

February 2002

# PRIVATE HEALTH INSURANCE

## Access to Individual Market Coverage May Be Restricted for Applicants with Mental Disorders



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## **Abbreviations**

APA	American Psychiatric Association
BCBSA	Blue Cross and Blue Shield Association
COBRA	Consolidated Omnibus Budget Reconciliation Act
HIAA	Health Insurance Association of America
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	human immunodeficiency virus
HMO	Health Maintenance Organization
NAMI	National Alliance for the Mentally Ill



United States General Accounting Office  
Washington, DC 20548

February 28, 2002

The Honorable Richard Durbin  
Chairman  
Subcommittee on Oversight of Government Management,  
Restructuring, and the District of Columbia  
Committee on Governmental Affairs  
United States Senate

The Honorable Edward M. Kennedy  
Chairman  
Committee on Health, Education, Labor, and Pensions  
United States Senate

About 19 percent of American adults suffer from some type of mental disorder each year. Most are nonsevere in nature but about 5 percent of adults have serious mental disorders. While many of these adults have access to employer-sponsored group health coverage or public programs such as Medicare or Medicaid, some without such coverage may seek to purchase health insurance directly in the individual market. This market provided about 12.6 million Americans with their sole source of health coverage in 2000. States are the primary regulators of individual health insurance, and most states allow individual market insurance carriers to medically underwrite—that is, evaluate applicants' health status and possibly deny coverage, offer more limited benefits, or charge higher premiums to applicants with any health condition, including mental disorders.

Because of concerns that individuals with mental disorders may face problems obtaining coverage for themselves and their families in the individual health insurance market, you asked us to examine carriers' underwriting practices in this market segment. In particular, you asked us to examine the following questions:

1. To what extent do states require individual market carriers to guarantee access to coverage and limit premiums for applicants and their families with mental disorders?
2. How do individual market carriers' coverage and premium decisions affect applicants with mental disorders, and how do these decisions compare to those for applicants with other chronic health conditions?

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3. When denied coverage, what other health insurance options are available to those with mental disorders?

To determine the extent to which states require carriers to guarantee access to coverage and the coverage options available to declined applicants in states without guaranteed access, we reviewed published summary data on insurance laws and programs to provide coverage for applicants denied individual market coverage in all of the states, including the District of Columbia.<sup>1</sup> We discussed state insurance laws and regulations with regulators in 6 states—California, Connecticut, Georgia, Illinois, Mississippi, and Montana—that are among the states in which carriers are not required to guarantee access to coverage in the individual market. We also interviewed health insurance agents in each of these states to discuss their experiences finding health insurance coverage for applicants with mental disorders.

To identify health insurance carrier practices related to coverage and premium decisions, we interviewed or obtained data from seven large health insurance carriers regarding their health plans and underwriting practices. Although we cannot generalize the practices of these seven carriers to all individual market carriers, the seven carriers collectively insure more than 10 percent of all individual market enrollees and sell coverage in most of the states in which carriers are permitted to medically underwrite. We examined the underwriting practices of the seven carriers for hypothetical applicants with one of six mental disorders and 1 of 12 other chronic health conditions. We selected the six mental disorders based on their prevalence—each affects over 1 million Americans—and we selected the 12 other chronic health conditions based on certain clinical characteristics they share in common with the mental disorders. We also analyzed 1997 health care cost and utilization data from the Medical Expenditure Panel Survey, a national survey administered by the Department of Health and Human Services. We conducted our work from July 2001 through February 2002 according to generally accepted government auditing standards. Appendix I provides more details about our scope and methodology, and a list of related GAO products is included at the end of this report.

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<sup>1</sup>Throughout the remainder of this report, the District of Columbia is included as a state.

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## Results in Brief

While in a minority of states health insurance carriers guarantee access to coverage for individuals with mental disorders, in most states individuals with mental disorders may face restrictions in purchasing health insurance for themselves and their families in the individual insurance market. Eleven states require carriers to accept all applicants regardless of health status. Coverage options vary, however. Eight of these 11 states require all carriers to guarantee access to coverage sold in this market. In 3 states, laws apply only to certain carriers, such as Blue Cross and Blue Shield plans, or certain periods of the year. Carriers in 9 of the 11 states are also required to limit the extent to which premium rates may vary between healthy and unhealthy individuals. The extent of premium rate regulation varies, ranging from pure community rating—where everyone pays the same premium—to rate bands that allow limited variation in rates for differences in individuals' health status and other factors, such as age, gender, or geography. In 6 additional states, carriers voluntarily guarantee access to coverage in the individual market and 3 of these also use community rating to establish premiums. In the remaining 34 states, carriers are permitted to deny coverage to applicants with mental disorders or other health conditions, and may deny coverage to applicants that are at higher-than-average risk to minimize claims costs and keep premiums more affordable for others.

In states without guaranteed coverage in the individual market, the seven carriers we reviewed would likely deny coverage more frequently for applicants with selected mental disorders than for applicants with other selected chronic health conditions. Specifically, for six mental disorders of generally moderate severity, carriers indicated that they would likely decline applicants 52 percent of the time. While these carriers' underwriting decisions varied depending on the mental disorder and specific characteristics of the applicant, most of the carriers would likely deny coverage to applicants with posttraumatic stress disorder, schizophrenia, manic depressive and bipolar disorder, or obsessive-compulsive disorder, and several would likely deny coverage to applicants with chronic depression. In comparison, for 12 other chronic health conditions of generally moderate severity—such as hypertension or diabetes—carriers indicated that they would likely decline applicants 30 percent of the time. In most instances in which coverage would likely be offered to applicants with either the selected mental disorders or other chronic health conditions, premiums would be higher and/or benefits would be restricted—for example, benefits specifically for treatment of the disorders or conditions could be permanently excluded. Some carrier officials said that mental disorders have greater variability and unpredictability in their associated costs, contributing to the decision to

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deny coverage to applicants with these conditions. However, our analysis showed similarly wide variability in total health care costs between the selected mental disorders and the selected other chronic disorders.

