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Michael Tanner column: Straight talk on ‘pre-existing conditions’

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As Senate Republicans prepare for their turn in the health care meat grinder, it increasingly appears that the question of pre-existing conditions will be toughest to address. This is an issue so fraught with emotion as to cry out for some straight talk.

First, let’s be clear about who we’re talking about when the conversation turns to pre-existing conditions: people who are already sick or at high risk of becoming sick. Insurance is — or should be — about managing risk. We buy coverage to protect us against events that are unlikely to happen but would carry a catastrophic cost if they did. Our premiums reflect both the likelihood of those events and the potential price of the medical care they’d require.

Consider that, in 1752, Benjamin Franklin started the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, the first wide-scale commercial-insurance company in the United States. In providing Philadelphians with insurance against the then-frequent calamity of house fire, Franklin made the common-sense decision to charge those who lived in wood houses, which were more likely to burn, higher premiums than those who lived in brick houses.

The Affordable Care Act essentially eliminated this type of risk-management, mandating identical premiums for both brick and wood houses, or in this case, someone in perfect health and someone in very ill health. It is this Gordian knot that congressional Republicans are attempting, in their usual inept way, to cut.

A lot of numbers have been thrown around about how many Americans have pre-existing conditions. Barack Obama, for example, has suggested that the number is as high as 133 million. But these figures grossly exaggerate the number of Americans who would be affected by changes to the ACA’s pre-existing-conditions provisions. They include, for example, Americans on Medicare or employer-provided health insurance, neither of which are subject to medical underwriting. If you get your health insurance at work, the company’s overall costs may increase to reflect its claims experience in the event that Congress’ reform bill gives insurers the right to charge more for those with pre-existing conditions, but your individual contribution will not increase because you have such a condition.

Democrats have also been circulating a long list of medical problems that meet the technical definition of pre-existing condition. Many of those conditions have little more than a marginal impact on premiums, and others are explicitly addressed by state laws that ban insurance companies from charging more for those who have them. For example, some commentators have

claimed that insurers might call rape or domestic violence pre-existing conditions. But even if an insurer was willing to bear the public outrage from doing so, 44 states currently prohibit the practice. Those that don't ban it explicitly, including states such as Vermont, would enact a ban at the first hint that an insurer might change its policies to punish a victim of rape or domestic abuse.

This politically motivated hysteria does not make the question of how the system should treat those with pre-existing conditions any less pertinent, of course. If you have a pre-existing condition, you are not being "insured" in any real sense, because there is no risk to manage or spread over a larger pool. But your health care costs still need to be paid, and there are essentially just four ways to allocate those costs.

We could require that people with pre-existing conditions bear all the costs themselves, either by paying an actuarially fair premium or by forgoing insurance and paying their costs out-of-pocket. For some the increases will be modest, more an inconvenience than a crisis. Charity care might fill in some of the gaps, and federal law would continue to require that hospitals provide emergency care. Nevertheless, it is likely that many people would not receive the care they need. As a result, virtually no one favors this option.

Second, other people in the insurance market could pay the costs. That's how the ACA works. The ACA mandates that healthy people, who are unlikely to use insurance, buy it anyway, and charges them much higher premiums than would normally be justified by their actuarial risk. The young and healthy essentially subsidize care for the older and sicker. This has the perverse effect of forcing some people who are struggling financially, such as those just out of college, to subsidize people who might be much better off financially. It also doesn't work, as the ACA's implementation showed, because not enough healthy people sign up to pay for the influx of sick people. Insurance companies then either drop out of the market, cut back on high-quality providers, or raise premiums. All of this in turn forces healthy people out of the insurance pool, threatening to create an adverse-selection death spiral.

Third, you can try spread the cost of insurance subsidies over the entire tax-paying population. That's the theory behind high-risk pools. Individuals with pre-existing conditions would be removed from the general insurance pool, allowing premiums for the rest of us to drop to levels reflecting our reduced risk. Most people's premiums will go down, while those in the high-risk pools face much higher premiums. To be feasible, this option thus requires government to subsidize premiums for those in the high-risk pools. Before the ACA, some 226,000 Americans were enrolled in high-risk pools in the 35 states that offered them. Some state pools were well-designed and worked fairly well, while others had problems. It remains to be seen whether a new generation of high-risk pools would be better. The major problem with this option is that it attempts to preserve the illusion that people with pre-existing conditions are being "insured," when in actuality the uninsurable are uninsurable and there is little point in continuing to include insurance-company middlemen between them and their health care providers.

Finally, we can take those with pre-existing conditions completely out of the insurance market and have taxpayers pay directly for their care — including them, for example, under Medicaid. That is the approach advocated by Sen. Rand Paul, among others. Its biggest downside is an increased risk of adding substantially to federal and state spending at a time when the growth in

Medicaid costs is already squeezing out other priorities such as education and infrastructure. Another risk is that directly paying providers might recreate the many problems plaguing existing programs such as Medicare, Medicaid, and the VA, with the specter of price controls, rationing, oppressive taxation, and debt looming as costs rise.

None of these options includes a magic money tree that provides "free care." We are arguing about who should pay, which is a natural and healthy debate to have in a democracy. But too much of the discourse surrounding this issue pretends that treating people with pre-existing conditions is cost-free. Moreover, all of this debate takes place against the backdrop of the ACA's ongoing implosion. The law's protections for those with pre-existing conditions may not count for much if, in the near future, there are no plans being sold on exchanges in their markets, or if none of the available plans cover the doctors or hospitals they need. And even where insurers have not yet pulled out of Obamacare, people with pre-existing conditions are currently being hurt by high premiums and deductibles wrought by the law's flaws.

This is not to suggest that the GOP's proposal is in any way coherent, of course. In their endless quest to be a little bit pregnant on the topic, Republicans have crafted a bill that manages to borrow the worst aspects of all the above models, and their unwillingness to be frank about the trade-offs involved deserves all the derision it has received.

But if Democrats have a better answer, we have yet to hear it.

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