

**If someone does not have access to health insurance through their workplace, they cannot afford their share of the premium for employer-sponsored coverage, or they don't qualify for government programs, the individual<sup>1</sup> insurance market may be an alternative.**

Most Americans get their health insurance at work as part of a group. (For more information, see Chapter 2, Employer-Sponsored Coverage.) But we buy other types of insurance, for example, policies for our homes and our cars, in the individual insurance market, contacting insurers on our own and looking for the best coverage for the lowest price.

In 2002, 16.5 million Americans under age 65 had health insurance purchased in the individual market. That number, roughly 6 percent of all Americans under age 65, is small compared to the number of Americans with employer-sponsored coverage (161.8 million people under age 65).

Over time, however, many more than 16.5 million people rely on individual health insurance, perhaps following a layoff or divorce, or while in jobs that don't offer health benefits. One recent study concluded that more than one in four working-age adults sought coverage in the individual market over a three-year period.<sup>2</sup>

For several reasons, it is more expensive to buy health insurance in the individual market than through an employer. One reason is that marketing and administrative costs per insured person are much higher for policies sold one-by-one. These increased costs are reflected in the price of individual policies.

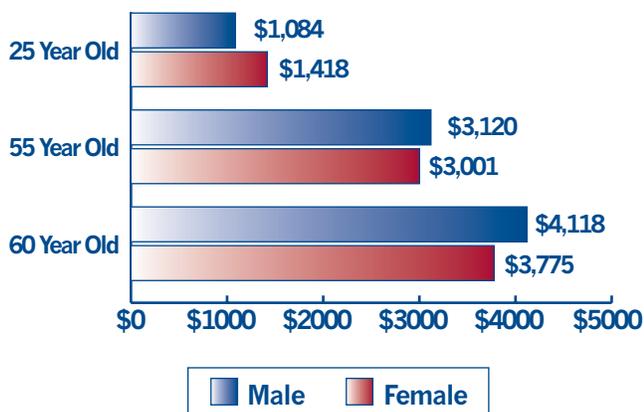
In addition, people buying individual insurance policies must pay the full premium. In contrast, those enrolled in employer-sponsored coverage pay an average of 15 percent of the total premium for themselves alone or 27 percent for family coverage.<sup>3</sup> What's more, a firm's contribution to the cost of health coverage is not included when employees calculate their taxable income. That saves many workers thousands of dollars in premium charges, and also saves them from paying thousands in income, Social Security and Medicare taxes. The exclusion of the employer contribution from the employee's taxable income will save workers \$101 billion in 2004 in individual income taxes alone. Employers are also allowed to deduct from their taxable incomes, as a business expense, what they paid toward their worker's premiums.

### KEYFACTS

- 16.5 million nonelderly people were covered by an individual health insurance policy in 2003.<sup>a</sup>
- In all but five states, individuals or families buying insurance on their own can be charged higher premiums, or be denied coverage, if they have health problems.<sup>b</sup> The five exceptions are Maine, Massachusetts, New Jersey, New York, and Vermont.
- The Health Insurance Portability and Accountability Act (HIPAA) requires insurance companies to sell policies to anyone who has had at least 18 months of continuous group coverage and is moving to an individual policy. This federal law has no restrictions on how much companies may charge for HIPAA individual coverage, although some states have set limits.
- High-risk health insurance pools existed in 31 states as of January 2004, mostly for persons with expensive health care needs who would otherwise have difficulty obtaining individual health insurance. Enrollment in all high-risk pools totaled about 173,000 in 2002.<sup>c</sup>
- Many proposals to reduce the number of Americans without health insurance would subsidize coverage in the individual market, often through federal tax credits.
- COBRA continuation coverage, which technically is group insurance through a worker's former employer, offers an alternative to individual health insurance for some people who are about to lose job-based group health coverage. Only about one in five unemployed workers eligible to buy COBRA continuation coverage actually does so.<sup>d</sup>

For key fact sources, see endnotes.

## EFFECT OF AGE ON INDIVIDUAL HEALTH CARE PREMIUMS



Note: Non-smoking individuals for a preferred provider organization with a \$500 deductible and a 80/20 coinsurance in Phoenix, Arizona.  
Source: [www.ehealthinsurance.com](http://www.ehealthinsurance.com) on April 22, 2004.



