one/an individual, I am denied more favorable underwriting/rates/cost savings and benefits afforded to companies of 2 or more. I have pre-existing conditions. From 2003 through 2007, I estimate I paid (out of pocket) an average of $7,000 per year in medical expenses. Most of these payments have been made using funds saved for retirement. The last "best" proposal I received for individual health insurance included a $10,000 deductible and an annual premium of over $5,000. Most of my $7,000 in annual medical expenses would be considered uncovered and would not count towards meeting my deductible. From my perspective, I would need to receive benefits in excess of $22,000 before I would "break even". If I work, I can make very good money, often grossing in excess of $75,000 per year. As far as I know, this income would exclude me from participation in any existing or proposed program supporting guaranteed access to health care. I have never benefited from government supported programs. No scholarships or loans, worker's comp, unemployment or Social Security. I have always planned on providing for myself - including paying for my health care during both my working and retirement years. I do not expect a "free ride". I want guaranteed access to competitively priced health care/insurance and I am willing to pay for it. I just need help leveling the playing field. No denial of coverage. No exorbitant premiums. No limited benefits - just because I am an individual with pre-existing conditions.”

Jamie from Clio, MI

"With the faltering economy my small cell phone business of 12 years is slowly sinking. I had Blue Cross Blue Shield of Michigan. In 1999, it cost $450.00 a month to cover myself, my husband and our three daughters. When I could no longer afford the coverage it was up to $1600.00 per month for my husband and I and only two of our college age daughters. Same coverage, an 80/20 split, so there were some 'out of pocket' expenses too. I have also been unable to maintain my term life insurance policy of 10 years. I still can't believe after 12 years in business that I wouldn't be able to pay my bills. It is very

heart wrenching. Especially when we had to cut our daughters off while they were still in college."

Joel from Brooklyn, NY

"I am among the uninsured. I cannot afford health insurance. I am a published, prize-winning novelist and I have been, among other things, in chronic pain for about seven years, in both knees. I also have other health problems I cannot see to, even though I know that this is dangerous, especially at the age of 61. I make enough money not to qualify for Medicaid, or even New York State's budget/help-out plan, but I am far from being able to afford health insurance at anything approaching the current rate. I'm in trouble and do not know if there is anything I can do about it. How's that for a story?"

Jan from Lebanon, CT

"My husband and I were squeezed out of our jobs as we approached the age of 60. We moved to a less expensive area, and are now self-employed. At age 62 we spend as much on our monthly health care premiums as we used to spend on our mortgage. Together we pay over $1300/mo. for premiums and the co-pays we are responsible for are higher. Having health insurance tied to employment does not make sense in the present atmosphere of job insecurity. We feel caught in a financial bind until we reach Medicare age."

Grace from Danielson, CT

"I work for a healthcare services company. In short, I do provide necessary services to disabled and elderly clients who would not otherwise be able to remain in their homes. They all have Social Security or Disability income that provides for doctor visits and medications and emergency surgeries when necessary. I have no health insurance from the company for whom I work. In 2006 I had to have an incisional hernia surgery. I waited until it had started to strangle itself. I received help through a federal program to pay my hospital bill. But there was no program to pay for my anesthesia bill or my doctor bill. The total bill was somewhere between $10,000 and $12,000 with about $7600 being paid on the hospital bill. The doctor has been real good to me and not pushed the issue. The anesthesia bill went to collection and is now registered with the credit reporting agencies. There is nothing I can do about this. This is a non-profit company. My weekly hours are less than 40 and I live in Connecticut which is the 2nd or 3rd most expensive state to live in. Every penny I make is tied up in survival. My rent has gone up $50 since the operation. My gas for the car (I pay all but a $50 stipend) has tripled, my electric bill has nearly doubled and my grocery bill has tripled. I am 58 years old and am having a hard time finding a good paying job. I got a $.25 raise in February and already the groceries and a recent raise in the electric bill have eaten that raise and next year's as well. I could very easily be homeless by this time next year. If it were not for help with heating oil I would already be there. Not because I don't work for a living but because what I make is less than an existence at this point. I suspect my electric will be shut off in May due to my inability to pay. If I become seriously ill I have nothing to help me with

expenses or medical bills. I make nearly $20,000 per year. Unless something is done to change this I am going under. I need help for a lot of things but I have no where to turn. According to the State of Connecticut I make too much money. Once upon a time I could have done well on this but not now."

Bea from Charlotte, NC

After she was laid off from her county social worker job, Bea opened her own practice but has struggled to afford adequate health insurance. She can only afford catastrophic coverage which does not cover her pre-existing conditions, including her arthritis. "I quickly realized that the American dream of owning your business is only for the young and healthy."

