Insurance Woes Common for Diabetes Patients

The high-deductible policies that are increasing in popularity 'really hit people with diabetes.'

BY JOYCE FRIEDEN
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WASHINGTON — Sixty-year-old Janice Ramsey used to have something in common with other Deltona, Fla., residents—she was a small business owner who had health insurance. But 7 years ago, all that changed.

Ms. Ramsey's problems started when she switched health insurance plans. "I purchased a new individual plan because the old one was a little high," she said at a press briefing sponsored by the American Diabetes Association and Georgetown University. "I had the plan for a year and a half, and then I went to use it." She needed the coverage to help pay for some blood work, which revealed that she had type 2 diabetes.

Once the claims for the tests were submitted, the insurer took another look at Ms. Ramsey's policy. "The plan said I must have had diabetes before I took their coverage, and they dropped me," she said. "I was out all the premiums I had [paid]."

She then found coverage through an association health plan that covers members of trade associations and other small groups. But after paying premiums on that plan for 18 months, she had trouble again.

"I found out that the policy I had bought was fraudulent," she said. "I had to use it because [the doctors] thought I was having a heart attack, and I went in for a catheterization. They didn't pay a dime."

She was stuck with $23,000 in bills, which she eventually paid back. The plan then went bankrupt, and "they were not licensed in Florida, so the insurance commissioner told me I didn't have a chance to get any money back," she added.

Since then, Ms. Ramsey has tried to get other coverage, to no avail. "I've contacted a lot of companies, and the answer is the same, 'Sorry, we cannot help you—you have diabetes,' " she said. "They kind of just hang up on you, like you don't even count." She is hoping that she can hang on for another 5 years, when she'll be eligible for Medicare.

Ms. Ramsey's case is not uncommon, according to Karen Pollitz, project director at the Georgetown University Health Policy Institute and lead author of a report analyzing 850 case studies of diabetes patients who have had problems obtaining or keeping adequate health care coverage. "Even before we began this report, there were studies providing evidence that people who have serious or chronic illnesses are disadvantaged in the insurance system in the U.S. today," she said.

On average, about 2 million Americans lose their health insurance each month, Ms. Pollitz noted. "Some move right on to the next plan, some are uninsured for a month or two, and some are uninsured for a very long time before they manage to regain their coverage." But the burden is not spread equally, since people in poor health are twice as likely to be without insurance for a lengthy spell as those in good health.

People with diabetes need coverage that meets the three A's: accessibility, affordability, and adequacy, she continued. "Most people's problems [were caused by] a transition in coverage. People had lost their prior coverage or were about to lose their coverage and had encountered obstacles or penalties that made it harder to move on to their next coverage."

Ms. Pollitz and colleagues attempted to resolve the patients' insurance problems, with little success. For example, 377 people who had lost their job-based coverage were eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but after they saw what the premiums would be—much more expensive than the premiums they paid on their earlier policies—only 15 people were able to enroll.

Further, 87 people were eligible for individual coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), but only 11 were able to buy the coverage. And 344 people lived in states that had high-risk pools to help the uninsured, but only 7 ended up enrolling. As for Medicaid, although a "large number" of patients had very low incomes—less than $1,000 per month—only 6 ended up being able to enroll in Medicaid, she said.

State high-risk pools were a good example of coverage barriers, according to Ms. Pollitz. Some of the pools were not very accessible; many had waiting lists or were closed to new enrollments. In Florida, where Ms. Ramsey lives, the high-risk pool "has been closed to new enrollees for more than a decade," she noted.

Affordability is another problem with high-risk pools, since the coverage always costs 50%-100% more than what a private individual insurance policy would cost. For example, in Illinois, premiums can range as high as $1,084 per month, she said. The plans also are age rated, so the costs can grow three to four times in size as beneficiaries approach age 65.

Adequacy is also an issue with high-risk pool policies, Ms. Pollitz said. "High-risk pools often exclude preexisting conditions, so the thing that makes you eligible in the first place is excluded for 6-12 months." Some pools also have limits on coverage for prescription drugs and mental health care.

On the private insurance side, the high-deductible policies that are increasing in popularity "really hit people with diabetes," she said, noting that supplies for diabetes patients, such as medications, test strips, and insulin, can range from $350 to $800 per month, depending on whether the patient is experiencing complications. "Those costs really add up."

