
Protect the Sick: Health Insurance Reform in One Easy Lesson

Deborah Stone

In most other nations, insurance for medical care is called sickness insurance, and it covers sick people.¹ In the United States, we have “health insurance,” and its major carriers — commercial insurers, large employers, and increasingly government programs — strive to avoid sick people and cover only the healthy. This perverse logic at the heart of the American health insurance system is the key to reform debates.

Focusing on sick people versus healthy people might seem a strange way to view the coverage issue. Most discussions of insurance categorize people into other groupings: the insured versus the uninsured; Caucasian whites versus other racial and ethnic groups; men versus women; poor and low-income people versus everybody else; children, adults, and the elderly; or citizens versus immigrants and undocumented aliens. More recently, health researchers have begun talking about “vulnerable populations,” using most of the same demographic groupings and adding other illness-inducing factors such as social isolation, stress, and impoverished neighborhoods.² But as I will show, insurance plans now use premiums, cost-sharing, and other design features in ways that indirectly divide each of these groups into the sick and the healthy, to the detriment of the sick. By shifting the costs of illness onto people who use medical care — that is, sick people — market-oriented reforms of the last few decades have eroded insurance in the name of strengthening it.

Ultimately, the issue that matters is whether insurance enables sick and high-risk people to get medical care. Covering or not covering *sick people* is the core issue of health insurance reform, both as a determinant of support and opposition to proposals, and as the proper yardstick for evaluating reform ideas.

Part I: Why U.S. Health Insurance Tends to Exclude the Sick

To understand the politics of health reform, we need to understand how the United States evolved into a medical insurance system that is profoundly incapable of fulfilling its purpose: making sure that sick people can get medical care. Without rehearsing the details of our episodic failures to pass some form of national health insurance,³ suffice it to say that the crucial result of these near-misses was a *de facto* national

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decision to rest responsibility for health insurance in the private sector, and to use government only as a last resort for populations the private market did not want to insure, notably, the poor, the elderly, the disabled, and the chronically ill. Indeed, Medicare and Medicaid rest on this fundamental principle, and their eligibility standards and terms of coverage embody government's desire to limit its responsibility to areas of "market failure."

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This allocation of responsibilities mirrored the libertarian bent of American political philosophy. In the libertarian view, private property and free markets are the guarantors of economic growth and political freedom. Thus, government's role should be limited to providing national defense, law and order, and economic security only for those citizens who are too deeply incapacitated to take care of themselves.⁴ This allocation of responsibilities also fairly guaranteed that the sickest and most disabled people would effectively become wards of the state for their insurance needs, because commercial or private insurance and social or public insurance operate by fundamentally different principles.

Insurance is a mechanism for pooling savings and redistributing funds from the lucky to the unlucky. Whether for car accidents, building fires, or illness, insurance is much like a lottery. When people pool their risks as well as their savings in a health insurance plan, they are taking their chances that they may never become sick or need expensive care, and that therefore most of their monetary contributions will go to help the health care plan members who *do* incur a need for expensive medical care. As in any lottery, they pay into the pot, regardless of whether they ultimately get to draw from it. The purpose of insurance, though, is to guarantee that certain agreed-upon individual needs will be paid for by a group — that is, a community.

Social insurance operates by the logic of solidarity. Under this logic, a community decides in advance that certain personal needs are deserving of social aid. The community undertakes to guarantee that those needs are met for all its members. The argument for financing medical care through social insurance rests on two

beliefs. First, good health is a prerequisite to everything else a person can accomplish, including learning, working, and creating. Vast disparities in access to medical care would compromise the ideal of equal opportunity that is also so deeply ingrained in American ideology.⁵

Second, insofar as much illness and disability is not caused by factors within individual control and can be treated or ameliorated only by skilled medical intervention, medical care should be distributed according to medical need, as judged by trained clinical professionals. To be sure, much can be done to promote healthy behavior through education, regulation, and other social institutions. But tackling health behavior is best done through these other institutions. The job of insurance is thus to finance medical care — to make sure that people get the care they need, regardless of why they need it.

Because illness and disability are not (largely) matters of individual choice, nor is treatment primarily a matter of personal taste, medical care should not be distributed according to ability to pay. Under the logic of solidarity, therefore, what people pay into a health insurance scheme should be unrelated to the amount of medical care they consume. Individual contributions may be assessed at a flat rate, or a rate proportional to income, but they are in no way linked to the amount of medical care people are expected to need or that they will actually use.

