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.
Availability of Coverage

In today’s health insurance marketplace, one of the many ways health insurers maximize revenue is to make use of aggressive underwriting practices to deny coverage to individuals with pre-existing conditions. In most states, when an individual wants to buy health insurance, they must fill out and submit a voluminous application that includes detailed information about their health history and status. Insurers then “underwrite” the application by reviewing the individual’s health history and assessing the likelihood he or she will incur future health costs. A Georgetown University 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. Health insurers maintain underwriting guidelines that can list as many as 400 medical conditions as reasons to trigger a permanent denial of coverage. For a person with a condition such as Type I diabetes, which insurers typically consider an “uninsurable condition,” navigating today’s marketplace has entailed a lifetime of worry about maintaining a viable source of coverage.

According to a study by the U.S. Government Accountability Office (GAO), average denial rates in the individual market are 19 percent, but they can vary dramatically market-to-market and insurer-to-insurer. For example, 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 or broker 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, insurers are required to provide coverage to people who apply for it, regardless of their health status. This provision went into effect for children under

The ACA’s Valentine to Veronica and Her Family: Peace of Mind

North Carolina resident Veronica L. was just 8 when she was diagnosed with Type I diabetes, a lifelong condition that most often strikes in childhood. Although the exact cause of Veronica’s disease is not known, it occurs when the immune system attacks the insulin-producing cells of the pancreas, leaving her unable to metabolize glucose without insulin injections. Type I diabetes requires Veronica’s mom, Nikki, to monitor her blood sugar around the clock—every time she eats, off times during the day, even through the night. And she uses a pump to inject insulin under her skin throughout the day and night.

“People don’t think this will affect them,” Nikki says. “Type 1 diabetes was not on my radar screen. But you don’t know what can come around the corner.” Keeping Veronica healthy and avoiding serious complications of the disease is something they live with every day.

The family is fortunate to have good coverage through Veronica’s father’s employer, but Nikki realizes that they could lose their current health care coverage just like anyone else. “To know that health coverage is tied to your employment worries me, when I think about her care, because we have to have it.” Nikki worries that one day, when Veronica is an adult, she could be denied coverage because of her Type 1 diabetes. She can’t live without insulin. “It’s not a question of quality of life; it’s a question of life,” said Nikki.

Knowing that the ACA prohibits insurers from denying her daughter coverage or charging her more because of her disease gives Nikki peace of mind. Nikki may lose sleep monitoring her daughter’s glucose throughout the night, but she doesn’t have to lose sleep worrying about her daughter’s future sources of coverage once she ages off her family’s plan.

Today, Veronica’s future looks limitless. She’s a talented musician and an A+ student. When she’s grown up, Veronica can make life and career choices without fear of being turned down for coverage or charged more because she has Type 1 diabetes.
Real Stories, Real Reforms

Waiting for Medicare: The ACA Will Help Fill the Gap

Karen M. of New Jersey was diagnosed with Multiple Sclerosis (MS) when she was 38. It is a chronic, progressive disease causing damage to the brain and spinal cord. For about 10 years, her health benefits through her employer enabled her to obtain her prescription medicine with an affordable co-payment, which allowed her to live and work without symptoms. Three years ago, however, she began experiencing one of the more common symptoms of MS—stiffness and muscle spasms in her legs—which made it difficult to walk without a cane. As it progresses, MS also causes cognitive difficulties, such as an inability to concentrate. Her doctor told her to stop working, but Karen was hoping to put off that day. Over time, the cognitive challenges made it increasingly difficult for Karen to do her job and she realized she would never again be able to effectively perform in a career she had taken great pride in for 22 years. On her doctor’s recommendation, Karen applied and was approved for Social Security Disability Insurance (SSDI) in March 2012, which also made her eligible for Medicare benefits. But Medicare rules require her to wait two years for coverage to start, so she enrolled in COBRA continuation coverage.