State-sponsored high-risk pools are the primary coverage option available to rejected applicants in most states. In 27 of the 34 states where carriers may deny coverage to applicants with mental disorders or other health conditions, high-risk pools offer coverage to applicants denied individual market coverage. The pools are subsidized—generally through assessments on carriers or state tax revenues—and premium rates are generally capped at 125 to 200 percent of standard rates for healthy individuals. Health benefits available under the pools are generally comparable to those available in the individual market, including similar restrictions on mental health benefits; however, benefits for mental disorders or other health conditions are not permanently excluded as they may be in the individual insurance market. Applicants have occasionally had to wait before receiving risk pool coverage when additional enrollment would exceed budget constraints set for the state-subsidized risk pools. However, in the 7 states that do not require carriers to guarantee access to coverage and do not have high-risk pools, most applicants without prior group coverage may have few, if any, alternatives.

Representatives of the American Psychiatric Association, the Blue Cross and Blue Shield Association, the Health Insurance Association of America, and the National Alliance for the Mentally Ill provided comments on a draft of this report, which we incorporated as appropriate.

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## Background

About 19 percent of the nation's adults and 21 percent of youths ages 9 to 17 have mental disorders at some time during a 1-year period. Among adults, about 5 percent have severe mental disorders, and nearly 3 percent have mental disorders that are both severe and persistent.<sup>2</sup> Mental disorders include a wide range of specific conditions of varying prevalence. For example, chronic mild depression and major depressive disorders collectively affect about 10 percent of all adults during a 1-year period, and attention deficit/hyperactivity disorder affects about 4 percent

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<sup>2</sup>U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, Md.: National Institute of Mental Health, 1999).

of youths age 9 to 17 during a 6-month period.<sup>3</sup> Table 1 indicates the prevalence of selected mental disorders, each of which affects more than 1 million adults in a given year.

**Table 1: Prevalence of Selected Mental Disorders among Adults during a 1-Year Period**

Disorder	Number with disorder (in millions)	Percentage of adult population
Chronic, mild depression	10.9	5.4
Major depressive disorder	9.9	5.0
Posttraumatic stress disorder	5.2	3.6
Obsessive-compulsive disorder	3.3	2.3
Bipolar disorder	2.3	1.2
Schizophrenia	2.2	1.1

Note: For posttraumatic stress and obsessive-compulsive disorders, adults are defined as individuals ages 18 to 54. Otherwise, adults are defined as individuals 18 or older.

Source: The National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, NIMH Publication No. 01-4584 (Bethesda, Md.: NIMH, January 2001). <http://www.nimh.nih.gov/publicat/numbers.cfm> (downloaded on May 22, 2001).

Health insurance is an important factor influencing whether individuals with mental disorders have access to treatments that can be effective in diminishing the symptoms of disorders and improving patients' quality of life. Absent treatment, according to the surgeon general, many individuals with mental disorders may suffer increased incidents of lost productivity, unsuccessful relationships, and significant distress and dysfunction. Untreated mental disorders among adults can also have a significant and continuing effect on children in their care.

## Many Americans Rely on the Individual Health Insurance Market

Although the majority (68 percent) of Americans under age 65 have employer-sponsored group coverage, a significant minority (5 percent, or 12.6 million) relied on private, individual health insurance as their only source of coverage in 2000.<sup>4</sup> Individuals with certain labor force or demographic characteristics are more likely to depend on individual

<sup>3</sup>See the National Institute of Mental Health, *The Numbers Count: Mental Disorders in America*, NIMH Publication No. 01-4584 (Bethesda, Md.: NIMH, January 2001). <http://www.nimh.nih.gov/publicat/numbers.cfm> (downloaded on May 22, 2001).

<sup>4</sup>This information is based on our analysis of the March 2001 Current Population Survey.

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coverage than the general population. For example, 14 percent of workers in agriculture, forestry, and fisheries, and 19 percent of the self-employed, relied exclusively on individual health coverage in 2000. Moreover, the individual insurance market is an important source of coverage for early retirees—people in their fifties and early sixties who are not yet eligible for Medicare. About 13 percent of retirees between 50 and 64 had individual health insurance as their sole source of coverage in 2000.

Moreover, federal and state laws provide certain guarantees for eligible individuals moving from group to individual coverage. Portability provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantee access to coverage for certain individuals leaving qualified group coverage. To implement these portability requirements, states adopted different approaches, typically including guaranteed coverage by individual market carriers or enrollment in a state high-risk pool.<sup>5</sup> To be HIPAA-eligible, individuals must meet certain requirements, including exhausting any group continuation coverage available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or state law.<sup>6</sup>

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## The Individual Health Insurance Market Differs from the Group Market

Important differences exist between the individual and group health insurance markets. Unlike employer-sponsored group coverage, where eligibility in a group is guaranteed by federal and state laws and premiums are generally based on the risks associated with a group of beneficiaries, eligibility and initial premiums in the individual markets of many states are based largely on an individual's health status and risk characteristics.<sup>7</sup> Also, unlike group markets, in which employers generally subsidize premiums, individuals must pay the full cost of their health insurance

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<sup>5</sup>Pub. L. No. 104-191, title I, 110 Stat. 1936, 1939.

<sup>6</sup>29 U.S.C. 1161-1169 (1994). COBRA provided that group health plans covering 20 or more workers must offer 18 to 36 months of continued health coverage at generally no more than 102 percent of the total premium, to former employees and their dependents in certain circumstances, such as when an employee is terminated, quits, or retires. Some states provide other options to help individuals extend group coverage or convert from a group to an individual policy when no longer eligible for group coverage.

<sup>7</sup>Under provisions established by HIPAA, group health plan issuers may not exclude a member within the group from coverage on the basis of the individual's health status or medical history. Similarly, the benefits provided, premiums charged, and contributions to the plan may not vary for similarly situated group plan enrollees on the basis of health status or medical history.

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premiums.<sup>8</sup> Finally, while both federal and state governments regulate group coverage, individual coverage is regulated almost exclusively at the state level.

