# An eroding model for health insurance

Working Americans once could rely on employer-based benefits. But more people are being forced into the individual market, where coverage is costly, bare-bones and precarious.

By Lisa Girion and Michael A. Hiltzik

October 21, 2008

***First of three parts***

Jennifer and Greg Danylyshyn of Pasadena are conscientious parents. They keep proper car seats in their used BMW, organic vegetables in the family diet and the pediatrician's number by the phone.

They don't have access to the group medical insurance offered by many employers. She's a stay-at-home mom. He's a self-employed music supervisor in the TV and film industry. So they buy individual policies for each family member.

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**FOR THE RECORD:**
Health insurance: An article in Tuesday's Section A about the nation's health insurance crisis said that nearly 46 million Americans have no medical coverage. The figure is a Census Bureau estimate of the number of U.S. residents without insurance; not all are American citizens. —

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As careful consumers, they shopped for the best deals, weighed premium costs against benefits and always assumed they could keep their family covered.

Then last spring Blue Shield of California stunned them with a rejection notice. Baby Ava, their happy, healthy 7-pounder, was born with a minor hip joint misalignment. Her pediatrician said it was nothing serious and probably temporary.

Still, Blue Shield declared the infant uninsurable. The company foresaw extra doctor visits, "the need for monitoring and an X-ray." Ava's slight imperfection "exceeds . . . eligibility criteria for acceptance," Blue Shield said.

"I was enraged, baffled; I just could not understand," recalled Jennifer, 36.

The family's experience is symptomatic of the nation's healthcare crisis. Ineligible for group insurance, millions of Americans are paying more for individual policies that offer less coverage and expose them to seemingly arbitrary exclusions and denials.

The health insurance system has become increasingly expensive and inaccessible. It leaves patients responsible for bills they understood would be covered, squeezes doctors and hospitals, and tries to avoid even minuscule risks, such as providing coverage to a newborn with no serious illness.

At the heart of the problem is the clash between the cost of medical care and insurers' need to turn a profit.

Today, four publicly traded corporations -- WellPoint Inc., UnitedHealth Group, Aetna Inc. and Cigna Corp. -- dominate the market, covering more than 85 million people, or almost half of all Americans with private insurance.

On Wall Street, they showcase their efforts to hold down expenses and maximize shareholder returns by excluding customers likely to need expensive care, including those with chronic diseases such as asthma and diabetes. The companies lobby governments to take over responsibility for their sickest customers so they can reserve the healthiest (and most profitable) for themselves.

Meanwhile, insurance premiums are becoming a heavier burden on employers, many of which say that rising healthcare costs cut into their ability to compete and, in some cases, to survive.

As a result, the percentage of Americans covered by traditional group health insurance has steadily declined. Nearly 46 million have no insurance at all. Medical debt has become a leading cause of personal bankruptcy and a growth business for collection agencies.

Even some top insurance executives agree the system is inefficient and sometimes inhumane.

Bruce Bodaken, chief executive of Blue Shield of California, says

that universal coverage is the answer.

Bodaken says government should mandate that everyone obtain health insurance and that insurers sell to all comers regardless of their health -- similar to a plan proposed by Gov. Arnold Schwarzenegger and defeated in the state Legislature last year.

The rationale of universal coverage, the norm in other industrialized countries, is that costs are manageable when everyone is covered because the risk pool includes the young and healthy to offset the older and sicker.

"One of the basic goals of universal coverage should be to change the health coverage business from avoiding risk to balancing health risks and focusing primarily on quality, service and cost-effective delivery," Bodaken wrote recently in the policy journal Health Affairs.

In the absence of such a system, and with group coverage increasingly unavailable, more and more Americans are left to rely on individual health policies. They are more expensive for all but the young and healthy and often provide fewer benefits.

They also are lightly regulated. Unlike group plans, which must accept all qualified applicants and can't base a member's premium on his or her medical history, individual plans in most states (including California) are free to cherry-pick the healthiest customers.

Insurers can reject applicants for even mild preexisting conditions. People have been turned down for individual policies because they have hay fever, have suffered from jock itch or use common medicines such as cholesterol-lowering drugs, records and interviews show. Even those lucky enough to have insurance are uncertain they can keep it or count on it in a crisis.

Sens. Barack Obama and John McCain both have released proposals for curbing costs and broadening access to health coverage, but both presidential candidates would preserve the private insurance industry as the system's backbone.

**Cherry-picking**

During her pregnancy, Jennifer Danylyshyn's regular visits to her obstetrician were covered by her Blue Shield policy. So was the delivery of Ava on March 24. The couple expected that Ava would be covered as a matter of course.

