Jonathan D. Walker M.D.
Allen County Retinal Surgeons, PC
7900 West Jefferson Blvd. #300
Fort Wayne, IN 46804

Office: 260 436 2181
Fax: 260 436 2567
Jonwalker22@gmail.com

AHIP Has a Plan for You

Between the recent election and the worsening economy, interest in healthcare reform has been increasing. There are a number of proposals, and they all include strong input from private insurance companies (the only exception to this is House Resolution H.R. 676, The United States National Health Insurance Act). Because the private insurance industry is such a fundamental part of our healthcare system, it is instructive to look closely at what they are supporting.

AHIP (America's Health Insurance Plans) is a trade and lobbying organization that represents about 1300 different insurance plans. In November 2008 they released a press statement outlining their proposal for healthcare reform in America.[1] Blue Cross Blue Shield Association, which covers about 100 million people, released a similar plan at the same time.[2] Here are the bullet points from the AHIP plan:

- Guarantee-issue coverage with no pre-existing condition exclusions.
- Establish an individual coverage requirement with an insurance coverage verification system, an automatic enrollment process and effective enforcement of the requirement that all individuals purchase and maintain coverage.
- Promote affordability by providing refundable, advanceable tax credits for moderate-income individuals and working families, and promoting tax equity whether coverage is obtained through an employer or the individual market.
- Ensure premium stability for those with existing coverage through a broadly funded reimbursement mechanism that spreads costs for the highest-risk individuals.

One of the frustrating things about the healthcare debate is that statements that sound valid can, on close inspection, become problematic. First of all, note that these points are very different from comments made by WellPoint CEO Angela Braly when she spoke to Wall Street analysts earlier in 2008.[3] She said, "We will not sacrifice profitability for membership," an oblique way of acknowledging that their goal is to avoid covering anyone that would cost money. (She also reassured the analysts that insurance companies could maintain profits by leaning hard on network doctors to accept lower reimbursement--but that is not germane to this discussion.)

The above bullet points are more conciliatory than Ms. Braly's comments, and they suggest that the insurance industry is actively trying to fix the problems with our healthcare system. One needs to "unpack" each of these statements, though, to get a true sense of what they mean.

The first point calls for "Guarantee-issue coverage with no pre-existing condition exclusions." This suggests that the insurance industry recognizes that the time for their traditional business model is ending. They can see that if they want to continue to insure the majority of Americans, they must come to the table with policies that seem inclusive rather than exclusive. They are saying they want to make sure that anyone can get coverage regardless of their medical problems. In essence, they want to be like Medicare. The question is: how do they propose to do that and remain solvent?

Part of the answer is in the second point: "Establish an individual coverage requirement with an insurance coverage verification system, an automatic enrollment process and effective enforcement of the requirement that all individuals purchase and maintain coverage." They want the government to require that everyone be insured, and to come up with a way to effectively monitor and punish those that don't obtain insurance. Again, on the surface this sounds reasonable—not unlike mandates that require everyone to buy car insurance. However, it begs the question of exactly how one punishes people that can't afford to buy health insurance—nor does it explain how the government would set up and pay for a system that monitors insurance purchases.

The big problem, though, is figuring out how everyone would be able to buy the newly mandated insurance. The private insurance industry is already incapable of providing insurance that is affordable. Presently, the average cost of an individual policy is about $4,700 and for a family of four it is about $12,600.[4] Even stripped down policies that are bundled with high deductibles are priced out of the market. The most glaring example of this is with the mandated insurance plan in Massachusetts. Going without insurance there carries a tax penalty of up to $912, yet people are not buying insurance because even bare-boned plans are far more expensive than the fine itself. And even if they do buy insurance, the policies are so filled with co-pays and deductibles that if people get sick they end up with huge healthcare costs on top of the cost of the insurance.[5]

If the companies already cannot provide an affordable product, how can they realistically offer "guarantee-issue coverage with no pre-existing condition exclusions"? This is where the third point comes in—starting with the first clause.

"Promote affordability by providing refundable, advanceable tax credits for moderate-income individuals and working families." In other words, the taxpayers will foot the bill in order to be sure everyone can buy insurance from private insurance companies. This is now an interesting chain of recommendations. First the companies make a statement about their intentions to cover everyone—something we all want. Then they want the government to make sure that everyone has to buy insurance—again, a reasonable request that fits in with the nation's sense that everyone should be responsible for themselves. Finally, because these goals together are unobtainable, they want to use tax dollars to make sure everyone has the money to buy their product.