Karen found it increasingly difficult to pay the family’s COBRA premiums of $1,335 a month with only $2,250 a month in SSDI income. Based on their income, their kids were eligible for Children’s Health Insurance Program (CHIP) but had to be uninsured for 90 days in order to qualify under New Jersey’s CHIP waiting period. It was a difficult decision, but in order to provide her children with more stable coverage and protect the family’s financial security, they took the risk and the kids went without coverage for 90 days. She and her husband had to make significant withdrawals from their retirement accounts to pay their health care costs, including COBRA premiums.

The Health Insurance Marketplaces will provide more affordable health insurance coverage for individuals who fall through the cracks of our employment-based system of coverage, including those between jobs and those who must stop working before they are eligible for Medicare. And many, like Karen, will qualify for financial help paying their premiums and cost-sharing, so they won’t have to deplete their savings or make difficult choices to maintain coverage without a gap.
Affordability of Coverage

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 the full cost of their premium. According to one national survey, among people buying insurance on their own, 31 percent spent 10 percent or more of their income on premium costs, compared to only 13 percent of people in employer-based coverage.12

For many, the cost of premiums can cause them to forego coverage completely. A national survey found that nearly three-quarters (73%) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high.13 And coverage is the least affordable for people who need it the most—those with pre-existing conditions. The same national survey found that 70 percent of people with health problems reported it “very difficult” or “impossible” to find an affordable plan, compared with 45 percent of people in better health.14

Older and less healthy individuals have had to pay more because health insurers manage costs by segmenting their enrollees into different groups and charging different prices based on health or other risk factors.15 In practice, this means that people can be charged more because of a pre-existing condition (even if they’ve been symptom-free for years), because of their age, gender (women are assumed to use more health care services), family size, geographic location, the work they do, and even their lifestyle. A Georgetown University study of rating practices in states with little rate regulation found rate variation of more than nine-fold for the same policy based on age and health status.16 People in their early sixties can be charged as much as six times the premium of people in their early twenties, based on age alone. Even young people, when rated based on health status, can be subject to significant costs for coverage.

ACA Offers New Choices for Family “Trapped” in High Cost Plan

Soon after Joshua L. was born nine years ago, a fetal cardiologist came into the room with a box of tissues and told his parents that their newborn’s heart defect was 100% fatal. Later, the cardiologist offered them somewhat better odds if Joshua underwent three high-risk surgeries. His odds of surviving the first surgery were about 5 percent. Joshua’s parents, Jodi and Mark, opted for the surgeries because they wanted to give their baby the best chance they could. Even though they were insured, they incurred monumental out-of-pocket costs.

Today, Joshua has not only beaten those odds, he is thriving. “He’s as healthy as a horse,” Jodi says. He plays baseball and golf and is a very happy child who seems like any other active little boy except for the scar on his chest and the medical bills that have piled up for his family.

Josh sees a cardiologist at least once a year and must undergo regular testing. Jodi estimates their annual health care expenses to be as much as $17,000 in out-of-pocket costs, including premiums—and that’s in good years when Josh is relatively healthy. Even though they have comprehensive medical insurance, the premiums and co-payments required to obtain needed medical care are prohibitive.

“I feel trapped” in this health insurance policy, Jodi says. If they try to switch to another individual market plan, they would have to pay extremely high rates because of Joshua’s health status—as much as $3,100 per month in Virginia, their home state.

Jodi imagines a future for Joshua under the ACA in which he can embark on a career that matches his skills and passions, secure in the knowledge he can get the health coverage he needs. He won’t have to choose a job just because it offers a good health plan. “He can start out of college…and he’ll have choices,” she says. “He is such an amazing child, and we love him so much. Like any parent, we want the absolute best for him.”
For older individuals, women, and people with pre-existing conditions, their premiums will become more affordable beginning in 2014. Under the ACA, using health status and gender to set premium rates is prohibited. Insurers are permitted to use only the following factors in setting premiums: age (limited to three times the premium of a young person), tobacco use, geographic location, and family size.