Individuals with pre-existing health conditions have a disadvantage. In most states, insurance companies are allowed to engage in medical underwriting in the individual market. Medical underwriting involves evaluating a person's health status to determine whether to charge more than the standard premium, exclude certain body systems or existing health conditions — such as diabetes — from coverage, or deny coverage altogether.<sup>4</sup>

To curb some of these practices, many states undertook reforms of their individual insurance markets in the 1990s, but few attempted comprehensive reforms. Some states enacted underwriting reforms to increase the availability of coverage, including guaranteed issue, renewability of insurance policies and limitations on exclusions for pre-existing conditions.<sup>5</sup>

By using medical underwriting, insurers can offer less expensive coverage to consumers while they are young and healthy. Conversely, people who are charged more because of their age or health status may have trouble getting coverage. (See chart, "Effect of Age on Individual Health Premiums.") One survey found that 35 percent of adults who tried to buy coverage said that it was very difficult or impossible to find a plan that met their needs and 53 percent said it was very difficult or

impossible to find an affordable plan.<sup>6</sup>

### CAN THE INDIVIDUAL MARKET BE MADE MORE BUYER FRIENDLY?

Making it easier and more affordable for Americans to move into the individual insurance market is a difficult public policy challenge, but some protections already are in place.

#### How Group COBRA Coverage Helps Individuals

So called "COBRA" coverage offers an alternative to individual insurance coverage for people who are losing job-based coverage, by giving them a chance to remain temporarily in their job-based group health plan. If a firm has at least 20 workers, those workers are covered by provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If such a company offers health insurance, and a worker participates, he or she is guaranteed the right to continue that coverage upon leaving the company, usually for a minimum of 18 months, some are eligible for up to 36 months. It doesn't matter if the worker left voluntarily or was terminated, unless the reason for termination was gross misconduct, e.g., embezzlement. Thirty-nine states have enacted "mini-COBRA" laws, giving some continuation protection to workers in firms with fewer than 20 employees.<sup>7</sup>

If the worker chooses to buy coverage through COBRA, he or she is, in effect, buying the company's policy as an individual. The ex-employee must pay the full cost of the premium — the worker share and the company share — plus a two percent administrative fee.

Using average employer-sponsored health plan costs for 2003, a worker would go from paying \$42 a month to cover himself or herself alone to \$288 a month for the same coverage. For family coverage, the worker's health insurance bill would increase from \$201 monthly to \$771,<sup>8</sup> perhaps while drawing an unemployment benefit instead of a paycheck. Cost is one of the primary reasons only about one in five workers eligible to buy COBRA coverage actually does so.<sup>9</sup> Another reason is that the unemployed worker may be able to get coverage through his or her spouse.

Whether it makes more sense for a worker who leaves a

job to choose COBRA coverage or an individual policy depends on the worker's budget and the health status of family members. If everyone in the family is healthy, comparable coverage may be cheaper in the individual market. But if someone in the family has a chronic condition or a serious health problem, insurance companies may quote a very high premium or refuse to offer coverage. In that case, COBRA — if it's available — may be the preferred way, and perhaps the only way, to continue coverage.

## **HIPAA**

The Health Insurance Portability and Accessibility Act (HIPAA), enacted in 1996, requires insurance companies in the individual market to offer policies to people, known as "HIPAA eligible" individuals, on a guaranteed issue basis. HIPAA eligible individuals are those who have left group coverage and whose COBRA coverage has expired. This means people cannot be turned down because they are sick, and no restrictions can be placed on coverage for pre-existing health conditions.

HIPAA does not require insurance companies to limit premiums, though, and often insurers charge very high rates to HIPAA-eligible individuals. Very few people buy HIPAA policies at these high premiums.<sup>10</sup> However, HIPAA does give states flexibility to impose premium limits. In addition, states can designate alternate kinds of coverage for HIPAA-eligibles, usually through high-risk pools. (See more in the "High Risk Pool" section of this chapter). A good description of rate regulations and other insurance rules in any specific state can be found at [www.healthinsuranceinfo.net](http://www.healthinsuranceinfo.net), a project of the Georgetown University Health Policy Institute.

## **New Market Tools**

People can now use the Internet to search for individual policies, which may make the fragmented individual market somewhat easier to navigate. This can help cut overhead costs for insurers, since they are marketing directly to consumers. In addition, Internet searching can provide consumers with useful information for making choices among policies, such as a cheaper price for a higher deductible.