Individual market carriers are concerned about the potential for adverse selection. Adverse selection occurs when people who believe they are healthy refrain from purchasing individual market coverage because of its high cost and unsubsidized nature. If healthy people refrain from purchasing coverage, high-risk individuals may make up a disproportionate share of those seeking to purchase individual coverage, causing claims costs to rise. Carriers may then need to raise premiums to compensate. Responding to the higher premiums, healthier members of the pool may disenroll, resulting in an increasing spiral of higher risks and higher costs. To mitigate the potential for adverse selection, carriers in most states are permitted to use medical underwriting—that is, evaluate the health status and risk characteristics of each applicant and make coverage and premium decisions based on that information.

Although both group and individual market health insurance plans generally include greater restrictions on mental health benefits than on benefits for other services, these restrictions are usually greater among individual market plans. Where not precluded by law, restrictions on mental health benefits can include (1) lower annual or lifetime dollar limits on what the plan will pay, (2) lower service limits, such as fewer covered hospital days or outpatient office visits, and (3) higher cost sharing, such as deductibles, copayments, or coinsurance. A typical group or individual health plan, in the absence of a requirement that mental health benefits and other benefits be equal, might cover unlimited hospital days and outpatient visits, pay 80 percent of covered services, and impose a lifetime limit of \$1 million for other benefits. However, for mental health benefits, a typical group plan might cover only 30 hospital days and 20 outpatient visits per year, pay only 50 percent of covered services, and impose a \$50,000 lifetime limit. Among individual market plans, if offered coverage, an individual may typically face even greater restrictions on mental health benefits, such as a lifetime dollar limit of \$10,000 or an annual dollar limit of \$3,500. Moreover, some individual market carriers

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<sup>8</sup>Under current tax law, individuals may be able to claim an itemized deduction for health insurance premiums to the extent that premiums and all other out-of-pocket health care expenses exceed 7.5 percent of adjusted gross income. Also, self-employed individuals may be able to deduct 60 percent of health insurance expenses, and this share is scheduled to rise to 100 percent in 2003. 26 U.S.C. § 162(l) (Supp. IV 1998).

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may offer no benefits for outpatient care, such as visits to a mental health professional; may offer mental health benefits only under a separate policy at an increased cost; or may not offer any benefits for mental health treatment.

Federal and state laws have begun to partially equalize benefit levels, although few of the laws apply to individual market plans. The Mental Health Parity Act of 1996 prohibited certain group plans from imposing annual or lifetime dollar limits on mental health benefits that are more restrictive than those imposed on other benefits, although provisions did not place restrictions on other plan features such as hospital day or outpatient visit limits.<sup>9</sup> The provisions apply only to group plans sponsored by employers with more than 50 employees and do not apply to coverage sold in the individual market. Several states have passed laws that exceed the federal law by requiring that plans not only require parity in dollar limits, but also in service limits and cost sharing provisions. However, most of these state laws apply to group coverage and not individual coverage. As of March 2000, only 10 states required that mental health benefits be on a par with other benefits for all coverage sold in the individual market.<sup>10</sup>

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## In A Minority of States, Individual Market Carriers Guarantee Access to Coverage

Access to the individual insurance market for persons with mental disorders or other health conditions depends largely on the insurance laws—and in limited instances, carrier practices—in their states. In 11 states, laws require that individuals with mental disorders or other health conditions be guaranteed access to coverage, regardless of health status. In 8 of the 11 states, all carriers participating in the individual market must guarantee access to at least one product to all applicants. In the remaining 3 states only certain carriers, such as health maintenance organizations (HMO) or Blue Cross and Blue Shield plans, guarantee access to coverage

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<sup>9</sup>Pub. L. No. 104-204, title VII, 110 Stat. 2847, 2944 (codified at 29 U.S.C. 1185a).

<sup>10</sup>Specifically, at our request for a prior report the National Conference of State Legislatures' Health Policy Tracking Service summarized state laws on mental illness coverage. This summary identified laws in 10 states that require individual market carriers to provide mental health benefits equal to other benefits for inpatient and outpatient services, deductibles, copayments, and coinsurance. These states generally define mental health benefits as those for mental disorders that are severe, serious, or biologically based. For more information, see U.S. General Accounting Office, *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited*, [GAO/HEHS-00-95](#) (Washington, D.C.: May 10, 2000).

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to all applicants. For example, in Michigan, state law requires the Blue Cross and Blue Shield plan to guarantee access to coverage for all applicants, and in Maryland, HMOs are required to have an open enrollment period every 6 months during which all applicants must be accepted regardless of health status.

In 9 of the 11 states in which carriers are required to guarantee access to individual market coverage, carriers must also limit the extent to which premium rates vary between healthy and unhealthy applicants and thereby improve the affordability of coverage for high-risk individuals. Rate restrictions generally fall into two categories known as community rating or rate bands. Carriers in 6 of the 9 states use community rating. Under pure community rating, carriers set premiums at the same level for all enrollees, regardless of health status or demographic factors. Under adjusted community rating, limited adjustments are made for certain demographic factors, such as age, gender, or geographic location, but generally not for health status. For example, Maine permits premium rates to vary by no more than 20 percent above or below the standard rate for certain demographic factors, including age. Three of the 9 states require carriers to use rate bands to reduce the variation in premiums. Like adjusted community rating, rate bands permit limited adjustments from a base rate, but typically provide for a greater number of adjustments, including for health status, and a greater degree of variation in premium rates. For example, Idaho allows carriers to vary premiums by up to 25 percent above or below the standard rate for health status. Table 2 indicates the states in which carriers are required guarantee access to coverage and whether they are also required to limit the variation in premium rates.

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**Table 2: States that Require Carriers to Guarantee Access to Coverage**

State	Guaranteed issue - all carriers	Guaranteed issue - certain carriers	Community rating	Rate bands
Idaho	X			X
Maine	X		X	
Maryland		X		
Massachusetts	X		X	
Michigan		X	X	
New Hampshire	X <sup>a</sup>			X
New Jersey	X		X	
New York	X		X	
Ohio	X			X
Vermont	X		X	
West Virginia		X		

<sup>a</sup>In New Hampshire, individual market health carriers will be permitted to medically underwrite effective July 1, 2002.

Sources: Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: The Commonwealth Fund, 2001). Institute for Health Care Research and Policy, 2000, *Summary Comparison of Individual Market Reforms* (Washington, D.C.: Georgetown University, June 14, 2000). <http://www.georgetown.edu/research/ihrp/chep> (downloaded on August 16, 2001). We also obtained information from the Blue Cross and Blue Shield Association. In addition, we updated certain information based on contacts with state insurance regulators.