Commercial insurance operates by a different logic, the logic of the market. In a market, consumers choose which goods and services they wish to consume as well as how much of each kind. They buy what they are willing to pay for, and they receive only what they are willing and able to pay for. Sellers of commercial insurance, like the sellers of any other kind of good, charge members of an insurance plan as closely as possible for the goods and services they will actually consume. Here is how one insurance company medical director explained the concept of actuarial fairness: "In theory, every individual should have a different rate, based on a multivariate analysis of every possible health condition and risk factor that can be evaluated."⁶

Because it is impossible for insurers to know in advance how much and what kind of medical care a person will need, they try to estimate the cost by using risk information, such as personal medical history, family history, and presence of known risk factors. With predictive information in hand, insurers then price an insurance policy according to the policyhold-

er's likelihood of using costly medical care. This way of setting insurance premiums is called "actuarial rating." People who already have an expensive disease, or those who have precursors, early stages, or risk factors, will be charged higher premiums for their coverage, or they might be deemed "uninsurable" and refused insurance altogether. To commercial insurers, charging sick people higher rates for insurance is eminently fair. If insurers did not identify people with a higher likelihood of needing medical care and charge them more than other policyholders, then they would be guilty of forcing the healthy to subsidize the sick.⁷

The actuarial system leads to three kinds of perverse results. First, the sicker people are, the more expensive their health insurance, and the less they will be able to afford the insurance to cover their needed medical care. Second, the higher people's risk for developing serious illness, the higher their premiums will be, and the less likely they, too, will be able to afford insurance so that they can obtain the proper monitoring and treatment of their potential illnesses. Third, people who have already had the misfortune to develop a serious illness are likely to be denied insurance coverage at any price. These are people who are most certain to need medical care.

Actuarial rating and exclusion of sick people does not make much sense from a purely functional point of view. It directly undermines the purpose of medical insurance, which is to assure medical care for people who need it. But commercial insurers use this system of actuarial rating for a simple reason: they are in this business to make a profit. One of the biggest fac-

employer groups received their insurance through non-profit Blue Cross Blue Shield companies that used community rating, a single premium rate for all large groups in a community, without any inquiry into the health histories or risks of individual members of these groups. But beginning around 1980, commercial insurers competed for large-group business by using "experience rating," a variation of actuarial pricing in which they examined the claims experience of groups and offered lower premiums to occupations, industries, or firms with healthier-than-average employees. The days of risk pooling and community rating — one price for everyone in a community — were numbered.⁸

The logic of the market and the actuarial pricing system that derives from it lead straight to the dilemma we now face: increasingly, only the healthy can obtain or afford medical insurance. As fewer employers offer insurance, and fewer employed people can afford the coverage that is offered, more people have no choice but to seek insurance as individuals.⁹ In the individual market, actuarial rating is nearly universal — and stringent.

One has to ask why any national medical policy would use such a system. At every juncture in state or national health reform, as public jurisdictions have sought to correct the failures of commercial health insurance and to ensure coverage for the people who most need medical care, commercial insurers have fought vigorously to defend the system of actuarial rating against public pressure for a system of social solidarity.¹⁰ As soon as a blood test to identify HIV

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tors in profitability is the cost of raw materials. For a commercial health insurer, insured people are its raw materials, and health services are its labor, machines, and supplies. The healthier its insured population, the lower its labor and production costs. Therefore, it pays to screen insurance applicants and select only the healthiest to insure.

From the 1930s through the early 1980s, commercial insurers used actuarial rating primarily when selling insurance to individuals and small groups. Large

became available, the insurance industry asserted its right to use test results to exclude people with HIV from health and life insurance coverage.¹¹ As genetic tests were developed to identify people with high likelihood (or sometimes certainty) of developing serious diseases, commercial insurers insisted on their rights to use those tests, too.¹² Even the recent federal legislation that bans so-called genetic discrimination includes a provision that insurance companies "still have the right base to coverage and pricing on

the actual presence of a disease.”¹³ As states sought to address coverage for their uninsured populations with community-rating schemes that would forbid exclusion of people with pre-existing illnesses, insurance trade associations fought (and contributed money to state legislators) to minimize the damage to their way of doing business.¹⁴

Part II: How Cost-Sharing Hurts the Sick and Erodes Their Coverage

Actuarial rating, high premiums, and direct exclusion of sick people are not the only mechanisms that prevent sick people from obtaining insurance to cover their medical care: cost-sharing is a more insidious mechanism. Cost-sharing means that people who *have insurance* must pay out-of-pocket for some of their care before their insurance will cover the remainder of their expenses.