The advantages to the private insurance industry are even more pronounced when one considers how healthcare costs are distributed across the population. Figure 1 is from the Agency for Healthcare Research and Quality, a branch of the Department of Health and Human Services. The data shows that only 20% of the population accounts for 80% of healthcare spending. This statistic tends to hold true for subsets of the total population—if you take any large group of people, the vast majority of them will have little or nothing in the way of health expenditures. This is certainly true for the 45 million uninsured, and the insurance companies are very aware of this. If they can get the government to mandate insurance then the insurance companies will suddenly have access to a huge market of healthy individuals. And increased revenue is guaranteed because under the AHIP plan the government will be providing tax credits to help them buy the policies and will be providing the enforcement to ensure the insurance is purchased.

The second clause of the third bullet is a bit more tedious, but still of interest. "Promoting tax equity whether coverage is obtained through an employer or the individual market." This refers to the fact that America's healthcare financing is very regressive (meaning that people with employer-based insurance and greater income essentially pay less for their coverage due to the tax structure). If the tax structure is changed to make financing progressive—which is how the vast majority of taxes work—it will help the average individual to be better able to purchase policies from the insurance companies. (As an aside, this aspect of American healthcare financing is thought to be unfair on both sides of the congressional aisle. The regressivity represents a significant government subsidy to people in higher tax brackets and makes it harder for those who are self-employed to obtain insurance. Changing this is an important part of, for instance, both Senator McCain's and the AMA's healthcare proposal. The AMA's Voice for the Uninsured web site has a good review of this subject.[6] The point here is that the private insurance companies know that if they include tax reform in their proposal they can be supporting something that most everyone agrees is valid and at the same time ensure that more money is available to buy insurance policies.)

But there is still a large problem with the bullet points. Although the insurance companies would be able to increase their revenue, they are still agreeing to cover anyone regardless of medical condition. This means they will inevitably get stuck with the 20% or so of sick patients that will actually be costing money. Or will they? This is where the fourth bullet point comes in.

"Ensure premium stability for those with existing coverage through a broadly funded reimbursement mechanism that spreads costs for the highest-risk individuals." What does that mean? The only way to comprehend this is to break it down in the context of what can be found on the AHIP web site.

For starters, "Ensure premium stability for those with existing coverage" means this: insurance companies know that if they do have to pay for sick people they cannot keep premiums low and

still make money—even if they can sell government subsidized insurance to the millions of healthy uninsured. Once they start getting hit with sick people they *have* to either raise the premiums or cut back on coverage. Both of these are going to be hard to do—they have already priced themselves out of the market (otherwise this whole problem wouldn't exist in the first place), and there are only so many ways they can cut back on coverage without running into various state laws that insist on a certain level of benefits to protect consumers. So they know that any reform has to have a mechanism built into it that will keep them from being totally responsible for anyone that is sick. How do they do that?

With the second part of the sentence: "Through a broadly funded reimbursement mechanism that spreads costs for the highest-risk individuals." Again, what exactly does that mean? The AHIP website gives the answer. There you will see that they propose "Guarantee Access Plans," which are loosely modeled on state high-risk pools.[7, 8] Although such programs are structured in various ways, they are all basically safety nets that allow the insurance companies to transfer the risk for anyone with a medical problem to the taxpayer. They have also never worked very well, largely because states don't have enough money to fund them effectively.[9] This particular "mechanism" to spread cost never fails to sound good when it is proposed, but in practical terms it is a poorly functioning taxpayer-funded bailout.

(It is worth dwelling a moment on this concept of state high risk pools. This resource is inevitably part of any proposal that involves private insurers, because there is no way to handle the cost of sick patients in the private market. When included as part of a proposal, it appears to be a perfect solution--but there is rarely a full discussion of the data that is available about the effectiveness of such programs. It turns out that they are already in place in over 30 states and they are inadequate, largely due to variable regulation and insufficient funding. The policies are expensive to purchase, with high premiums and high deductibles, and they often delay coverage for the preexisting conditions that put people in need of such programs in the first place. As a result, these pools only cover about 190,000 individuals nationally (2006 data). The point is that one should be very suspicious of any plan that invokes state high risk pools yet does not acknowledge the data that already exists about problems with such programs. It turns out that the only way to make the programs effective is with far more federal money—once again the taxpayer bears the ultimate cost with no control over the process. Reviews of the subject are referenced.[10-12])

The AHIP plan is also very upfront about another way to spread the cost on to the taxpayer. They call for "shoring up the health care safety net by making eligible for Medicaid every uninsured American living in poverty and strengthening the Children's Health Insurance Program."[13] It seems odd that the champions of the free market approach to healthcare are insisting that Medicaid—a consistently underfunded and dysfunctional program—be "shored up". But they have to insist on this because they need Medicaid and related programs to absorb patients that are too expensive and/or too poor to be maintained on private coverage.