In 6 additional states, certain carriers—typically Blue Cross and Blue Shield plans—voluntarily guarantee access to coverage. In 3 of these 6 states, carriers use community rating to establish premiums. In the states where carriers do not use community rating, premiums for high-risk applicants may be significantly higher than standard rates. For example, several insurance agents in North Carolina said guaranteed access coverage for high-risk applicants in the state can cost several times the standard rate for a healthy applicant, or about \$1,000 to \$1,200 monthly. (See table 3.)

**Table 3: States in Which Certain Carriers Voluntarily Guarantee Access to Coverage**

State	Carriers voluntarily guarantee access to coverage	Carriers voluntarily use community rating
District of Columbia	X	
Hawaii	X	X
North Carolina	X	
Pennsylvania	X	X
Rhode Island	X	
Virginia	X	X

Sources: Lori Achman and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: The Commonwealth Fund, 2001). Institute for Health Care Research and Policy, 2000, *Summary Comparison of Individual Market Reforms* (Washington, D.C.: Georgetown University, June 14, 2000). <http://www.georgetown.edu/research/ihrp/chep> (downloaded on August 16, 2001). We also obtained information from the Blue Cross and Blue Shield Association.

Analysts have written extensively on the trade-offs involved in health insurance regulations intended to improve access to coverage. In general, requirements that carriers accept all applicants and limit the variation in the premiums they charge can result in improved access and affordability for high-risk applicants but may result in higher premiums for healthy applicants, which may lead some to discontinue their health insurance coverage.<sup>11</sup>

## In Other States, Applicants with Mental Disorders May be More Likely to be Denied Coverage

In the 34 states where individual market carriers are not required to guarantee access to coverage, carriers may deny coverage to any high-risk applicant, but may be more likely to deny coverage to those with mental disorders than other chronic health problems. The seven carriers participating in our study that sell individual market coverage in many of these states were more likely to deny coverage for hypothetical applicants with selected mental disorders (52 percent of the time) than for other selected chronic health conditions (30 percent of the time). Some carrier

<sup>11</sup>For more information on the trade-offs of insurance market reforms and the experience of states adopting various reforms, see: Katherine Swartz, *Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?* (New York: The Commonwealth Fund, 2000); Len M. Nichols, "State Regulation: What Have We Learned So Far?" *Journal of Health Politics, Policy and Law*, Volume 25 (2000); Jill A. Marsteller and others, *Variations in the Uninsured: State and County Level Analyses* (Washington, D.C.: The Urban Institute, 1998); and U.S. General Accounting Office, *Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs*, *GAO/HEHS-97-8*, (Washington, D.C.: November 25, 1996).

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officials said it is more difficult to predict treatment costs for applicants with mental disorders, perhaps contributing to the reluctance of some carriers to offer coverage. However, our analysis of treatment cost variation for selected mental disorders and other chronic health conditions found that both had similarly wide variations in costs.

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### Individuals with Selected Mental Disorders Likely to Incur High Claims and Thus Be Denied Coverage

Carriers participating in our study would likely deny coverage to slightly more than half of the applicants currently being treated for one of six selected mental disorders. Generally, where not precluded by state or federal law, carriers may decline coverage to any applicant considered to be high risk. Health care cost and utilization data indicate that individuals with mental disorders, like others with health problems, are likely to incur higher-than-average health care costs. Thus, carriers may deny coverage or, if they offer it, charge a higher premium or restrict benefits, subject to state regulations.<sup>12</sup>

We asked the seven responding carriers to assume a hypothetical applicant had a selected mental disorder that had been previously diagnosed, and was of moderate severity and for which the applicant was on prescription medication or had otherwise received medical treatment for the disorder within the prior year. We found that most carriers would likely reject an applicant with posttraumatic stress disorder, schizophrenia, manic depressive and bipolar disorder, and obsessive-compulsive disorder. (See table 4.) Nearly half would likely deny coverage for chronic depression. In most instances in which coverage would likely be offered, applicants would be charged higher premiums and could have benefits limited—such as by permanently excluding coverage for the mental disorder. For example, one carrier would accept for coverage an applicant with chronic depression, but would charge 45 percent above the standard rate. Another carrier would similarly accept an applicant with chronic depression, but would eliminate coverage for treatment of the depression in addition to charging the applicant 40 percent above the standard rate. An applicant or family member with attention deficit disorder would least likely be denied coverage. Only one carrier would

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<sup>12</sup>Carriers we contacted for this study and a related study of the individual insurance market in 1997 (GAO/HEHS-97-8) indicated that from 5 to 33 percent of all individual market applicants are rejected due to preexisting health conditions, with most carriers typically rejecting about 19 percent. Information provided by officials from seven state high-risk pools suggests that a minority of risk pool enrollees who were rejected by individual market carriers—from about 4 to 14 percent—have mental disorders.

likely deny such an applicant outright, and three carriers would likely offer full coverage at the standard rate. The other three carriers would likely offer coverage but charge higher premiums, offer more limited benefits, or both.

**Table 4: Likely Underwriting Decisions of Seven Carriers for Hypothetical Applicants with Selected Mental Disorders**

Mental disorder	Likely underwriting decision (number of carriers making underwriting decision)		
	Deny coverage	Offer coverage, but increase premium and/or limit benefits	Offer full coverage at standard rate
Posttraumatic stress disorder	5	2	0
Schizophrenia	5	2	0
Manic depressive and bipolar disorder	4	3	0
Obsessive-compulsive disorder	4	3	0
Chronic depression	3	4	0
Attention deficit disorder	1	3	3

Source: Carrier responses to GAO request.

Carrier underwriting practices can vary considerably. For example, an official from one carrier said that only applicants with serious cases of depression and obsessive-compulsive disorders who are heavily medicated would be declined coverage, while another carrier indicated it would decline any applicant with chronic depression, regardless of severity, if currently under treatment. Officials from two carriers pointed out that declined individuals could reapply and be accepted later if their health problems resolve themselves. One of the carrier officials said an initially declined applicant could be offered coverage under a plan other than the one applied for, although the premiums would likely be higher. Health insurance agents we contacted similarly emphasized the variability of carrier underwriting practices.

