



Guaranteed success?

No one would let emotions rule his retirement funds. Yet we expect health insurance – a complex financial instrument – to meet primitive emotional needs. The health reform debate is truly about this tug-of-war between financial and emotional logic.

The core issue is demonstrated in two tiny but crucial sections of the America's Affordable Health Choices Act, the House version of the health reform bill: guaranteed issue and pre-existing conditions. These fill a need to be taken care of when we are ill. But they won't help more people get insurance, or do a thing for costs.

“Guaranteed issue” means that a health insurer cannot turn away a customer. Obama cites a New Hampshire entrepreneur in his New York Times Op-Ed piece (“Why We Need Health Care Reform” 8/16/09): “because she has hepatitis C, she cannot find an insurance company that will cover her.” Guaranteed issue would mean that the insurer would have to sell her a health plan.

All 50 states have guaranteed issue for group insurance; it's people buying health insurance by themselves who face this problem. Fourteen states (including Maine) already have guaranteed issue in place for these people.

In theory, these states should have fewer people uninsured, because everyone can get and keep health insurance. In reality, three of the states had **more** uninsured people than the national average of 17.2% of people age 0 to 64; three were close to the national average,

and the rest were lower. Having guaranteed issue did not give a state an “edge” to beat the national average.

If insurers were dropping sick customers right and left, then states without guaranteed issue should have more uninsured people. Yet the state with the lowest uninsured – besides Massachusetts which requires all citizens to have health insurance – has no guaranteed issue. How does Hawaii have only 9.5% of its people uninsured, when insurers can drop their sick customers? Clearly, insurers dropping customers is not a big factor in whether people are insured or uninsured.

Even though a person has a health insurance plan, his plan may not cover all of his health problems. Federal law allows health insurers to refuse to cover “pre-existing conditions” for up to 12 months. A pre-existing condition is basically any illness the person had before he bought the health insurance plan. (After 12 months and with no gap in health insurance, all plans must cover all of a person’s illnesses. The problem only gets solved, however, if the insurer is willing to sell a plan to the customer; this circles back to guaranteed issue.)

The House bill eliminates the 12-month wait on pre-existing conditions. Insurers would have to pay for all of a person’s health problems from the first day. This makes sense to the person who wants his health taken care of, but not to the person who wants to make money selling health insurance.

The health insurer has a natural aversion to selling to a known ill person: they are volunteering to lose profits. And profits are the driving force: for-profit insurers cover more than half of Americans. Even the non-profits have to make money to stay in business.

Obama’s NY Times editorial cites a 2007 national survey, showing that “insurance companies discriminated against more than 12 million Americans” who had a pre-existing

illness. “Discriminated against” is a dramatic, anger-provoking way to describe an insurer who upheld a legally binding contract that the customer willingly bought. Would we describe a mutual fund as “depriving” retirees of money when share value had sunk?

For the insurer, the transaction is financial. For the ill or well person, it is emotional.

The struggle for health reform is the struggle between health insurer profit and people needing expensive care. The more we lean toward paying all health costs for all people, the more we lean away from market (financial) forces. The trick will be striking a new balance between the head and heart, the financial and emotional aspects of health care.

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