The Hit List

Insurance companies are forcing more and more HIVers to choose between losing their policy or dropping their doctor. Dave Gilden hatches some plots to undo this Catch-22.

December 1, 1999 By Dave Gilden

Last summer, with profiles in the press (including a *POZ* cover) and his new show opening to good reviews, New York City artist Barton Benes was on a roll. But in August, out of the blue, he got what many HIVers might consider the worst possible news. Oxford Health Plans, the giant HMO that's rebuilding its financial health after a brush with bankruptcy, dropped Benes' doctor from his health plan. A self-employed artist, Benes is one of some 210,000 New Yorkers with an individual—as opposed to group—insurance policy. Although Oxford claims that its individual plans are a money-losing operation, New York state law (in a hard-won product of a coalition effort led by AIDS activists) says it cannot eliminate them. Still, Oxford is making these customers, especially the chronically ill, feel unwanted. Last year, it asked the state for a 69 percent rate hike. This was stymied by a one-time state subsidy. New York officials made it plain this year that they would approve only small premium increases.

So on June 23, the company did the next best thing. Oxford announced that it was switching individual members from its "Freedom" network of preferred providers to its "Liberty" one, a cheaper network half the size that many small businesses choose for group coverage. "People did not want a large rate increase," Oxford spokesperson Maria Gordon Shydlo says. "So to keep costs flat, we had to take a look at the physicians network."

Beyond such soothing sentiments is the harsh fact that HIVers like Benes are hard hit by the change: In New York City, the number of AIDS docs available to Oxford's individual-policy holders shrank by 60 percent. Only 59 of some 350 HIV specialists citywide are on the Liberty list, according to a Gay Men's Health Crisis (GMHC) survey.

Howard Grossman, Benes' doctor since 1987, is not on the list, and Benes will have to search long and hard to find a new primary-care physician or else pay for Grossman out of his own pocket. Grossman explains that the fee schedule for the Liberty list is just too low. "There is no way I can afford to take the Liberty plan and still stay in business," he says. "It's the worst of the HMO model."

Benes is frightened by the prospect of ending his long-term relationship with Grossman. "I know Howard, and he refers me to the specialists I want," he says. "But more than the referrals, Howard

has seen how my body works. He can recognize right away when something's going wrong." As treatment strategies and other HIV care grow increasingly complex and individualized, a doctor's knowledge of a patient's medical history can mean the difference between life and death.

Susan Dooha, a longtime GMHC lobbyist, puts her finger on the flaw in the individual-plan system: "People buying this coverage tend to be those with health problems who cannot be without coverage. Healthy people, meanwhile, often avoid the expense of individual policies, preferring to take a chance until they can get a less expensive group plan." It's a vicious cycle: When an HMO raises premiums to make up for the money lost on individual policies, it drives still more healthy people off the plans. "Insurance is not an ideal way to pay for health care for people who are really sick," Dooha says.

Patients understandably follow their doctors. By cutting back on its list of physicians, Oxford managed to keep its healthy policyholders (who incur fewer expenses) while forcing its sicker ones to find other plans to cover their expensive doctors and treatments. Unfortunately, these cutbacks are likely to spread, domino-like, as other state health insurers become overloaded with Oxford's chronically ill refugees. To avoid the complete collapse of individual plans, GMHC and several other advocates are pushing New York state to stabilize the plans plans financially with subsidies from an existing—but under-utilized—state health fund financed by fees that hospitals charge insured patients.

The insurance industry backs this proposal to shore up the troubled individual policies, but the wait-and-see state government is not expected to act on it this year. Other states have tried different solutions to the individual insurance problem with varying success. In the states with the strongest subsidy programs, such as Iowa and New Jersey, the cost of individual plans is controlled and the healthy as well as the sick purchase them. In other states, such as Kentucky, the individual-insurance market has completely collapsed. About half the states have abandoned plans for their sickest citizens altogether, opting instead for state-supported high-risk pools. This puts an extra burden on taxpayers, but results in lower insurance premiums overall, since it isolates the high-cost patients.

Meanwhile, the ultimate solution, which would cover everyone's health care, awaits elaboration. "Of course, the best solution would be to put everyone in the same pool," Dooha says. That way, we would all support one another's health costs rather than leaving the seriously ill (and most of us will eventually be in that boat) to bail themselves out at unbearable costs. But is the public willing to pay for someone else's HIV? Unless that public brings political pressure to bear, politicians will continue to twiddle their thumbs, and health insurance for people like Barton Benes will continue its gradual meltdown.

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