A 2001 study by the firm eHealthInsurance.com, a private, online company that provides health insurance premium quotes, looked at 20,000 customers from 45

states who bought coverage through its web site. Typical premiums ranged from \$1,200 to \$1,500 a year for individual coverage, and most enrollees received policies that were classed as "comprehensive." The study notes, however, that "premiums paid by certain individuals are much higher than the average. Individuals paying high premiums may typically have pre-existing conditions, be near Medicare age, or reside in one of the few states with high prices due to guaranteed issue regulation for the individual market."<sup>11</sup> The eHealthInsurance study only examined premiums of policies that were purchased. It does not reflect rates quoted to customers who decided not to purchase coverage.

Another 2001 study by researchers at Georgetown University found that coverage in the individual market was expensive or nonexistent for those with pre-existing conditions. Insurance companies were asked for coverage and price quotations for seven hypothetical applicants. All had some health condition, ranging from seasonal hay fever to HIV-positive status. Only about 10 percent of the applications for coverage resulted in clean offers, or approvals of coverage at the standard price without restrictions related to medical condition. The rest of the applicants were quoted higher than normal rates, offered limited benefits, or rejected entirely.<sup>12</sup>

## **State Regulation**

States are in charge of regulating insurance companies, including their prices and marketing practices. A handful of states - New York, New Jersey, Maine, Massachusetts, New Hampshire, Kentucky, Washington and Vermont - have rules requiring individual health insurance companies to accept all applicants (guaranteed issue, discussed earlier). Some states also guarantee renewability of policies, charge everyone the same price regardless of their health status (community rating) and place limitations on exclusions for pre-existing conditions.<sup>13,14</sup>

This approach to regulating health insurance ensures lower prices for older and sicker purchasers, who are more likely to need care. But it increases the cost of insurance for younger and healthier individuals, compared to what they would pay in states without such regulations. Insurers must raise rates for these healthier, lower-risk customers to compensate for the cost of

covering the other higher-risk purchasers. Some states have tried consumer protection legislation, only to see their efforts fail. Washington State, for example, passed a law in 1993 attempting to make

### STATES WITH HIGH-RISK POOLS AS OF JANUARY 2004

Alabama	Kansas	North Dakota
Alaska	Kentucky	Oklahoma
Arkansas	Louisiana	Oregon
California	Maryland	South Carolina
Colorado	Minnesota	South Dakota
Connecticut	Mississippi	Texas
Florida*	Missouri	Utah
Illinois	Montana	Washington
Indiana	Nebraska	Wisconsin
Iowa	New Hampshire	Wyoming
Kansas	New Mexico	

\*Florida's pool has been closed to new enrollment since 1991.

Source: Communicating for Agriculture and the Self-Employed (2003/2004). "Comprehensive Health Insurance for High-Risk Individuals." Seventeenth Edition, updated by personal communication with Karen Pollitz, April 2004.

individual coverage less restrictive and less expensive. The result: most insurers stopped writing individual policies in the state.<sup>15</sup> To keep insurers in the market, in 1995 the state legislature repealed some of the reforms and made significant changes to others.

Individual coverage reform in Kentucky suffered the same fate. In 1994, the Kentucky legislature passed a law creating standard benefits packages that were to become the only health insurance products sold in the state after July 1995. The law also prohibited insurers from charging more for a policy based on a person's health status, past claims or gender (community rating, as described earlier). Insurers' ability to cancel policies was also restricted. As in Washington State, nearly all insurers exited the market and the legislature had to repeal many of the reforms in 1996.<sup>16</sup>

In most states that have repealed their individual market regulations, state law allowed insurers, even before repeal, to continue selecting who they would insure, sometimes called "cherry picking"; this thwarted rules requiring the pooling of higher risk people with lower-risk ones.<sup>17</sup>

### High-Risk Pools

Many states have created high-risk pools to help people who have trouble buying health insurance in the individual market. In most states, high-risk pools also offer coverage to HIPAA-eligible individuals. As of April 2004, 31 states had set up high-risk pools.

Policies bought from high-risk pools are typically priced at one-and-one-half to two times the standard premium charged by private insurers. Even with this premium surcharge, high-risk pools lose money because there are no healthy enrollees with low medical expenses to cross-subsidize the higher medical expenses of sick enrollees. As a result, states must use tax dollars to help finance high-risk pool coverage. Most states charge health insurance companies an assessment to help pay for high-risk pools. A few states rely on other revenue sources, such as taxes on doctors, hospitals, or cigarettes.<sup>18</sup> (See box, "States with High-Risk Pools as of January 2004.")