There are three main kinds of cost-sharing: (1) deductibles, usually set as flat dollar amounts patients must pay for themselves before insurance will start covering care; (2) co-insurance, whereby patients pay a certain percentage of their medical expenses, such as the typical 20 percent for hospital stays; and (3) co-

With insurance as the root cause, the solution is simple: reduce the amount of insurance coverage people have. Many of these economists and other conservative policy thinkers would do away with health insurance altogether and replace it with personal savings accounts. But because health insurance is one of the more popular items in the policy basket, directly taking away people’s health insurance (say, by ending employee health plans or Medicare) is politically impossible. Instead, reformers have been able to chip away at insurance coverage by re-designing it in ways that force sick people to pay for more of the care that they need.¹⁶

While the people without any insurance (“the uninsured”) make headlines, the people with insurance are steadily losing coverage beneath the radar of public notice. Cost-sharing makes people who *do have insurance* pay for a greater share of their care. And here is the rub: cost-sharing comes into play only at the moment when a person seeks medical care or drugs. Only people who are sick or who think they might be sick seek care. Cost-sharing thus targets sick people far more effectively than actuarial rating. Actuarial rating depends on predictive or probabilistic infor-

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payments, usually relatively small flat dollar amounts between \$10 and \$25 dollars that patients must pay toward each unit of service, such as a doctor visit or prescription. Often these co-payments are set much higher — \$50-\$100 — for emergency room visits that are not true emergencies.

Over the last 35 years, health reform has focused on increasing patient cost-sharing. Prominent health economists have insisted that insurance coverage leads people to consume more medical care than they need because it subsidizes the costs for them. Full insurance coverage (in this theory) makes medical care effectively free, and partial coverage lowers the price patients pay below the true cost of care.¹⁵ Accordingly, health insurance coverage is the root cause of both rising medical prices and escalating social expenditures on medical care.

mation; cost-sharing relies on people’s actual health status and need for medical care. Cost-sharing at the point of use is an actuary’s dream — no need for all that data collection and multivariate analysis. Under cost-sharing, each person pays exactly in accordance with the care he or she uses.

By making the users of care pay for it (or some of it), cost-sharing discourages sick people from getting care. For people with low-incomes and tight budgets, cost-sharing can effectively deny them access to care. The evidence is overwhelming that cost-sharing reduces the use of medically effective care. The uninsured represent full cost-sharing, and we know that when people are uninsured, they postpone or avoid doctor visits, fail to fill prescriptions, and fail to seek or continue recommended follow-up care.¹⁷ High cost-sharing has the same effect on the insured. High deductibles make people more likely to delay or avoid

getting care because they are worried about costs, and this problem is most severe for people who have chronic illnesses or are in poor health.¹⁸ Cost-sharing for prescription drugs lowers adherence to drug regimens.¹⁹ It leads people to refill prescriptions sporadically only when they can afford the co-payments, and sometimes to discontinue drugs altogether.²⁰ For patients with some serious chronic illnesses such as congestive heart failure, diabetes, and schizophrenia, higher cost-sharing for prescription drugs is associated with greater use of medical services.²¹ And while these effects seem to be strongest among people with low-incomes, no evidence suggests that people with higher incomes are not also sensitive to cost-sharing, as economic theory predicts.²² Doctors say that with increased cost-sharing, some insured people are fore-

tured this dilemma for people like her, that is, people with substantial resources and high social standing but who have a history of serious illness. She criticized John McCain's health plan with the simple observation that "[n]either one of us would be covered by his health policy."²⁵ Edwards has incurable breast cancer; McCain has been treated for melanoma.²⁶ Common vocabulary suggests another indicator of widespread concern about the problem. Up until the late 1980s or so, the term "pre-existing condition" was arcane insurance jargon. By the time Bill Clinton ran for president and made universal coverage his top domestic issue, he could use the term in political speeches without defining it.

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going care they need because they are reluctant, or perhaps unable, to afford the co-payments.²³ International comparisons corroborate this effect of cost-sharing. For example, people who need hemodialysis — people who by definition suffer from kidney failure — must pay on average \$114 per month for their dialysis-related drugs in the U.S. compared to less than \$8 in the United Kingdom. In the U.S., 29 percent of dialysis patients — between a quarter and a third — sometimes do not buy their medications because of concerns about cost. In the U.K., however, less than six percent of dialysis patients go without their drugs because of cost worries.²⁴

The bottom line is clear: cost-sharing reduces and sometimes effectively eliminates insurance coverage for the sickest people, the people who most need regular treatment, tests, and drugs.

Part III: Taking the Measure of Reform Proposals

What gives the current reform movement its emotional and moral force is the experience of middle- and high-income people with the fundamental injustice at the heart of health insurance: health coverage is harder to get if one has been sick, and one is likely to be thrown out or priced out of the market the moment illness strikes. Elizabeth Edwards, lawyer and wife of two-time presidential contender John Edwards, cap-

genuinely covers the sick and those with high risk of serious illness. That is also precisely the feature of reform that will generate the stiffest opposition from the insurance industry. Reform is not going to be easy, and those who care about insuring the sick need to be on their toes.