Published research also illustrates the variation in carrier underwriting practices as they relate to mental disorders. For example, one recent study specifically examined individual market carrier treatment of situational (short-term) depression. The study of carriers in eight localities around the country found that 23 percent would decline an applicant, 62 percent

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would offer coverage with a premium increase and/or a benefit limit, and 15 percent would offer full coverage at the standard rate.<sup>13</sup>

In addition, carriers' underwriting practices relating to applicants with a history of treatment for mental disorders can vary considerably. Information we obtained during current and prior work examining the individual health insurance market indicates that some carriers may require applicants to be treatment-free for 6 months to 10 years before applications will be considered, depending on the carrier and the prior disorder. For example, the underwriting manual of one multistate carrier indicates that applicants treated for a specified set of mental disorders of moderate severity could be declined if treated within the prior year and either declined or accepted at a higher premium if treated from 1 to 5 years prior to the current application. Another carrier underwriting manual indicates that applicants treated for any neurotic or psychotic disorder would be declined until treatment-free for 2 or 5 years, depending on the nature and severity of the prior disorder.

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### Carriers May Be More Likely to Decline Applicants with Mental Disorders than with Other Chronic Health Conditions

To determine whether disparities exist in carrier underwriting practices based on whether an applicant has a mental or other chronic health condition, we compared the seven carriers' likely underwriting decisions for six mental disorders with 12 other chronic health conditions.<sup>14</sup> Our comparisons show that, although any applicant with a health condition may be declined, most carriers were more likely to decline applicants with one of the selected mental disorders than other selected chronic health conditions—52 percent versus 30 percent, respectively. (See figure 1.) For 52 percent of the 42 underwriting decisions related to applicants with the selected mental disorders, the carriers in our study indicated that they would likely decline the applicants. Only 7 percent of applicants with the selected mental disorders would likely be accepted at the standard premium with standard benefits. The remaining 41 percent would likely be

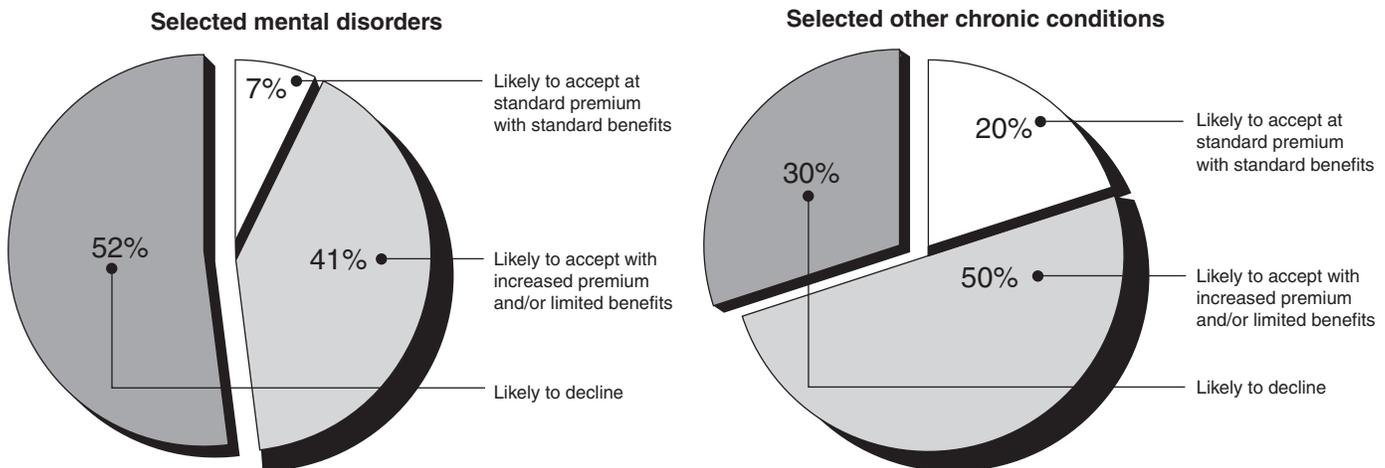
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<sup>13</sup>Georgetown University Institute for Health Care Research and Policy and K. A. Thomas and Associates, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (The Kaiser Family Foundation, 2001) <http://www.kff.org> (downloaded on August 14, 2001). The authors examined underwriting treatment of hypothetical applicants by 19 insurance companies in eight markets around the country.

<sup>14</sup>As we did for the selected mental disorders, we specified that the hypothetical applicants' other chronic conditions had been previously diagnosed and were of moderate severity, and that the applicant was on prescribed drugs or otherwise received medical treatment within the prior year.

accepted for coverage, but with increased premiums and/or limited benefits. Estimates of premium increases ranged from 20 to 100 percent above the standard rate for a healthy applicant. Benefit restrictions typically involved exclusions of coverage for treatment of the disorder either temporarily—for example, one carrier would likely exclude coverage for 2 to 5 years—or permanently. In comparison, for only 30 percent of the 84 underwriting decisions related to applicants with other selected chronic health conditions would the carriers likely decline the applicants. Similar to applicants with the selected mental disorders who might be accepted for coverage, applicants with other selected chronic health conditions accepted for coverage would also likely face other adverse underwriting actions. In half of the instances, applicants with other selected chronic health conditions would be charged a higher premium, offered more limited benefits, or both. In 20 percent of the instances an applicant would likely be offered full coverage at the standard premium rate.

**Figure 1: Seven Carriers More Likely to Deny Coverage to Applicants with Selected Mental Disorders**



Note: Percentages reflect the seven carriers' likely underwriting decisions for the six mental disorders and 12 other chronic conditions.

Source: Carrier responses to GAO request.