When the company rejected the baby because of the hip misalignment, her parents appealed with the help of their pediatrician.

"Certainly, this cannot be a condition which warrants the denial of insurance benefits; especially to this beautiful, healthy baby girl," wrote Dr. Stephanie A. Heller.

Blue Shield refused to budge.

Meanwhile, the Danylyshyns kept to their well-baby schedule. Ava received her regular checkups, weigh-ins and vaccinations. But the doctor bills went to the couple's two-bedroom Pasadena bungalow, not to Blue Shield.

Then, before Ava began to crawl, her joint problem corrected itself. Presented with a clean bill of health from an orthopedic specialist, Blue Shield agreed to insure Ava -- after six months and more than $2,000 in unreimbursed care.

The insurer agreed to cover only Ava's future medical needs. The tab for the care she had already received was her parents' responsibility.

Blue Shield spokesman Tom Epstein called Ava's case "a good example of what's wrong with the current system and why it needs to be fixed."

Insurers insist that they can't stay in business without excluding chronic disease sufferers, known in the industry as "clinical train wrecks." But companies in the individual market also want to avoid even marginal risk -- adopting a practice some insiders call "hangnail underwriting."

Even nonprofits such as Blue Shield of California are obliged to follow prevailing market practices, lest they be swamped with the highest-cost customers.

"That's the game," said Cindy Ehnes, director of the California Department of Managed Health Care. Risk selection, she said, "must be part of every insurer's strategy or else they potentially will get all the bad risk."

Such cherry-picking tripped up Pam Munter when she applied for individual coverage two years ago. She had retired from a clinical psychology practice in Oregon and moved to California, where her insurance applications were rejected, one after another.

The reason: She takes Prevacid for gastroesophageal reflux disease. It is a widely prescribed drug with annual sales exceeding $3 billion.

In Oregon, Munter paid $400 a month for health insurance. In California, the only coverage she could get was through the state-run high-risk pool. She paid $1,000 a month for a policy with a benefit limit of $75,000 a year, and was lucky to get it. California often has a long waiting list for the high-risk pool.

Medicare came to Munter's rescue when she turned 65. Now she pays less than $250 a month.

**Rejection and rescission**

Rudy Rivas is on the front line of the healthcare system. He sells medical insurance from a home office in Whittier and counsels customers at his kitchen table. These days demand is high, but so are rejections.

On a recent day, he hung up the phone after talking to a woman in her 50s who had lost her job and her group health insurance coverage along with it. He couldn't find an insurer willing to take her on because of a preexisting medical condition.

"She's not indigent. She owns her own house. She doesn't qualify for Medi-Cal. What can she do?" Rivas said. "This is a common call that we're having. It's tough."

Rivas doesn't blame the insurers. But he spends a lot of time explaining to clients the harsh realities of the individual market.

"Insurance is about one thing -- adverse risk," Rivas said. "If I'm a

carrier and I started taking on people who are 5-foot-10 and over 265 pounds, I'm going to get all the people who are overweight. And I can't keep my doors open that way."

Another way that insurers keep medical losses down is by jettisoning customers they say did not qualify for coverage in the first place.

Several insurance companies have established departments dedicated to reviewing the applications of customers who file costly medical claims. The goal is to discover evidence that the clients failed to disclose preexisting conditions when they applied. Insurers cite such omissions as grounds to cancel policies retroactively, a process known as rescission.

Health Net Inc. of Woodland Hills, a nationwide insurer with 6.7 million members, avoided spending $35.5 million by canceling the policies of about 1,600 California customers over six years, according to company documents disclosed last year by the Los Angeles Times.

The documents showed that Health Net paid bonuses to an employee based, in part, on how many policies of sick enrollees she canceled. An arbitrator this year awarded $9 million to one Health Net customer -- a Gardena hair salon owner who was undergoing chemotherapy for breast cancer when her policy was canceled.

Public controversy, political pressure and legal challenges are forcing insurers to tread more carefully in rescinding policies. However, rescission remains a powerful tool that the industry is fighting to retain.

"Rescission . . . helps protect against fraud in the individual market," said Chris Ohman, president of the California Assn. of Health Plans.

**Losing coverage**

Sally Marrari thought she was covered when she was admitted to Cedars-Sinai Medical Center complaining of sharp pain and shortness of breath. A few months earlier, she and her husband, Rick, who own an auto repair shop in Los Angeles, had taken out

a family insurance policy.

She spent three days at Cedars-Sinai undergoing tests and was later diagnosed with lupus, a chronic, arthritis-like disease. When the hospital's $25,000 bill came due in late 2006, Anthem Blue Cross of California refused to pay -- and then rescinded Marrari's coverage.