Because states want to control their subsidies to high-risk pools, the pools often charge high deductibles or offer limited benefits. A few high-risk pools also limit enrollment and have waiting lists.<sup>19</sup> In 2002, about 173,000 Americans were enrolled in high-risk pools.<sup>20</sup> In 2002, Congress voted to promote the development of high-risk pools through grant programs to states that both offset financial losses in qualified high-risk pool programs and encourage states to establish new high-risk pools. As of May 2004, about \$30 million had been awarded to states for this purpose, with another \$50 million expected to be awarded by mid-2005.<sup>21</sup>

## CURRENT POLICY DEBATES AND PROPOSALS

### Tax Credits

One ongoing debate concerning individual health insurance is whether tax credits to help people buy individual policies are an effective way to expand health coverage for the uninsured. Those who believe so point

out that most uninsured people are not eligible for job-based health benefits and don't qualify for Medicaid or Medicare. They also say it is important to let individuals make their own coverage choices.

Critics of using tax credits for individual insurance note that individual policies are inherently more costly than group coverage and tend to provide less comprehensive benefits. They also warn that subsidies for individual health insurance may lead to a decline in employers offering or employees enrolling in employer-sponsored group health coverage.

A related debate is over the size of the tax credit subsidy. Advocates for individual health insurance tax credits have tended to favor credits limited to a certain dollar amount. They argue limited subsidies will encourage people to shop wisely for coverage, since they will be paying a substantial portion of the insurance premium with their own money. Proponents say this will encourage insurers to offer lower-priced policies, which will help slow the growth in health insurance premiums. Critics argue that large subsidies are needed for the uninsured, most of whom have low incomes and cannot afford to pay much, if anything, to obtain health insurance.

Another key issue has to do with what rules should govern individual health insurance. Advocates for individual health insurance tax credits believe free market competition will result in the most efficiently priced coverage for the greatest number of people. Critics argue that government-enforced market rules are necessary to ensure that people who are older and sicker can also have access to affordable coverage. These might include restrictions on rate variations, barring the consideration of pre-existing conditions, and similar rules. Many policy makers and analysts have made proposals to use tax credits in the individual market to cover more of the uninsured.<sup>22</sup>

While the theoretical merits of tax credits are debated by proponents and opponents, the country already has some limited experience with them. The Trade Act of 2002 created a new tax credit to pay 65 percent of health insurance premiums for workers certified by the Department of Labor as qualifying for Trade Adjustment Assistance (TAA), having lost their jobs due to foreign competition. Others are eligible as well, including those who get pension payments from the

Pension Benefit Guaranty Corporation (PBGC). Roughly 180,000 workers, plus family members, may qualify for the tax credits. The tax credits are fully refundable, which means they are available to eligible workers who owe little or no federal income tax.<sup>23</sup>

### HSAs

Another current issue involves health savings accounts, or HSAs. As part of the new Medicare prescription drug coverage law, Congress enabled nonelderly individuals and workers who are covered by health insurance policies with high deductibles to establish tax-favored health savings accounts (HSAs). The policies must have deductibles of at least \$1,000 for an individual and \$2,000 for a family. (For more on this new law to promote HSAs, see Chapter 8, Health Care Costs.)

The purpose of the HSA is to help people put aside money for out-of-pocket health care expenses. Contributions to the HSA are tax deductible, can be accumulated over the years, and are not taxed when withdrawn, as long as they are used to pay for health care needs. Individuals can buy high-deductible policies and make tax-favored contributions to HSAs, and employers can offer such options to their workers.<sup>24</sup>

Advocates of HSAs want to establish more affordable health insurance options and create financial incentives for people to shop wisely for both health insurance and health care. According to the president's Council of Economic Advisors, "reforms that lead to more direct interaction between consumers and health care providers, relying less on third-party payers such as insurance companies, have the potential to increase the efficiency and therefore the cost-effectiveness of health care markets."<sup>25</sup> HSAs are also appealing, according to proponents, because they encourage cost sensitivity, are owned by the individual and are fully portable.

Critics say that high deductible policies are not attractive to low-income uninsured people, who can't afford the substantial out-of-pocket costs that come with them.<sup>26</sup> Of particular concern are chronically ill people, who may delay necessary care as a result of greater cost sensitivity.<sup>27</sup> Also at issue is the potential for HSAs to segment the individual health insurance market further, with younger healthier people opting for high-deductible plans, resulting in higher premiums for those who seek more traditional policies or the disappearance

of low-deductible plans altogether.<sup>28</sup> For a fuller description of the debate over how best to address the problem of the uninsured, see Chapter 1, The Uninsured.