While carriers may be more likely to decline applicants with more costly disorders, in some cases they may also be more likely to decline applicants with mental disorders than applicants with other chronic conditions with similar costs. Figure 2 compares the seven carriers' likely underwriting

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decisions related to the selected mental and other chronic health conditions. We grouped the disorders into four cost quartiles to enable comparisons of underwriting decisions for mental and other chronic health conditions that have similar expected health care costs. Cost estimates reflect the average total annual health care costs (including insured and out-of-pocket costs) for individuals with the specified mental disorders or chronic conditions, based on national health care cost and utilization survey data.<sup>15</sup> For example, for the mental disorder and the other chronic health condition in the highest cost quartile, five of the seven carriers would likely decline an applicant with schizophrenia while one would likely decline an applicant with osteoarthritis.

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<sup>15</sup>Because of data limitations, cost estimates are not precise estimates of the treatment costs for each disorder or condition, but rather are estimates of the range of treatment costs for groups of clinically similar disorders or conditions. See appendix I.

**Figure 2: Seven Carriers' Likely Underwriting Decisions for Applicants with Selected Health Conditions**

Condition	Most likely underwriting decision of carriers a through g													
	Mental disorders							Other chronic conditions						
	a	b	c	d	e	f	g	a	b	c	d	e	f	g
Cost quartile 1 (\$1,689 - \$3,427) <sup>a</sup>														
Attention deficit disorder	○	○	○	●	○	○	○							
Asthma								○	○	○	●	○	○	○
Intervertebral disc disorders								○	○	●	●	●	○	○
Migraines								○	○	○	○	○	○	○
Other backache/strain								○	○	●	●	●	○	○
Pelvic inflammatory disease								○	○	●	○	●	○	○
Spondylosis (deterioration of intervertebral discs)								○	○	○	●	●	○	○
Cost quartile 2 (\$3,428 - \$5,166)														
Chronic depression	○	●	●	●	○	○	○							
Obsessive-compulsive disorder	●	●	●	●	○	○	○							
Posttraumatic stress disorder	●	●	●	●	●	○	○							
Epilepsy								○	●	●	○	●	●	○
High cholesterol								○	○	○	●	○	○	○
Hypertension								○	○	○	○	○	○	○
Cost quartile 3 (\$5,167 - \$6,905)														
Manic depressive and bipolar disorder	○	●	●	●	●	○	○							
Rheumatoid arthritis								○	●	●	●	●	●	○
Type II diabetes								●	●	○	○	●	○	○
Cost quartile 4 (\$6,906- \$8,644)														
Schizophrenia	●	●	●	●	●	○	○							
Osteoarthritis								○	○	○	○	●	○	○

Underwriting decision:

- = Likely to decline
- = Likely to accept with increased premium and/or limited coverage
- = Likely to accept with standard coverage, standard rate

<sup>a</sup>Annual cost estimates are derived from the Medical Expenditure Panel Survey, 1997, sponsored by the Department of Health and Human Services. Estimates are not definitive measures of the costs associated with particular disorders, but rather are used to group disorders within broad categories of cost for comparison purposes.

Source: Carrier responses to GAO request.

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## Cost Variability Cited as a Key Reason to Deny Coverage to Applicants with Selected Mental Disorders

To explain the greater likelihood of denying coverage to applicants with the selected mental disorders, several carrier officials and agents said that costs for treating mental disorders can be subject to greater variability than costs for treating other chronic health conditions, making it more difficult to accurately price for the unknown risk. They cited three factors that may contribute to treatment cost variability and unpredictability. First, they said that diagnosing mental disorders involves greater subjectivity than diagnosing most other health conditions. According to one carrier representative, different clinicians might arrive at different diagnoses for mental disorders, which, in turn, suggest different treatment approaches and thus variable claims costs. Second, several carrier officials and agents said that an individual with a mental disorder is likely to have additional health problems. For example, a carrier official said that someone suffering from depression or an anxiety disorder is also likely to incur claims for the treatment of stomach problems, headaches, or chronic fatigue. Finally, several carrier officials and agents said that certain forms of treatment for mental disorders have a tendency to be overused. For example, an agent said that many individuals become dependent upon and thus overuse expensive outpatient therapy or certain prescription drugs.

Representatives from one carrier that generally accepts individuals with mental disorders said that the carrier has found no basis for disproportionately excluding applicants with mental disorders. According to one senior official of this carrier, which has a large pool of individual market enrollees, enrollees with mental disorders are not more likely to suffer from comorbid conditions than those with physical conditions. And while this official agreed with other carrier officials and agents that outpatient therapy has the potential for overuse, he believed that the plan's cost sharing arrangements and service limits mitigate this tendency without the need for more restrictive underwriting. Regarding the subjectivity in diagnoses and varied treatment approaches, the official said that a majority of mental health treatment involves outpatient therapy, for which costs per visit are relatively predictable, and the number of visits is limited by cost sharing arrangements and service limits.

To examine the extent of cost variation associated with the six mental disorders and 12 other chronic health conditions we reviewed, we analyzed national health care cost and utilization data and found that both

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types of disorders had similarly wide variations in cost.<sup>16</sup> We also analyzed the data to determine whether individuals with the selected mental disorders had a higher number of additional health problems on average than did individuals with the selected other chronic health conditions and did not identify a disparate relationship, that is, both the mental disorders and chronic conditions had similar average numbers of comorbidities—from 3.4 to 6.1 for the mental disorders and from 4.2 to 6.6 for the other chronic conditions.

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## High-Risk Pools Are the Primary Source of Coverage for Applicants with Mental Disorders Who Are Denied Coverage

Options available to individuals with mental disorders who are denied coverage in the individual market are limited. For most, state high-risk pools serve as the primary source of coverage. High-risk pool coverage typically costs 125 to 200 percent of standard rates for healthy individuals, and the risk pools' mental health benefits are generally comparable to those available in the individual market, including more restrictions on mental health benefits than other benefits. In 7 states without guaranteed access laws or risk pools, most applicants denied coverage in the individual market may have very limited or no coverage alternatives.