And even though they tend to be healthy, many young adults have been unable to afford health insurance in the individual market, particularly as many are just launching careers and work in part-time or other jobs that do not offer health coverage. However, many young adults are newly gaining access to more affordable coverage because of a provision of the ACA allowing them to stay on their parents’ health plans up to age 26. This provision, which went into effect in 2010, has helped lead to a significant decline in the number of young adults who are uninsured: from 13.6 million in 2010 to 11.7 million in 2012, a decline of 1.9 million.17

More significantly, many of these young adults and millions of other Americans will soon gain access to premium tax credits that will help make coverage more affordable. An estimated eight million people are projected to take advantage of the premium tax credits in the ACA, with an average per-recipient tax credit of $4,553.18

Adequacy of Coverage

Currently, the insurance coverage available to individuals buying it on their own falls far short of the typical employer-based plan. In addition to paying higher premiums, people buying individual policies face limited benefits and much higher deductibles (the amount the policyholder owes for health care services covered by the

When One Young Person’s Life Took a Detour, the ACA Provided Help Along the Way

Just after graduating from the University of California Santa Cruz in 2011, 22-year-old Kalwis L. was sure he was so tired because he wasn’t taking care of himself. But when his neck started swelling, he figured he better have it checked out. He learned that he had stage 3 Hodgkin’s lymphoma. At the time, he had a short term policy available to recent graduates. With medical expenses quickly growing to more than $8,000, Kalwis expected his plan to help cover his costs after he met his deductible, but it didn’t. Even though he hadn’t been diagnosed prior to enrolling in his policy, Kalwis’ insurance company argued that his cancer was a pre-existing condition. As a result, they wouldn’t cover any of his care.

His parents, both of whom work at jobs that don’t offer coverage, and his aunt helped cover the costs of chemotherapy. It was a hardship for them, but after his mom lost her only brother to cancer, they were not going to let Kalwis fight cancer on his own.

The chemotherapy treatments left Kalwis very little energy to fight his plan’s denials of coverage for care he needed, or to navigate the unruly world of insurance for a person with a serious health condition. When his temporary coverage ran out, he applied for individual coverage but was denied, and was found ineligible for California’s Medicaid program. He was in the middle of his eight months of chemotherapy treatments when he learned about the Pre-existing Condition Insurance Plan (PCIP), created under the ACA. His final four rounds of chemo were under his $2,000 deductible for the PCIP plan, but most of the cost of the CT scan he needed to track the progress of his treatment was paid by PCIP.

With his battle with cancer behind him, Kalwis started a full time job with health benefits that cover his ongoing care. His next job may offer him benefits, too, but if it doesn’t, he can still shop for coverage without the worry of being turned down or charged more because of his history of cancer.
plan before the plan begins to pay) and other forms of cost-sharing, such as co-payments and coinsurance. They also spend a much larger share of their income on health insurance and health care than those with employer-sponsored coverage.\textsuperscript{19} A Commonwealth Fund survey found that 60 percent of people with health problems reported it “very difficult” or “impossible” to find a plan with coverage they needed, compared to about one-third of respondents without a health problem.\textsuperscript{20} 

The number of “underinsured” individuals has risen dramatically over the last decade, such that there are nearly twice as many today as there were in 2003. Further, individuals purchasing coverage on their own were more than twice as likely to be underinsured as those who had coverage through an employer-based plan.\textsuperscript{21} In general, someone is considered underinsured when they have insurance but because of high deductibles, high co-payments, or non-covered benefits, the insurance offers inadequate financial protection for the health care services people need.\textsuperscript{22} One primary reason people buying individual insurance coverage can have high out-of-pocket costs is that many individual market plans—over half according to one study—do not meet the minimum standard of coverage provided for under the ACA.\textsuperscript{23} Coverage in the individual market today can be inadequate for many reasons, including:

\textbf{Pre-existing condition exclusions.} In many states, insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses on their application for an individual policy. 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 into a person’s health history to determine whether the current condition was pre-existing. This is sometimes called “post-claims underwriting.”