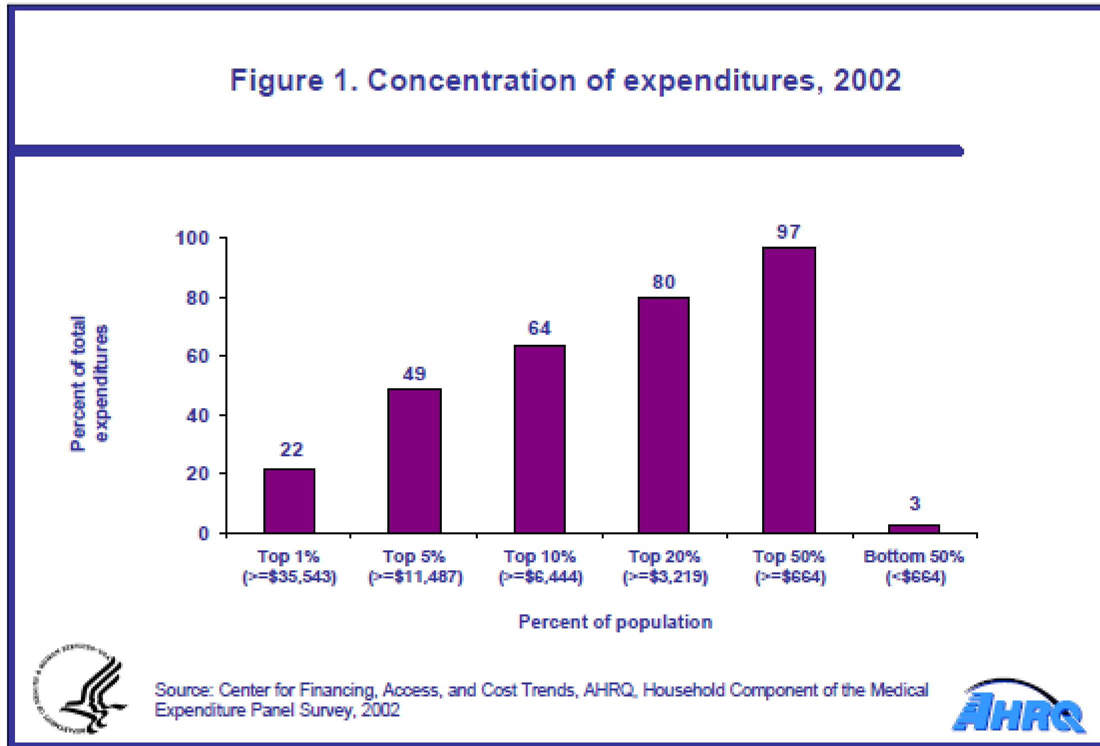
These machinations do not mean that the insurance companies are inherently bad. They clearly feel that their approach offers the best chance at reform, and they also have to think about their obligation to their shareholders. But their proposal can only be sustained with massive taxpayer support: First, the government needs to ensure that everyone buys their product. Then they want taxpayers to help anyone that can't afford it by providing tax credits. Then they want taxpayers to be ready to pay for the safety net of Medicaid and they want the taxpayers to fund high-risk pools to pay for anyone that gets sick enough to drive down profits (or, as they put it, to "de-stabilize premiums"). If we do all that, then they promise to perform their longstanding role of moving money from payers to providers after withdrawing their profits. And by the very nature of their proposal, they will do this for the healthiest people that are least likely to need care.

Nor can they claim that they can control healthcare costs. There are so many companies and they are so fragmented that they have no real leverage over the entire healthcare market. All they can do is compete amongst themselves with policy premiums and then try to minimize payouts by avoiding sick patients and creating layers of rules. The overwhelming bureaucracy that already exists in our healthcare system accounts for almost a third of healthcare spending. The AHIP proposal would only add more confusion given the need to police the purchase of insurance, the need for IRS monitoring of tax credits, and the regulations that would be required to determine eligibility for the various state bailout options such as high risk pools and Medicaid.

It is worth reading the full AHIP proposal[14]—they also support reforms that are clearly needed such as emphasizing primary care and streamlining medical information systems. Someone put in some hard work to lay it all out, but the result is a collection of good ideas that are wrapped around the worrisome proposals discussed here. Unfortunately, AHIP and Blue Cross Blue Shield carry a tremendous amount of influence with our government and they will have a major role in any attempt at reform.

As practicing physicians, we know that dealing with private insurance companies is time consuming and does nothing to facilitate better patient care or control costs. There may be a reluctance to interfere with their interests for philosophical reasons and because they pay us more, at least for now. Still, after reviewing their proposal for healthcare reform one has to ask if we really want these people controlling the decisions that will profoundly affect our practices and our patients.

Figure 1. (Note—this is the best version I have and it is probably not good enough to print. I can provide the original PDF (which is also probably not good enough) or I can have someone lay it out in Illustrator (unless you have someone that can do it).



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