## STORY IDEAS

- Does your state have a high-risk pool? If so, how many are enrolled? How is the pool subsidized? Is there a long waiting list? How much do policies cost?
- Workers in almost every state are eligible for subsidies of their premiums if they lose their jobs because of foreign trade. Are workers in your area taking advantage of the subsidy? Many states are allowing workers to use the subsidies, in the form of tax credits, in their high risk pools. How well is that strategy working?
- Log on to a Web site offering health insurance, such as Quotesmith.com or eHealthInsurance.com. Make up some hypothetical buyers and check out prices for several different communities in your area. See how age and gender affect the premium quotes. Do this for people with no health problems or conditions.
- Interview insurance brokers on how they find policies for people with chronic health problems.
- If your state is one of those using community rating in the individual market — New York, New Jersey, Maine, Massachusetts, New Hampshire, Kentucky, Washington and Vermont in July 2004 — compare premiums for a healthy 25-year-old and a healthy 55-year-old with those from a nearby state that does not engage in community rating. If you're from one of the other states, do the same thing in reverse.
- Has your state tried reforming the individual market, whether by community rating or in some other way? How were premiums affected? How was availability of coverage affected?

## SOURCES AND WEBSITES

### Analysts/Advocates

Linda Bilheimer, *Senior Program Officer*, The Robert Wood Johnson Foundation, 609/627-7530

## CANDIDATES' VIEWS

President Bush favors giving tax credits to Americans to purchase policies in the individual marketplace. His FY 2005 budget includes a proposal for a tax credit for individual insurance, capped at \$1,000 per person (\$3,000 for families), and phased out beginning at an individual income level of \$15,000 (\$25,000 for families).<sup>29</sup> Senator Kerry favors tax credits to help uninsured people buy into a new program much like the current health plan for members of Congress and federal employees.

The credit would equal 25 percent of the premium for those age 55 to 64 with salaries below 300 percent of the federal poverty level (FPL). For uninsured people between jobs at the 300 percent FPL income level, the credit would equal 75 percent of the premium.<sup>30</sup>

In his 2005 budget, President Bush proposed to allow people to fully deduct the premiums they pay for high-deductible individual health insurance policies purchased in combination with a health savings account (HSA). HSAs are already tax-preferred. Senator Kerry opposes HSAs, claiming they are tax shelters for the affluent and the healthy.

Linda Blumberg, *Senior Research Associate*, The Urban Institute, 202/261-5769

Stuart Butler, *Vice President and Director of Domestic and Economic Policy Studies*, The Heritage Foundation, 202/546-4400

Deborah Chollet, *Senior Fellow*, Mathematica Policy Research, Inc, 202/554-7528

Gary Claxton, *Vice President and Director of Changing Healthcare Marketplace Project*, Kaiser Family Foundation, 202/347-5270

Richard Curtis, *President*, Institute for Health Policy Solutions, 202/789-1491

William Custer, *Associate Professor*, Georgia State University, 404-651-3041

David Cutler, *Professor of Economics*, Harvard University, 617-496-5216

Pamela Farley Short, *Professor of Health Policy and Administration*, Pennsylvania State University, 814/863-8786

Judy Feder, *Dean*, Georgetown University Health Policy Institute, 202/687-0880

Paul Fronstin, *Director of Health Research and Education*, Employee Benefit Research Institute, 202/775-6352



Beth Fuchs, *Principal*, Health Policy Alternatives, 202/737-3390

Jon Gabel, *Vice President*, Health System Studies, Health Research and Educational Trust, AHA, 202/626-2688

Paul Ginsburg, *President*, Center for Studying Health System Change, 202/484-4699

Sherry Glied, *Professor and Department Chairman of Health Policy & Management*, Columbia Univ. Joseph L. Mailman School of Public Health, 212/305-0299

John Goodman, *President*, National Center for Policy Analysis, 972/386-6272

Jonathan Gruber, *Professor of Economics*, Massachusetts Institute of Technology, 617/253-8892

Robert Helms, *Resident Scholar*, American Enterprise Institute, 202/862-5877

Chris Koyanagi, *Policy Director*, Bazelon Center for Mental Health Law, 202/467-5730, x118

Jeff Lemieux, *Executive Director*, Centrist.org, 202/546-4090

Barbara Lyons, *Vice President and Deputy Director of The Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, 202/347-5270

Robert Emmet Moffit, *Deputy Director of Domestic Policy*, The Heritage Foundation, 202/546-4400