Many reform ideas promise greater insurance coverage, but they are potentially Trojan horses, bearing stealth mechanisms that will further erode the coverage of sick people. Six current reform ideas bear careful examination:²⁷

1. *We will increase insurance coverage by reducing costs and making insurance more affordable.* "Reducing costs" is a slippery promise. It could mean reducing cost-sharing, but it might also be code for reducing the cost of health insurance to employers or government. If a proposal is going to reduce costs by making insured people bear a higher proportion of their insurance costs, then it will shrink, not expand, risk-pooling, and it will diminish health insurance for the sick.

2. *We will increase personal responsibility for health.* Like motherhood, "personal responsibility" is one of those value phrases that nobody can oppose. Exactly what does a proposal mean by the phrase? Personal responsibility could mean a moral duty to

take good care of oneself, live a healthy lifestyle, and avoid preventable illness and injury. Personal responsibility could also mean financial responsibility: individuals should pay more for their own care. Proposals to end coverage of routine health care and provide insurance only for catastrophic care rest on this idea. In this sense, personal responsibility means planning and saving for the normal and predictable medical events of life, just as one would save for the costs of buying a new car when the old one runs down. Personal responsibility here does not mean, as it does in a culture of social solidarity, mutual responsibility for everyone's welfare through social insurance.

3. *We will make health insurance more affordable by increasing prevention and wellness programs, thus lowering total expenditures on health care.* Apart from the weak and mixed evidence that prevention programs actually do save money,²⁸ many prevention programs shift costs to people who are at risk of chronic or serious disease. As Wendy Mariner has shown, many wellness programs effectively raise insurance rates for people with risk factors such as obesity, smoking, or diabetes by giving premium “discounts” to people without these risk factors.²⁹ Some plans waive cost-sharing requirements or give “bonuses” to members who successfully meet health “goals,” where the goals are risk factors in disguise (blood pressure, blood sugar, body mass index, for example).³⁰

over, health savings accounts are the antithesis of insurance. If people paid for their health care through their own personal savings accounts, then they would have complete control over their own spending — no one would be looking over their shoulder saying, “We don’t cover that.” Of course, most people would not be able to save enough to cover all their families’ medical expenses. Personal savings accounts offer account holders freedom over small expenditures, but no help once their or their families’ needs exceed their savings. Individual health savings accounts offer the freedom *not* to buy health care, but this is hardly a freedom worth having.

5. *We will return power to the people with consumer-directed health care.* Consumer-directed and consumer-driven health care are often euphemisms for reduced insurance coverage and greater cost-sharing, all with the intent of making people more cost-conscious as they think about whether to use medical care.³² These plans typically offer people a meager budget, but give them authority over how they spend it. They get symbolic power but less medical care.³³ Like every other kind of cost-sharing, consumer-directed care forces people to ration their use of care, tests, and drugs, and leads them — especially sick people — to use fewer medically necessary services.³⁴

All proposals for health reform ought to be scrutinized for the hidden details and the extent of their patient cost-sharing. The ultimate test of any reform is its ability to fulfill the fundamental purpose of insurance: to ensure that people who need medical care are able to receive it by spreading responsibility for the financial costs of illness. The best reform will be the one that most socializes the costs of medical care.

4. *We will make health insurance more available and affordable by giving consumers more control over their health spending.* One variation on this theme is health savings accounts, a vehicle that enables people to put aside money for medical care without paying income taxes on it, just as they can put money for retirement into an Individual Retirement Account.³¹ The hitch, though, is that to be eligible for the tax exemption, the health savings account must be part of a high-deductible health plan. Thus, any reform proposals that promote health savings accounts carry a hidden but hefty push to high cost-sharing. More-

6. *We will expand coverage by building on the current system of employer-based and private coverage.* The current system of employer-based and private coverage incorporates the very principles of actuarial and experience rating that erode coverage for the sick. Reformers who propose to build on the current system should be closely interrogated about how they plan to curb the systematic propensity to de-insure the sick.

Many reform efforts from the left have approached the lack of health insurance as a problem of discrimination, and indeed, actuarial pricing and exclusion *has*

disadvantaged African Americans, women, and people with disabilities.³⁵ However, even with legislative bans on gender, race, disability, genetic or any other kind of discrimination, health insurance will fail to do its job — pay for the treatment of illness — as long as cost-sharing persists and increases. For example, as noted earlier, even the recent Genetic Information Nondiscrimination Act, which forbids insurers from using genetic information to set premiums or deny insurance, permits them to continue to base coverage and pricing on the actual presence of a disease.³⁶ Insurers have long been successful at evading legislative and regulatory bans on discrimination by skillfully designing their benefits packages and restricting coverage of costly treatments.³⁷

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