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

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\textbf{Waiting for 2014: One Family’s Story}

Losing health care coverage just before your due date is not something you read about in “What to Expect When You’re Expecting.” But just before their new baby was born, Wisconsin parents Beth and Aaron F. learned that Aaron had lost his job and with it, his family’s health insurance. With money from their savings and lots of help from family, they scraped enough together to pay the high-cost COBRA premiums to continue their coverage.

Unfortunately, their bad luck didn’t end there. Shortly after delivery, their newborn son, Henry had a seizure and stopped breathing. His doctors soon determined he had suffered a stroke before he was born, the result of a clot. The stroke affected 85 percent of the left side of Henry’s brain and caused cerebral palsy that affects his ability to control the right side of his body.

When they switched to Beth’s small employer plan, they learned their new plan was not as comprehensive as their COBRA coverage. Plans available to small employers typically come with limits that large employer plans don’t have. The new plan excluded coverage for physical therapy and occupational therapy if those interventions are needed because of developmental delays. In that context, such services are considered “habilitative” services, which are frequently not covered under individual and small-group plans. Because Henry’s therapy needs stem from a stroke he suffered before he was born, his plan denied coverage.

But for Henry’s family, it doesn’t matter why he needs his therapies; they just know he needs them and their plan won’t cover them. Under the ACA, insurers who sell policies to individuals and small employers must cover a core set of benefits, including habilitative services. Beth and Aaron are hopeful that once the law is fully in place they will not have to worry as much about whether or not their son’s essential care will be covered by insurance.
Limited Benefits. Insurers selling health insurance in the individual 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, 20 percent of adults with individually purchased insurance lack coverage for prescription medicines, but only five percent of those with employer-based coverage do.

To improve the value of coverage, the ACA sets a minimum benefit standard 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. These 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 (i.e., doctor visits); emergency services; hospitalization; maternity and newborn care; mental health and substance use 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. The essential health benefits give individuals and small employers assurance that their benefits will meet a minimum standard for adequacy.

Lifetime and Annual Limits. Prior to enactment of the ACA, it is estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people were in plans with annual dollar limits on their benefits. Those limits can be a matter of life and death. The Affordable Care Act ushered in a ban on lifetime limits, and put immediate restrictions on annual dollar limits (banning them completely in 2014).

For Martin, the ACA Ban on Lifetime Limits Has Ended His Coverage Circus

Missouri resident Martin A. has severe hemophilia, a rare bleeding disorder that prevents his blood from clotting normally. Since he had his first job in 1984, he's managed to maintain health insurance so he can get the life-saving treatments he needs. But trying to maintain that coverage has been like a high wire act without a net, as Martin has had to jump from one plan to another to keep access to life-saving care. He had to make the right move at the right moment or risk falling through the cracks.

Martin's hemophilia requires him to use a clotting factor every other day, at a cost of up to $60,000 per month. Bleeding into his joints has caused them to deteriorate, so he has had one total knee replacement surgery, but lives with limited function and pain in his other knee and both shoulders and elbows. With costs like these, Martin has blown through lifetime limits with three different plans: his own employer plan, the Missouri high risk pool, and his wife’s employer plan.

Because he retired on disability, Martin qualified for Medicare, but faced the standard two year wait for coverage to begin. He knew his coverage under his wife's plan was going to hit the lifetime limit before his two year wait was up. Because he couldn't risk a gap in coverage, Martin took some chances with his routine care—using an older, less safe clotting factor less frequently—and putting off a needed surgery. When he hit the limit on his wife's plan, he returned to the high risk pool, but worried he would soon hit that lifetime limit again.

Martin describes his journey like this: “It’s an incredible amount of stress and uncertainty and at times despair and hopelessness when you can’t see any options.” When he would land in new coverage, it was like “getting some breathing space, but you know it won’t last and there seems to be no light at the end of the tunnel.”