Jack Meyer, *President*, Economic and Social Research Institute, 202/833-8877, x \*812

Mark Pauly, *Bendheim Professor*, Wharton School, University of Pennsylvania, 215/898-2838

Ron Pollack, *Executive Director*, Families USA, 202-628-3030

Karen Pollitz, *Research Professor*, Georgetown University Health Policy Institute, 202/687-0880

Diane Rowland, *Executive Vice President and Executive Director of The Kaiser Commission on Medicaid and the Uninsured*, Kaiser Family Foundation, 202/347-5270

Greg Scandlen, *Director of Consumer-Driven Healthcare*, Galen Institute, 703/299-8900

Cathy Schoen, *Vice President of Health Policy Research and Evaluation*, Commonwealth Fund, 212/606-3864

Richard Sorian, *Vice President of External Relations*, National Committee on Quality Assurance, 202-955-5102

Katherine Swartz, *Director of Graduate Studies*, Harvard University, 617/432-4325

Ken Thorpe, *Robert Woodruff Professor and Chair Department of Health Policy and Management*, Rollins School of Public Health at Emory University, 404-727-3373

John Trout, *Senior Consultant*, Alliance for Retired Americans, 561-575-3797

Grace-Marie Turner, *President*, Galen Institute, Inc., 703/299-8900

Judy Waxman, *Vice President for Health And Reproductive Rights*, National Women's Law Center, 202-588-5180

Myrl Weinberg, *President*, National Health Council, 202/785-3910

### Government and Related Groups

Dean Rosen, *Health Policy Advisor*, Office of Senate Majority Leader Bill Frist, M.D., 202/224-3344

### Stakeholders

Mary Grealy, *President*, Healthcare Leadership Council, 202/452-8700

Angela Hunter, *Director of Federal Affairs*, Council for Affordable Health Insurance, 703/837-1387

Charles (Chip) Kahn III, *President*, Federation of American Hospitals, 202/624-1534

Gary Lauer, *President and CEO*, eHealthInsurance.com, 408/542-4800

Mary Nell Lehnhard, *Senior Vice President*, Blue Cross/Blue Shield Association, 202/626-4781

Vip Patel, *Founder*, eHealthInsurance.com, 408/542-4800

Kate Sullivan, *Director of Health Care Policy*, US Chamber of Commerce, 202-463-5734

Janet Trautwein, *Vice President of Government Affairs*, National Association of Health Underwriters, 703/276-3806

### Websites

Alliance for Health Reform  
www.allhealth.org

America's Health Insurance Plans  
www.ahip.org

The Commonwealth Fund  
www.cmwf.org

eHealthInsurance.com  
www.ehealthinsurance.com

Employee Benefit Research Institute  
www.ebri.org

Georgetown University Health Policy Institute  
[www.healthinsuranceinfo.net](http://www.healthinsuranceinfo.net)

Heritage Foundation  
[www.heritage.org](http://www.heritage.org)

Institute for Health Policy Solutions  
[www.ihps.org](http://www.ihps.org)

Kaiser Family Foundation  
[www.kff.org](http://www.kff.org)

National Association of Insurance Commissioners,  
[www.naic.org](http://www.naic.org)

The Robert Wood Johnson Foundation,  
<http://www.rwjf.org/>

State Coverage Initiatives  
[www.statecoverage.net](http://www.statecoverage.net)

Urban Institute  
[www.urban.org](http://www.urban.org)

