The Center on Health Insurance Reforms
Georgetown University Health Policy Institute

Robert Wood Johnson Foundation

Real Stories, Real Reforms

September 2013

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Introduction

Having affordable, adequate health insurance coverage is essential to the health and financial vitality of American families. People without health insurance are significantly less likely to receive necessary care, and a lack of meaningful coverage has resulted in medical debt being a primary cause of personal bankruptcies.[1]

Yet today, approximately 48 million non-elderly Americans are uninsured, and approximately 19 million Americans under age 65 obtain their health insurance through the individual market, meaning they do not have coverage through their employer or public programs such as Medicare and Medicaid.[2] Anyone can find themselves at any time in the position of being uninsured, or required to buy coverage in the individual market. A recent survey found that in 2012, 30 percent of adults under age 65 did not have health insurance for some period of time.[3] People who buy health 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. The individual market tends to be a last resort when people do not have an offer of employer-based coverage or are ineligible for public coverage.

To date the individual market has been an inhospitable place, particularly for people in less than perfect health.[4] That's a lot of us. According to one estimate, between 50 and 129 million non-elderly Americans have at least one pre-existing condition that would threaten their access to health care and health insurance.[5] These include a wide range of conditions, from back pain and prior sports injuries to chronic illnesses such as diabetes and asthma, as well as diseases like cancer. But until now, in most states, applicants for health insurance can be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors. Insurers can also issue policies that don't cover critical medical services like pharmacy benefits, mental health benefits, maternity coverage or any of the care required to treat a person's pre-existing condition. And before enactment of the Patient Protection and Affordable Care Act (ACA) in 2010, insurers could—and did—drop (or rescind) an individual's coverage if they got sick, and often imposed annual and lifetime dollar limits on covered benefits.

The ACA includes numerous reforms intended to address the shortcomings in the individual market. These set a minimum federal standard for an individual's access to affordable and adequate health insurance, with state flexibility to enact stronger consumer protections if they wish.

As part of a project funded by the Robert Wood Johnson Foundation, researchers at Georgetown University's Center on Health Insurance Reforms documented eight families' efforts to navigate the health insurance system. The focus of this project was to provide insight on how the private health insurance marketplace works today for these families. Their experiences are not unique and help illustrate the problems that people can have obtaining meaningful, comprehensive coverage at an affordable price. Their experiences also demonstrate how the ACA has already begun improving people's coverage options, and how it will continue to improve access to health care and families' financial security when all the reforms are in full effect.