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Ten Small-Scale Reforms for Pre-Existing Conditions

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Most proposals for dealing with the problems of pre-existing conditions would completely divorce health insurance premiums from expected health care costs, requiring health plans to enroll individuals regardless of their health status. Yet a policy of trying to force health plans to take enrollees they do not want risks jeopardizing the quality of care they receive.

Instead of suppressing the price system, following are 10 ways of dealing with this problem that make greater use of it. In a reformed health care system, the chronically ill - along with their doctors, employers and insurers - should find lower-cost, higher-quality, more-accessible care in their economic self-interest.

1. Encourage Portable Insurance. In almost every state, employers are not allowed to buy the kind of insurance employees most want and need: Insurance they own and can take with them from job to job, and in and out of the labor market. Most of the time, the problem of pre-existing conditions arises precisely because health insurance isn't portable. When employees switch jobs, they must switch health insurance as well. It is at this point that they may face medical underwriting, exclusions, higher premiums and perhaps denial of coverage altogether. To make matters worse, many employees are trapped in jobs they cannot leave because they cannot afford to lose their health insurance.

To begin to solve these problems, we should move to a system in which employees can take their health insurance with them when they travel from job to job.

2. Allow Special Health Savings Accounts for the Chronically Ill. Studies show that diabetics, asthmatics and other chronic patients can manage their own care as well as or better than conventional physician care and at lower costs. We need to explore new ways to empower patients - especially the chronically ill - by allowing them to manage more of their own care and more of their own health care dollars. Also, patients should be able to purchase services that are not paid for by traditional health insurance, including telephone and e-mail consultations and patient education services.

Cash and Counseling pilot programs in Medicaid are underway in more than half the states. Homebound, disabled patients manage their own budgets, and are responsible for hiring and firing those who provide them with services. Satisfaction rates approach 100 percent (virtually unheard of in any health plan anywhere in the world). This program could become a model for chronic illness care everywhere.

3. Allow Special Needs Health Insurance. Instead of requiring insurers to be all things to all people, we should allow plans to specialize in treating one or more chronic conditions. Plans could specialize, for example, in diabetic care, heart care or cancer care. Also, they should be able to charge a market price, and price and quality competition should be encouraged.

4. Allow Health Status Insurance. To facilitate the market for chronic illness insurance we should encourage a division of conventional insurance into two separate kinds of insurance, with two separate premiums. Standard insurance would cover the health needs of people during the insurance period. Health status insurance would then pay future premium increases people face if they have a change in health status and then try to switch to another health plan.

5. Allow Self-Insurance for Changes in Health Status. Tax law allows employers to pay for current-period medical expenses with untaxed dollars. There is no similar opportunity for either employers or employees to save for future changes in health status that could substantially increase medical costs. Clearly, people need the ability to save for contingencies in a Health Savings Account (HSA) for future, rather than current, medical costs.

6. Give People on Their Own the Same Tax Break Employees Get. Most people who have a problem finding a health plan that will accept them with a pre-existing condition are trying to buy insurance in the individual market. Yet, unless they are self-employed, they get virtually no tax relief - even the self-employed are penalized vis-à-vis employer-provided insurance. This should be a no-brainer: All insurance should get the same tax relief regardless of where it is obtained, and individuals should get the same tax relief regardless of how they obtain it.

7. Allow Providers to Repackage and Reprice Their Services Under Medicare and Medicaid. Most providers today are trapped in a payment system that encourages high-cost, low-quality care. By contrast, we should encourage innovative solutions to the care of diabetes, asthma, cancer, heart disease and so on. Along these lines, providers should be able to offer a different bundle of services and be paid in a different way, so long as they reduce the government's overall cost and provide a higher quality of care. For example, Geisinger Health System in Pennsylvania offers a 90-day warranty on heart surgery. If the patient returns with complications in that period, Geisinger promises to attend to it without sending the patient or insurer another bill. The problem is that Geisinger doesn't get financial support from Medicare for this practice, even though it can save money for Medicare overall.

8. Allow Access to Mandate-Free Insurance. Studies show that as many as one out of four uninsured Americans has been priced out of the market for health insurance by cost-increasing, mandated benefits. These are mainly healthy people. At the same time, however, these mandates raise premiums for the chronically ill and divert dollars away from their care. There is no reason a diabetic should have to pay for another person's in vitro fertilization, naturopathy, acupuncture or marriage counseling in order to obtain diabetic care.

9. Create a National Market for Health Insurance. More competition, especially among special needs insurers (see number 3), would be a huge benefit for the chronically ill. Being able to buy insurance across state lines would encourage that competition.

10. Encourage Post-Retirement Health Insurance. If the past is a guide, more than 80 percent of the 78 million baby boomers will retire before they become eligible for Medicare, but only one out of every three has a promise of post-retirement health care. Both employers and employees should be able to save in tax-free accounts in anticipation of future health costs. Moreover, employers should be encouraged to negotiate with insurers to cover their retirees at group rates. Employers should also be able to pay some or all of the premium for retiree-owned insurance, or make deposits to the retiree's HSA with pretax dollars (see number 5).

Conclusion. These 10 reforms would encourage insurers to compete to cover patients with chronic illnesses, rather than trying to avoid them. They would give doctors and other health care providers incentives to innovate, and to use technology in order to improve quality and reduce costs.

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