## ENDNOTES

- a U.S. Census Bureau (2004). "Health Insurance Historic Tables, Table HI-6." Aug. 26. ([www.census.gov/hhes/hlthins/historic/hihist6.html](http://www.census.gov/hhes/hlthins/historic/hihist6.html)) Retrieved on Aug. 26, 2004.
- b Lucia, Kevin & Karen Pollito (2004). "Summary of Key Consumer Protections in Individual Health Insurance Markets." Georgetown University Health Policy Institute, April. ([http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination\\_limits.pdf](http://www.healthinsuranceinfo.net/newsyoucanuse/discrimination_limits.pdf)) Retrieved May 12, 2004.
- c Communicating for Agriculture and the Self Employed (2003/2004). "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis." Seventeenth Edition, p.2, 23. ([http://www.naschip.org/communicating\\_for\\_agriculture.htm](http://www.naschip.org/communicating_for_agriculture.htm))
- d Lambrew, Jeanne M. (2001). "How the Slowing U.S. Economy Threatens Employer-Based Health Insurance." The Commonwealth Fund, November, p.4. ([http://cmwf.org/programs/insurance/lambrew\\_slowingeconomy\\_511.pdf](http://cmwf.org/programs/insurance/lambrew_slowingeconomy_511.pdf)) Retrieved May 12, 2004.
- 1 Though this type of insurance is popularly known as "individual," analysts refer to it as "non-group," since policies cover both individuals and families.
- 2 Duchon, Lisa & Cathy Schoen (2001). "Experience of Working-Age Adults in the Individual Insurance Market: Findings from the Commonwealth Fund 2001 Health Insurance Survey." (Issue Brief No. 514). The Commonwealth Fund, December, p.1. ([http://cmwf.org/programs/insurance/duchon\\_indins\\_ib\\_514.pdf](http://cmwf.org/programs/insurance/duchon_indins_ib_514.pdf)) Retrieved April 28, 2004.
- 3 Kaiser Family Foundation & Health Research and Educational Trust (2003). "Employer Health Benefits: 2003 Annual Survey." p. 1. ([www.kff.org/insurance/ehbs-archives.cfm](http://www.kff.org/insurance/ehbs-archives.cfm)) Retrieved April 27, 2004.
- 4 Pollitz, Karen, Richard Soriano, & Kathy Thomas (2001). "How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?" (Publication No. 3133). The Kaiser Family Foundation, June 20, p.2. (<http://www.kff.org/insurance/20010620a-index.cfm>) Retrieved April 28, 2004.
- 5 Fuchs, Beth (2004). "Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s." The Robert Wood Johnson Foundation, Research Synthesis Report No. 4, June.
- 6 Duchon, Lisa & Cathy Schoen (2001). "Experience of Working-Age Adults in the Individual Insurance Market: Findings from the Commonwealth Fund 2001 Health Insurance Survey." (Issue Brief No. 514). The Commonwealth Fund, December, p.1. ([http://cmwf.org/programs/insurance/duchon\\_indins\\_ib\\_514.pdf](http://cmwf.org/programs/insurance/duchon_indins_ib_514.pdf)) Retrieved April 28, 2004.
- 7 [www.healthinsuranceinfo.net](http://www.healthinsuranceinfo.net) includes state-by-state profiles that outline each state's COBRA-like laws.
- 8 The Kaiser Family Foundation & Health Research and Educational Trust (2003). "Employer Health Benefits: 2003 Annual Survey." p. 19, 74. (<http://www.kff.org/insurance/ehbs-archives.cfm>). Retrieved April 27, 2004.