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## Risk Pools Operate in Most States Where Carriers Medically Underwrite

Risk pools operate in 27 of the 34 states where individual market carriers do not guarantee access to coverage for all applicants.<sup>17</sup> A risk pool is typically a state-created, not-for-profit association that offers comprehensive health insurance benefits to high-risk individuals and families who have been or would likely be denied coverage by carriers in the individual market. Premiums for pool coverage are higher than standard insurance coverage for healthy applicants, although not necessarily higher than a high-risk applicant could be charged in the individual market if coverage were available. State laws generally cap risk

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<sup>16</sup>For example, we analyzed the 1997 Medical Expenditure Panel Survey to compare the 10th and 90th percentile of total medical costs (including insured and out-of-pocket costs) for individuals with the selected mental disorders and other chronic disorders. For the mental disorders, the high-cost cases were from 33 times (for affective disorders such as manic depression and bipolar disorders) to 80 times (for depression and other mental disorders) higher than the low-cost cases. For the 12 other selected chronic disorders, the high-cost cases were from 37 times (for hypertension) to 114 times (for migraines and other headaches) higher than the low-cost cases.

<sup>17</sup>Risk pools in Alabama and Florida are not included because Alabama's risk pool is open only to certain individuals losing group coverage under HIPAA provisions and Florida's risk pool has been closed to new applicants since 1991.

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pool premiums at 125 to 200 percent of comparable commercial coverage standard rates.

Health benefits contained in state high-risk pool plans are generally comparable to those available in the individual market; however, benefits for mental disorders or other health conditions are not permanently excluded as they can be in the individual insurance market. Also like private plans, nearly all plans offered by risk pools use features that restrict mental health benefits more than other benefits. For example, see the following.<sup>18</sup>

- Five pools set significantly lower lifetime dollar maximum limits for mental health benefits (\$4,000 to \$50,000) than for other benefits (\$1 million to unlimited).
- Eight pools impose more restrictive limits on inpatient mental hospital days (commonly 30 or fewer) than on other inpatient hospital days (often unlimited).
- Six pools limit mental health outpatient visits to from 15 to 20 annually, and one offers no outpatient benefits, though other outpatient visits are generally unlimited.
- Five pools reimburse 50 percent for mental health benefits rather than the usual 80 percent for other benefits.

Because medical claims costs exceed the premiums collected from enrollees, all risk pools operate at a loss, thus requiring subsidies. States generally subsidize their pools through various funding sources, including surcharges on private health insurance premiums (individual and group) and state general revenue funds. In three recent instances, risk pool applicants have had to wait for coverage to take effect because of funding limits. As of January 2002, risk pool applicants in California and Louisiana had to wait to receive benefits under the pool. In California, applicants must wait about 1 year to receive benefits. In Louisiana, applicants have been waiting since August 2001 for funding to become available. The risk pool in Illinois has had waiting lists in the past because of inadequate funding, most recently from September 2000 through the early summer of 2001.

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<sup>18</sup>Communicating for Agriculture, *Comprehensive Health Insurance for High-Risk Individuals—A State-by State Analysis*, Fifteenth Edition (Fergus Falls, Minn.: 2001/2002). Data reported on the mental health benefits contained in each state risk pool were not always complete; therefore, the examples cited above may not be exhaustive.

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## In 7 States, Applicants with Mental Disorders May Have Few or No Coverage Options Available

In 7 states without a guaranteed issue requirement or a high-risk pool,<sup>19</sup> applicants with mental disorders or other health conditions who are not eligible for continuation of group coverage or HIPAA portability coverage and who are denied coverage in the individual market may have very limited or no other access options.<sup>20</sup> For example, in Georgia, insurance regulators said that, absent eligibility for a publicly funded program for low-income individuals such as Medicaid, individuals with mental disorders who are denied coverage by private carriers in the individual market have no other available coverage options.

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## Concluding Observations

In most states, applicants with any health problems may have difficulty finding affordable coverage in the individual insurance market, and those with mental disorders may face even greater challenges. Because of concern that individuals with mental disorders will incur more variable and less predictable health care costs than individuals with other chronic health conditions, some carriers may be more likely to deny them coverage. However, our analysis of national health care cost data did not identify such a disparity for the selected mental and other chronic disorders we reviewed. If applicants with mental disorders obtain coverage, mental health benefits are typically more restricted than other benefits in most states. Although most applicants who are denied individual market coverage for any health condition may obtain coverage in a state-sponsored high-risk pool, affordability is still an issue, with premiums typically 125 to 200 percent of standard rates in the private market. Moreover, like private coverage, high-risk pools typically restrict mental health benefits more than other benefits. In those few states with neither guaranteed coverage nor high-risk pools, most applicants with mental disorders may have few, if any, options for health insurance coverage.

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## Comments From External Reviewers

Representatives of the American Psychiatric Association (APA), the Blue Cross and Blue Shield Association (BCBSA), the Health Insurance Association of America (HIAA), and the National Alliance for the Mentally

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<sup>19</sup>The 7 states are Alabama, Arizona, Delaware, Florida, Georgia, Nevada, and South Dakota.

<sup>20</sup>In 15 states that guarantee access to coverage for HIPAA-eligible individuals through a high-risk pool and report enrollment numbers, about 21 percent of risk pool enrollees are HIPAA-eligible individuals.

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III (NAMI) provided comments on a draft of our report. The APA and NAMI representatives concurred with the report's findings and conclusions, while BCBSA and HIAA expressed several concerns about some of our findings and conclusions.

BCBSA and HIAA commented that coverage is more widely available to applicants with mental disorders in many states than we concluded. For example, HIAA indicated that it would be more appropriate to consider the 27 states with high-risk pools to have guaranteed access to health insurance. We agree that either approach—guaranteed access in the individual insurance market or high-risk pools—can provide applicants with access to health insurance coverage. However, we distinguished those states with carriers that are required or voluntarily agree to guarantee access from states with high-risk pools because there are differences in how individual insurance carriers underwrite in these states. For example, in states with guaranteed access in the individual insurance market, some or all carriers do not deny coverage to applicants with mental disorders and there are often premium restrictions that make coverage more affordable for high-risk applicants. In contrast, in states that do not guarantee access in the individual insurance market, carriers can deny coverage to applicants but the applicants can seek coverage through a high-risk pool. Like plans typically available in the individual market, high-risk pool benefits for mental disorders are often more limited than other benefits, premiums are typically 125 to 200 percent of standard individual insurance rates, and a few states have had waiting lists for eligible high-risk pool participants. As we have noted, only 7 states have neither guaranteed coverage in the individual insurance market nor a high-risk pool program.