Fortunately, with the threat of losing his high risk pool coverage looming, the ACA was enacted and with it, a ban on lifetime limits. That provision allowed him to re-enroll in his wife's employer plan, where he can remain until his Medicare benefits begin.
Breast Cancer Patient Had to Become a Fundraiser to Make Up for Insurance Plan Shortcomings

When she was just 28—long before anyone expects to get hit with a serious medical condition—Iowa resident Stacy C. was diagnosed with breast cancer. The coverage she had through her employer, a nursing home where she worked as a certified nurse assistant, covered all the care she needed: radiation and part of the cost of her biopsy, lumpectomy, and chemotherapy. But it left her with a big tab for out-of-pocket costs: $9,000. Thankfully, the treatment worked and her cancer went into remission.

Five years later, in 2009, she discovered another lump and learned she had cancer in the other breast. She needed a mastectomy right away, followed by chemotherapy. However, by this time she had changed jobs—she worked as a home health aide—and had an employer-based plan with limited benefits. It covered only $1,000 of her surgery costs, $6,000 of her hospital costs and just five doctor visits, which she blew through in just a couple of weeks. And because the hospital wouldn’t give her chemotherapy without payment upfront, in the middle of dealing with the emotional turmoil and physical challenges of a cancer diagnosis, Stacy had to become her own fundraiser to make up for the shortcomings of her insurance plan. But although she was able to raise money through family and friends, she still had to pay about $24,000 out-of-pocket for her care.

Stacy is now cancer-free but still uninsured. She works for a telemarketer that doesn’t provide benefits, even though she works between 40 and 56 hours a week. And she owes almost $40,000 in medical bills, including $9,000 from her first diagnosis. That’s about twice what she makes in a year. The medical bills have driven her to the verge of bankruptcy.

In 2014, Stacy can buy coverage through a health insurance marketplace without worrying about being turned down or charged more because of her cancer, or incurring out-of-pocket costs without limit. And she’ll probably qualify for financial help paying her premiums and out-of-pocket costs.

High Out-of-Pocket Costs. Individual 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. As a result, many of these plans are very low value, below the minimum standard in the Affordable Care Act. One study in California found that individual policies pay for just 55 percent of the expenses for covered services, compared to 83 percent for small group health plans. 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 then that medical debt is a primary cause of personal bankruptcies, with an estimated 20 percent of Americans reporting problems paying medical bills. Of those, approximately 40 percent had some form of health insurance. Medical debt can have significant, long-term financial consequences for families. Many lose their good credit, eat up retirement savings to pay off debt, or take on credit card debt at high interest rates.

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 levels, with Platinum plans being the most generous (enrollees will pay, on average, 10 percent of the out-of-pocket costs) and Bronze plans being the least generous (enrollees will pay, on average, 40 percent of the out-of-pocket costs). The ACA also sets new limits on the total amount of out-of-pocket spending consumers must incur, based on their income. For 2014, those limits are set at $6,350 for individuals and $12,700 for families. In addition, for individuals earning up to $28,725 annually (up to $58,875 for a family of four), the ACA provides cost-sharing subsidies that will reduce their out-of-pocket spending.
Real Stories, Real Reforms

ACA Reforms Free Up Entrepreneurs to Focus on Their Business

Joe and Virginia M. moved from New York City to Memphis in 2007 to start a music school for young children and a local theater group. But in following their dreams to start new businesses, Joe and Virginia gave up the security of the health care coverage that came with Joe’s job. At first they relied on COBRA with premiums of $600 per month. And they felt lucky to have it, particularly when their son Harlan was born in 2008. When COBRA expired, they sought a plan on Tennessee’s private market.

Building these new businesses and raising a family take most of Joe and Virginia’s time and energy. Health insurance should be the last thing they worry about. They would rather put their energy into their work, but they need to know they have coverage for routine care as well as the unforeseen. Unfortunately, for self-employed entrepreneurs, navigating the world of health insurance is a “wild west” of inadequate and unaffordable health insurance options.