- 9 Lambrew, Jeanne M. (2001). "How the Slowing U.S. Economy Threatens Employer-based Health Insurance." The Commonwealth Fund, November, p.4. ([http://cmwf.org/programs/insurance/lambrew\\_slowingeconomy\\_511.pdf](http://cmwf.org/programs/insurance/lambrew_slowingeconomy_511.pdf)). Retrieved May 12, 2004.
- 10 U.S. General Accounting Office (1999). "Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards." (GAO/HEHS-99-100). May. (<http://www.gao.gov/archive/1999/he99100.pdf>). Retrieved April 28, 2004.
- 11 Patel, Vip (2001). "Analysis of National Sales Data of Individual and Family Health Insurance: Implications for Policymakers and the Effectiveness of Health Insurance Tax Credits." *EhealthInsurance*, June, p. 1, 2, 8. (<http://www.ehealthinsurance.com/ehealthinsurance/eHealth2.pdf>). Retrieved May 10, 2004.
- 12 Pollitz, Karen, Richard Sorian, & Kathy Thomas (2001). "How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?" (Publication No. 3133). The Kaiser Family Foundation, June 20, p.2. (<http://www.kff.org/insurance/20010620a-index.cfm>). Retrieved April 28, 2004.
- 13 Fuchs, Beth (2004). "Expanding the Individual Health Insurance Market: Lessons from the State Reforms of the 1990s." The Robert Wood Johnson Foundation, Research Synthesis Report No. 4, June, p.9.
- 14 Pollitz, Karen. Personal Communication, July 15, 2004.
- 15 Shipley, Thomas (1999). "Demos Budge on Health Care Coverage." *Seattle Post-Intelligencer*, March 29.
- 16 Kirk, Adele M. (2000). "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts." *Journal of Health Politics, Policy and Law*, February. (<http://muse.jhu.edu/journals/jhp/>).
- 17 Kirk, Adele (2000). "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky, and Massachusetts." *Journal of Health Politics, Policy and Law*, 25(1). (<http://muse.jhu.edu/journals/jhp/>).
- 18 Communicating for Agriculture and the Self Employed (2003/2004). "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis." Seventeenth Edition, p.2, 23. ([http://www.naschip.org/communicating\\_for\\_agriculture.htm](http://www.naschip.org/communicating_for_agriculture.htm)).
- 19 Achman, Lori & Deborah Chollet (2001). "Insuring the Uninsurable: An Overview of State High-Risk Insurance Pools." (Document No. PR01-59). Mathematica Policy Research, Inc., August. ([http://cmwf.org/programs/insurance/achman\\_uninsurable\\_472.pdf](http://cmwf.org/programs/insurance/achman_uninsurable_472.pdf)). Retrieved May 11, 2004.
- 20 Communicating for Agriculture and the Self Employed (2003/2004). "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis." Seventeenth Edition, p.2, 23. ([http://www.naschip.org/communicating\\_for\\_agriculture.htm](http://www.naschip.org/communicating_for_agriculture.htm)).
- 21 Pollitz, Karen, personal communication, May 25, 2004.
- 22 The Lewin Group (2003). For an analysis of ten proposals by leading health policy experts, see Shiels, John, and Haight, Randall, "Cost and Coverage of Ten Proposals to Expand Health Insurance Coverage." ([http://www.lewin.com/Lewin\\_Publications/Uninsured\\_And\\_Safety\\_Net/CoverageAnalysisTenProposals.htm](http://www.lewin.com/Lewin_Publications/Uninsured_And_Safety_Net/CoverageAnalysisTenProposals.htm)).
- 23 Dorn, S. (December 2003). "The Trade Act of 2002: A Basis for Future Health Coverage of Unemployed Workers?" Alliance for Health Reform. ([www.allhealth.org/pub/pdf/TAA%20Issue%20Brief.pdf](http://www.allhealth.org/pub/pdf/TAA%20Issue%20Brief.pdf)). Retrieved Aug. 27, 2004.
- 24 Internal Revenue Service (2004). "Health Savings Accounts (HSAs)." *Internal Revenue Bulletin 2004-2*, January 12. ([www.irs.gov/irb/2004-02\\_IRB/ar09.html](http://www.irs.gov/irb/2004-02_IRB/ar09.html)). Retrieved May 11, 2004.
- 25 Council of Economic Advisors (2004). "Economic Report of the President, Transmitted to the Congress February 2004." p. 199. ([http://www.gpoaccess.gov/usbudget/fy05/pdf/2004\\_erp.pdf](http://www.gpoaccess.gov/usbudget/fy05/pdf/2004_erp.pdf)). Retrieved May 11, 2004.
- 26 Glied, Sherry, et al. (2002). "Bare Bones Plans: Are They Worth the Money?" The Commonwealth Fund, May. ([http://cmwf.org/programs/insurance/glied\\_barebones\\_ib\\_518.pdf](http://cmwf.org/programs/insurance/glied_barebones_ib_518.pdf)). Retrieved May 11, 2004.

- <sup>27</sup> Miller, Tom (2004). Panelist at Alliance for Health Reform Briefing, "Consumer-Directed Health Care: The Next Big Thing?" July 9, transcript, p.43. ([http://www.kaisernetwork.org/health\\_cast/uploaded\\_files/070904\\_alliance\\_briefing\\_transcript.pdf](http://www.kaisernetwork.org/health_cast/uploaded_files/070904_alliance_briefing_transcript.pdf)). Retrieved August 9, 2004.
- <sup>28</sup> Shearer, Gail (2004). Testimony before the Joint Economic Committee of Congress. Feb. 25. ([www.allhealth.org/recent/audio\\_07-09-04/cu-testimonyonhsa.pdf](http://www.allhealth.org/recent/audio_07-09-04/cu-testimonyonhsa.pdf))
- <sup>29</sup> Office of Management and Budget (2004). "Budget of the United States Government, Fiscal Year 2005." Transmitted to Congress on February 2, p.152. (<http://www.gpoaccess.gov/usbudget/fy05/index.html>). Retrieved May 11, 2004.
- <sup>30</sup> "A Plan for Stronger, Heathier Families and Children" (2004). Website of the Kerry - Edwards campaign. ([www.johnkerry.com/issues/health\\_care/family.html](http://www.johnkerry.com/issues/health_care/family.html)). Retrieved July 27, 2004.