Further, both BCBSA and HIAA noted that at least some states with requirements that carriers guarantee access to all individuals have had negative unintended consequences, such as average premium increases, some individuals dropping coverage, and some carriers leaving the market. While it was beyond our scope to assess the experience of states that require carriers to accept all applicants and limit premium variation, we have noted that there are trade-offs between increasing access and affordability for high-risk applicants while increasing premiums for healthy applicants and we cite other studies that have further examined these issues.

BCBSA and HIAA also indicated that the reports' findings on the number and percentage of applicants who would be denied coverage are dependent on the mental and other chronic disorders selected for study.

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For example, BCBSA stated that if different chronic disorders had been selected, such as cancer, heart disease, chronic obstructive pulmonary disease, or human immunodeficiency virus (HIV), the difference in denial rates between applicants with mental disorders and those with other chronic disorders may have disappeared. We agree that our findings are limited to the specific conditions selected and the carriers responding to our requests for information. We did not compare mental disorders to nonmental disorders of a more serious or life-threatening nature—such as those cited by BCBSA—because we did not believe such comparisons would be valid, and previous studies have shown that insurers are likely to deny coverage for applicants with many of these life-threatening conditions.<sup>21</sup> We selected the other chronic conditions based on several criteria to enhance their comparability with mental disorders, in particular that they be of a chronic and manageable nature. We agree that within either the selected mental disorders or other chronic disorders there is a range of clinical severity, expected treatment costs, and insurer underwriting practices. Therefore, we asked the seven carriers to consider that each of the disorders was of moderate severity and that the applicant was taking prescribed drugs or received other medical treatment for the disorder within the past year.

BCBSA and HIAA provided other technical comments that we incorporated as appropriate.

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As we agreed with your office, unless you publicly announce this report's contents earlier, we plan no further distribution until 30 days after its date. We will then send copies to other interested congressional committees and members. We will also make copies available to others on request. Please

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<sup>21</sup>See for example [GAO/HEHS-97-8](#) and Georgetown University Institute for Health Care Research and Policy and K.A. Thomas and Associates, *How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* (The Kaiser Family Foundation, 2001). <http://www.kff.org> (downloaded on August 14, 2001).

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call me at (202) 512-7118 or John Dicken, assistant director, at (202) 512-7043 if you have any questions. Other major contributors are listed in appendix II.

*Kathryn G. Allen*

Kathryn G. Allen  
Director, Health Care—Medicaid  
and Private Health Insurance Issues

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# Appendix I: Scope and Methodology

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To determine the extent to which states require individual market carriers to guarantee access to coverage, we reviewed summary data for all states published by the Commonwealth Fund in collaboration with Mathematica Policy Research, Inc. in August 2001, and the Institute for Health Care Research and Policy, Georgetown University, updated as of June 14, 2000. Although we did not independently verify these data, we did follow up with state insurance regulators in selected instances when we had reason to believe that the summary data were no longer current. We also contacted insurance regulators in 6 states—California, Connecticut, Georgia, Illinois, Mississippi, and Montana—to discuss the implications of state insurance regulation. We selected these states to represent a cross section of states in which carriers are not required to guarantee access to coverage in the individual market.

To identify health insurance carrier practices related to coverage and premium decisions, we contacted 25 individual market carriers nationally to request their participation in our study. We also asked the BCBSA and the HIAA to contact some of their members to request participation. Seven carriers that offer HMO, preferred provider organization, or traditional fee-for-service plans across the country agreed to participate. We interviewed or obtained data from these carriers regarding their health plans and underwriting practices. We cannot generalize the practices of these seven carriers to all individual market carriers; however, the seven carriers collectively insure more than 10 percent of all individual market enrollees and sell coverage in most of the states in which carriers are permitted to medically underwrite.

We compared the underwriting practices of the seven carriers for selected mental disorders and other chronic health conditions. We selected six mental disorders, each of which affects over 1 million Americans. We selected the other chronic health conditions based on certain clinical characteristics they share in common with mental disorders. Among other criteria, the health conditions selected are generally of a chronic and manageable nature, may require prescription drug therapy, may require care throughout the patient's life, and may be of intermittent severity. We asked the seven carriers to consider that each of the disorders was of moderate severity and that the applicant was taking prescribed drugs or received other medical treatment for the disorder within the past year. We discussed our approach of comparing mental disorders and other chronic health conditions with mental health experts and an insurer risk management consultant. To ensure that individuals with the mental disorders and chronic health conditions we compared were likely to incur similar health care costs, we analyzed 1997 cost data from the Medical

Expenditure Panel Survey, a national survey of health care cost and utilization administered by the Department of Health and Human Services. We calculated the total average annual health care costs incurred by individuals with the selected disorders. These cost data do not provide definitive estimates of the cost of treating specific disorders, however, because the data set aggregated costs for several clinically similar disorders. For example, treatment costs for obsessive-compulsive disorders are aggregated with costs for other related disorders, including hypochondria, panic disorder, and phobic disorders. We also used the data to examine the extent of variation in total health care costs incurred by individuals with the selected mental and other disorders and the extent to which individuals with the selected disorders are likely to have additional health problems.

Finally, to examine additional health insurance coverage options available to high-risk individuals, we summarized state high-risk pool program information published in the literature and reviewed alternative coverage options during our interviews with insurance regulators in the 6 states. We also interviewed health insurance agents in the 6 states to discuss their experiences finding coverage for clients with mental disorders.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

John Dicken, (202) 512-7043

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## Acknowledgments

Randy DiRosa and Betty Kirksey made key contributions to this report.

In addition, Kelli Jones and Kara Sokol provided statistical support.

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# Related GAO Products

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*Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited.* [GAO/HEHS-00-95](#). Washington, D.C.: May 10, 2000.

*Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards.* [GAO/HEHS-99-100](#). Washington, D.C.: May 12, 1999.

*Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators.* [GAO/HEHS-98-67](#). Washington, D.C.: February 25, 1998.

*Private Health Insurance: Millions Relying on Individual Market Face Cost and Coverage Trade-Offs.* [GAO/HEHS-97-8](#). Washington, D.C.: November 25, 1996.

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