



AB 786 (Jones): Setting Standards for Individual Health Insurance

For the millions of Californians without access to employment-based coverage, buying health insurance on their own in the individual market is a daunting, confusing, and often expensive experience. Consumers want affordable health plans with adequate protection in case they get sick. However, given the number of products in the individual market, which vary based on what services they cover and the costs to consumers, it is nearly impossible to adequately compare insurance plans. AB 786 (Jones) would set standards and categorize plans in the individual health insurance market so that consumers can determine a plan's value and more easily comparison shop.

Not All Insurance Plans Are Created Equal

The individual health insurance market has hundreds of products that vary on features such as out-of-pocket costs and the scope of services covered. Unfortunately, there is currently no way for consumers to compare plan features across insurers, and trying to figure out which plan fits best can be confusing and overwhelming. This puts consumers at an incredible disadvantage and makes it nearly impossible for them to comparison shop.

As a result of this confusion, many consumers who purchase individual insurance coverage become victims of deceptive industry marketing practices and end up with inadequate, junky insurance that does not provide real coverage (see box on junk insurance). All too often, consumers do not realize how little coverage they actually have until it is too late – when they are already sick and accumulating medical bills and debt. To prevent similar situations, consumers should be able to determine the level of coverage and protection that an insurance plan will provide at the time they purchase the plan.

AB 786: Setting Standards and Preserving Choice

To address this issue, legislation (AB 786) by Assemblymember Jones would set standards in the individual market thereby allowing consumers to make informed purchases based on the value of the coverage and ensuring that any coverage purchased on the individual market actually has value. More specifically, AB 786 (Jones) would:

- Minimize “junk insurance” by requiring insurers to use standard contract terminology and report all plan information to appropriate state agencies;
- Limit the financial exposure of consumers by requiring all plans to have maximum out-of-pocket costs; and
- Allow consumers to compare plans and make more informed purchasing decisions by requiring all plans to be classified into a number of categories or tiers (to be determined), based on the comprehensiveness of benefits and variation in cost-sharing.



AB 786 allows for the sale of a wide range of insurance products (including those with high deductibles), but creates a system where consumers will be better informed of the choices they have when purchasing coverage. In particular, AB 786:

- Does NOT eliminate lower-cost plans with high deductibles;
- Does NOT require all insurers to cover specific services, like maternity care; and
- Does NOT force people to drop or change the coverage they already have.

Reforming the individual insurance market, as AB 786 (Jones) would, is an important step in ensuring that the health insurance plans that consumers buy have value and that consumers can know that value when they purchase the plan. Without the provisions of AB 786, insurers will continue to sell junk insurance to unknowing consumers, who will find out much too late that they are not protected.

What is junk insurance?

The group of products, referred to as “junk insurance,” are “so-called affordable individual plans with huge coverage gaps.” These junk insurance plans *seem* affordable because they generally have lower premiums than other insurance plans, but they offer only a fraction of the coverage consumers actually need. More specifically, these plans do not offer “major medical” coverage and limit the number of services and the amount of services that are covered, but do not limit the costs consumers must pay out-of-pocket when they get sick.

Unfortunately, those people with a junk insurance plan do not find out how little coverage they truly have until after they are sick. At that point, it is too late and patients are stuck with thousands of dollars in medical debt. Health insurance should “give you the care you need, when you need it, and some financial security so you don’t end up out on the street” when you get sick.

Junk insurance is not the same as *underinsurance*.

To be underinsured is to have insurance that does not adequately cover your health care needs. For example, high-deductible plans leave many consumers underinsured because it only provides coverage for those patients with high medical bills who meet the deductible.

Junk insurance, on the other hand, is marketed as better coverage than it actually is and so leaves consumers *unknowingly* underinsured. These plans exclude coverage of certain services through complicated contract language that is not transparent to consumers. For example, chemotherapy treatments may not be covered by the plan, but it is not listed among the “non-covered services” section of the plan contract, so there is no way for consumers to actually know that chemotherapy is not covered until they need it.

See also: “Hazardous health plans: Coverage gaps can leave you in big trouble,” *Consumer Reports*, (May 2009), p. 24-29.