Even though his family is relatively healthy, the best plan Joe could get was one that had a $2,500 deductible, with premiums of $398 per month—and a six month wait before their coverage would even begin. Since they enrolled, they’ve seen their premiums nearly double—to about $700 per month. In the last year alone, premiums jumped 17 percent.

Sometimes Joe has thought about whether there is a better plan for them, but shopping around would be time-consuming and frustrating because of the bewildering array of options and inability to make “apples to apples” comparisons of premiums, benefits, cost-sharing and other important factors.

Beginning in October, Joe can shop for coverage on the Health Insurance Marketplace. Joe and his family won’t have to worry about being denied because of health conditions. And they can shop with confidence that the Marketplace plans have met minimum quality standards and must limit their out-of-pocket costs. Even better for Joe, the web-based Marketplace will offer a streamlined, simplified shopping experience in which he can compare and choose a plan that works best for his family. And then he can get back to his life’s work.

Transparency of Coverage

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 their coverage works. For people shopping on the individual market, they must undergo medical underwriting, which requires them to complete voluminous application forms, and agree to allow insurers to investigate their medical history. Health insurance policies are written in legalese and difficult for even highly educated consumers to understand. It is little wonder then that Americans rate reading up on their health insurance policy as a less appealing activity than preparing their income taxes or going to the gym.31

Prior to enactment of the Affordable Care Act, individuals attempting to buy insurance coverage in the individual market faced confusing choices, with little transparency about what their policy would actually cover—and what it would not. They have had almost no ability to effectively compare health plans on an apples-to-apples basis.

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. First, it creates state-based health insurance exchanges, or “marketplaces,” that will help consumers make apples-to-apples comparisons among health plan options, and allow them to shop with confidence, knowing that all participating plans have met minimum quality standards.
In addition, the ACA requires insurance companies to provide a new Summary of Benefits and 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. Consumer testing by Consumer Reports has found that consumers rated their Summary of Benefits and Coverage as more helpful than other sources of plan information, such as employer guides and health insurers’ brochures.32

The law also includes new expectations for insurer accountability. 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 increases must provide detailed and public justification for those increases. Insurers must also spend at least 80 percent of individual market premiums on health care and improving health care quality. If they don’t meet that standard, they must issue rebate checks to enrollees. This policy was in effect for 2011, and in 2012 nearly 12.8 million Americans received rebates totaling more than $1.1 billion.33 The aggregate amount of rebates declined in 2013, to $504 million, largely because insurers are beginning to moderate their premium increases and operate more efficiently. As a result, an estimated 77.8 million consumers are saving $3.4 billion in up-front premium costs.34

### Conclusion

The insurance marketplace as it exists before full implementation of the ACA does not work for the people who need it most. Anyone with any health condition at any point in their lives can face difficulty obtaining insurance coverage, particularly in the individual insurance market. People in this market have problems with access, with affordability, and, if they can obtain a health insurance policy, it is often not adequate to meet their needs. In addition, until enactment of the ACA, the complex and confusing process of comparing and buying plans discouraged many consumers from obtaining coverage.

The ACA ushers in sweeping reforms that will improve Americans’ experience buying insurance and, most importantly, provide them with more meaningful access to health services and help protect them financially when they get sick or injured. These changes are transformative—and not all will have immediate impact. But over time, people like Veronica, Joshua, Kalwis, Henry, Martin, Karen, Stacy and Joe will benefit from a system that is fairer and more accountable.
Endnotes


3 Supra. n. 1.


7 Supra. n. 4.

8 Supra. n. 6.

9 Id.


12 Id.


14 Id.


16 Supra. n. 4.

17 Supra. n. 1.


19 Supra. n. 13.

20 Id.

21 Id. Supra. n. 1.


24 Supra. n. 13.


27 Supra. n. 23.


30 Supra. n. 1.


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