"They told me they canceled me because I was lying," recalled Marrari, 51, of Playa del Rey.

After reviewing Marrari's application, Anthem said she had failed to report having taken an antidepressant years earlier. The company said she also omitted mention of a digestive disorder, an iron deficiency and back pain.

Marrari said she didn't know she had a digestive disorder or an iron deficiency when she filled out the application. As for the back pain, she understood it to be a side effect from a hysterectomy, which she says she did list on her application.

Marrari said she took the antidepressant Prozac under a doctor's care after her father died a decade ago. She stopped using the medication after a year.

"They asked if I had mental problems, and I said no, which is true," she said. "I don't have mental problems."

Marrari, one of 6,000 Anthem Blue Cross of California customers who have lost coverage in recent years, is suing the insurer in an effort to have her policy reinstated.

Anthem declined to discuss her case.

Without insurance, Marrari's medical treatment has been expensive and intermittent. She and her husband managed to pay the $25,000 bill from Cedars-Sinai, she said, and they have spent another $25,000 or more on her care, including an annual $1,000 scan to see whether fluid has built up around her heart, a risk with lupus.

She sought treatment in Mexico, borrowed money from her in-laws to pay for tests, and is compensating one specialist by repairing

the doctor's vintage Porsche and giving it a new paint job.

Marrari says she can't afford prescription pain medications so she simply lives with the pain. Sometimes it becomes overwhelming. One day last summer Marrari sought relief at the emergency room of St. John's Hospital in Santa Monica. She got a bill for $10,000.

"I cried," she said. "I'm trying to get them to reduce it."

**Skimming the risk pool**

Insurers trying to lure the healthiest and most profitable customers are devising cheap, stripped-down policies aimed at younger buyers.

Tonik, for example, offers a line of low-priced individual plans with deductibles as high as $5,000 a year. It is a product of WellPoint Inc., the parent of Anthem Blue Cross of California, and promises starting premiums as low as $74 a month.

The plan provides no maternity care, excludes most mental health coverage and is limited to generic drugs.

Tonik epitomizes policies aimed at "young invincibles" -- men ages 19 to 29. They are least prone to chronic diseases, rarely go in for checkups and typically don't have families. All but the most serious medical claims are likely to fall short of Tonik's high deductibles.

WellPoint contends that such plans bolster the country's healthcare system by drawing in customers who otherwise might not buy any insurance.

But there are hidden costs to skimming the healthiest customers from the risk pool. Those left behind pay more. Or they go without insurance, meaning that taxpayers foot the bill for their care.

California Lt. Gov. John Garamendi said that 60% of all deliveries in California were covered by Medi-Cal, the government health program for the indigent.

"Why should we cover pregnant women?" asked Garamendi, a former state insurance commissioner. "Because the cost of an unhealthy child remains in the community. Why is that? Because

insurance companies have shed the risk."

**'A matter of economics'**

Premiums on all forms of insurance have surged in recent years. Between 2002 and 2007, premiums rose 78%, outpacing inflation (17%) and wages (19%). In the individual market, without an employer's subsidy, consumers bear the full cost of coverage.

Most states don't regulate how premiums are set. As a result, women tend to pay more than men (because they have higher medical expenses on average). Rates also go up with age. For many people older than 50, premiums can rival mortgage or rent payments.

When Peter and Brenda Koerner of rural Pennsylvania, both in their 50s, couldn't afford individual policies, they gambled -- and prayed that their health and good luck would hold until Medicare kicked in.

The Koerners sell gifts and custom T-shirts at fairs and street festivals in northeastern Pennsylvania and in their store, Cosmos Crystal Shop, in Carbondale.

"We've been lucky playing the Russian roulette game with not having any health insurance and basically trying to be as careful as you can," Peter Koerner said.

One day about two years ago, he was using a hydraulic splitter to replenish the wood pile that heats their home. Something slipped. His left thumb was severed.

He tried to stop the bleeding with rubber bands, packed the amputated digit in ice to "increase my chances of reattachment" and got a neighbor to drive him to the local hospital.

Doctors in the emergency room cleaned and stitched the wound, but he would have to be airlifted to a bigger hospital for reattachment surgery.

Koerner loves working with his hands. He is a trained goldsmith and silversmith, repairs his car and enjoys sculpting. He knew he would miss his thumb. But there were "too many other bills to

pay."

He left his thumb at the hospital.

"It was plain a matter of economics," Koerner said. "I knew I could live without it."

Girion and Hiltzik are Times staff writers.