The features of health insurance that hurt diabetes patients and others with chronic illnesses "were all adopted for reasons that were perfectly logical," such as keeping insurance companies solvent, protecting insurers from adverse selection, or being able to offer cheaper premiums. "But those [features] tended to have been adopted one change at a time, so it was hard to step back and take a look at the big picture," Ms. Pollitz said.

She added that the perspective of chronically ill patients "is a very important one to adopt when looking at proposals to change the health insurance system, because if change won't make it better for people who are sick, then what's the point?" ■

The report is at www.healthinsuranceinfo.net/diabetes_and_health_insurance.pdf.

Senator Breaux Pushes for Individual Insurance Mandate

BY MARY ELLEN SCHNEIDER
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NEW ORLEANS — The real social crisis facing America right now isn't fixing Social Security but tackling the problem of the uninsured, former Sen. John Breaux said at the annual meeting of the American Academy of Dermatology.

"The crisis that I see in health care in this country is the fact that we have 44 million Americans who have no form of health insurance whatsoever," he said.

And the crisis is likely to get worse as more and more companies are opting not to provide health insurance to their employees, said Mr. Breaux, a Democrat who represented Louisiana in the U.S. Senate for the past 18 years.

But the problem isn't how much money is being spent on the system, he said, it's the way the system is organized. Currently, most individuals receive their health coverage either through their employer or through Medicare, Medicaid, or the Department of Veterans Affairs. If they don't fit into one of these eligible groups, or their employer doesn't provide coverage, they are unlikely to be insured.

One way to get away from this traditional system of coverage would be to create a federal mandate that every individual must have health insurance, Mr. Breaux said. Under this type of plan, the government would offer subsidies to low-income individuals to purchase coverage.

The government would also need to create some type of state or multistate purchasing pools and ensure that the system prevents adverse risk selection so that insurance could be purchased at a reasonable price, he said.

Mr. Breaux compared such a plan to the existing requirement in most states that drivers must have a liability insurance policy. "People understand that and they have accepted that," he said.

Under such a system, if an individual without insurance sought care in an emergency department, he or she would be enrolled in a purchasing pool at that time, he said. Or people might need to show proof of health insurance when they get their driver's license, he said.

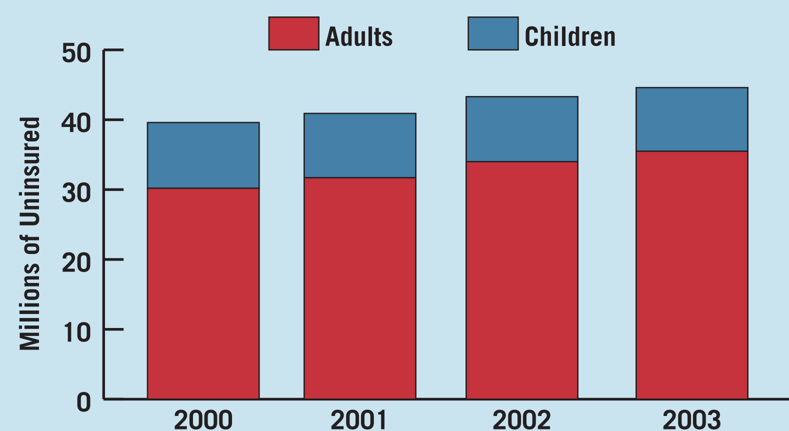
Mr. Breaux predicted that such a plan would help to move away from the current segmented system of health care and the waste, fraud, abuse, and duplication that accompanies each of those separate bureaucracies.

And providing insurance to more Americans would cut down on overall costs because it would allow more people to have access to preventive treatments. The best way to get a handle on health care costs is through disease management, Mr. Breaux said, but you have to get the patients into the physician's office to do that.

Although it's unlikely that such a system would be enacted anytime soon, it's a worthy goal, Mr. Breaux said.

"As we try to get a handle on the costs, we have to move away from the fact that we can just regulate it to death and control costs through regulation," he commented at the meeting. ■

DATA WATCH



Notes: Based on data from the March supplements to the Current Population Survey. Excludes persons aged 65 and older and those in the armed forces.

Sources: Urban Institute, Henry J. Kaiser Family Foundation

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