Pre-existing Conditions: the Cost of Exclusions

Keith from Lakewood, OH

"My wife and I are retired, more by reason of lost employment than anything else. We are not yet eligible for Medicare. When our coverage under COBRA was soon to end, I searched high and low for affordable health insurance. I called agents. I searched over the internet. I called insurance companies directly. What I found is that, because I have high blood pressure (which has been under control for years) and she has Type 2 diabetes (also under control), we are unable to buy a private policy for anything less than $3000 a month, for each of us! And even at that price, I couldn't get a firm commitment without paying three months premiums in advance. That's $18,000! As a result, my wife was forced to find another job (she's an RN, and therefore much more employable than I am) just for the health insurance. So instead of traveling the US in our RV, as we had hoped, she's working the night shift at a local hospital, and I'm picking up odd jobs as I can while we wait for Medicare."

Neil from Pepper Pike, OH

"Due to pre-existing conditions, I have been relegated to few choices for insurance coverage, and all at extremely high costs. Premiums for my wife and myself, with $1000 deductibles, have been exceeding $24,000 per year for many years! I have not been able to find insurers willing to cover us at a reasonable cost. Regulated, universal coverage is the only answer to provide health coverage for all persons without bankrupting so many."

Carolyn from Media, PA

"After my COBRA coverage ended, I applied for health insurance as an individual. I decided to work for myself and I am 53 years old. A couple of companies rejected me but finally I received coverage but with exclusions for depression, migraines, and high cholesterol and a high deductible. All of these conditions are treated with medication. Originally, the rate was about $350, which I thought was reasonable. Unfortunately, after

just 4 years my rate is now over $512. My agent tells me the plan has closed which means that my premiums will continue to skyrocket since no new members will be added to the pool. I applied for insurance again and was rejected for the same reasons. I see these conditions as somewhat common and assume that only someone in perfect health can receive an individual health plan. On the other hand, someone with cancer can obtain insurance as long as they are employed (typically). Since I have many years before I am eligible for Medicare, this situation is a big concern. I do not understand why individuals cannot have guaranteed access like employed people since the insurance company's overall risk is still spread. But, I suppose the rate they would charge would be astronomical. I wish there was some organization that individuals could join and gain coverage as part of a large pool. One other issue is the treatment of these costs at tax time. My total costs run about $10,000 which is a large percentage of income. If costs do skyrocket, I might have to lower my standard of living. The overall health care situation in this country is astonishing given our supposed wealth as a nation. We claim to have the best health care but this is not borne out by surveys and studies. Certain politicians scare the populace with terms such as ""socialized medicine"" and drown out other voices of reason. Shame on us."

Michael from Iowa City, IA

"I wanted to switch to a healthcare policy with the highest deductible in order to lower my premiums. My individual policy was with Wellmark of Iowa and I also got my current policy with Wellmark. In order to get virtually the same policy, except with a higher deductible, they called me and said that I would have to agree to waive coverage for mental health, anything to do with my eyes, and anything to do with my G.I. tract. Their request for the waivers surprised me because I had had very little problems with those things. I agree to sign the waivers in order to save money because of the lower premiums that come with the high deductible policy."

Kim, from Minneapolis, MN

Kim’s husband was having a difficult time sleeping so he saw his doctor who sent him home with a 3 week sample pack of anti-depressants. Her husband had no previous history of depression, but five weeks later he took his own life. After her husband’s death, Kim saw a therapist for grief counseling. Kim ended up leaving her job in advertising to devote her time to drug safety advocacy and do freelance work. She paid for 18 months of COBRA coverage and then shopped around for an individual health plan. Since she had no serious health issues in her past, she expected her coverage would be affordable. But the insurer she had received coverage through previously refused to issue her an individual policy because they said that her participation in grief counseling was an indication of possible mental illness. Kim was able to get coverage through a second insurer but only on the condition that she would not file any claims for counseling for two years.

The "gotcha" of out-of-network limitations

John from Pelham, AL

This twenty-three year old young father had an accident on a four wheel vehicle in a rural area. When the ambulance arrived, the EMT decided he needed to be taken to the hospital by helicopter. John spent three days in the hospital recovering from his injuries and left with a $9,000 bill because his insurance company said the ambulance and helicopter were not preferred providers.

Charles from Alma, GA

Charles ("Buddy") was diagnosed with prostate cancer but his insurance company denied payment for the services from the doctor who diagnosed him. While the doctor's office on the first floor is part of his insurance company's network, the second floor where biopsies are done is not part of the network. When Charles needed surgery he had a very difficult time finding doctors that belonged to his insurer's network who could perform the surgery in hospitals that were also part of the network. It was only after his state legislator intervened on his behalf that Charles was able to resolve his issues with his insurance company. "It's not the cancer that is going to kill me, it's the insurance company."

Andrea from Murphy, TX

Andrea's son was having difficulty breathing shortly after he was born and was rushed to the hospital's Neo-Natal Intensive Care Unit (NICU) for treatment. Two days later he was doing fine and discharged to go home. Andrea was then informed by her insurance company that the Doctor who treated her son in the NICU was not part of the insurer's network. Less than half of the $1,145 NICU bill was covered by her plan even though he needed emergency care. When she had to bring her son back a second time to the ER, she was charged $600 for his care. Andrea discovered that there are no hospital emergency rooms in Texas that will take her insurance. Her family spends $7,000 annually on health insurance.