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Should You Care About Your Insurance Company's Welfare
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The general attitude toward insurance companies is that they exist to deny coverage and that they are making vast sums of money by doing so. Many public policy makers blame the high cost of health care on insurance companies. Politicians, wanting to change healthcare, needed a straw man in order to motivate people to support radical change in healthcare. Not wanting to fail as others had, political leaders chose to demonize insurance companies. The problem is that while they chose an unpopular and easy target, they chose a target that has little to do directly with the rising cost of healthcare.

To blame insurance companies for increasing healthcare cost is like blaming the police for increasing crime rates. Police can indirectly allow an increase in crime but they do not cause crime or crime rate increases. Insurance companies' premium rates reflect the rising cost and utilization of healthcare; they did not directly produce the increased cost.

Indirectly, by the nature of their industry, insurance executives can unwittingly contributed to the cost of care by insulating policy holders from the shock of the true cost of their care. Companies try to address this with deductibles, co-pays and prior authorizations, in order to suppress the accessing of care, but these steps only made insurance companies look greedier and greedier. Managed care was supposed to address the trajectory of healthcare costs but also actually only aggravated the problem. In fact, controlling insurance premium rates will do NOTHING to control the cost of healthcare.

Insurance companies did not create entrepreneurship in medicine; Medicare did. Insurance companies did not create expensive technology in medicine; progress did. Insurance company rates do not create the expensiveness of healthcare; those rates only responded to the cost created by other factors. There have been and there are excesses in the health insurance industry, but the limiting of the growth of insurance premium rates will do absolutely nothing to reduce or control the cost of healthcare. Neither tort reform nor insurance regulations will solve the problem of healthcare costs.

The Crucial Issue for Healthcare Consumers

In this atmosphere of hostility between healthcare consumers and healthcare insurers, is there any circumstance under which a patient should care about the welfare of his/her health insurance company? The question seems ridiculous to most people because aren't all insurance companies making huge profits and aren't all insurance premiums exaggerated in order to support those profits? Aren't the policies of insurance company all for the financial benefit of the health plan? A new one I heard recently was, "My insurance company told me that I had to try other medications before I can get the drug I have been taking. I know drug reps are doing this so they can see the use of their own products increase."

My answer to the question of whether healthcare consumers should be concerned about the success of their insurance carrier may be different than yours. My answer is, "Yes, there are circumstances in which a patient should care about the economic welfare of his/her health plan."

Historically, healthcare existed in an atmosphere where there were multiple "sides" whose interests were assumed to be in conflict. Consumers wanted to get more care for less cost and wanted their healthcare decisions based on what the patient wanted and not on what he or she needed, or on what was appropriate. Historically, insurance companies did wanted to pay for as few things as possible in order to maximize profits. Historically, healthcare deliverers -- providers, hospitals, nursing homes, suppliers, insurance companies, health plan executives, government policy makers – were seen as antagonists without common interests, or collegial goals.

Partners

Over the past 25 years, participants in the healthcare system have increasingly seen themselves as partners. In the 1990s, many healthcare executives and healthcare providers began to see the value of one another. The organization of healthcare provided by executives was seen to be adding value to healthcare and executives began to see that they could provide more value to their members by collaborating with, rather than competing with and/or fighting with healthcare providers. All of the "deliverers" of healthcare began to see their common interest with each other.

Medicare Part A, B, C, D

Medicare Part A provides patients hospital insurance; part B provides medical office and ambulatory care coverage, and Part D provides patients medication coverage. It is in Part C that the above discussion becomes most relevant. Part C is what is called "Medicare Advantage." This is a program where you get Parts A, B, and D, and a number of other benefits all rolled into one.

It is here where your interest in the health of your health plan comes into play. For the past twenty years, Southeast Texans have had the benefit of Medicare Part C. Depending upon how the health plan is organized, the health plans (insurance company), healthcare providers, and

patients are in a dynamic partnership where their interests become aligned more than in any other healthcare payment model.

Plans, Patients, Providers

Here is how it works. Medicare transfers the risk and the responsibility for the providing of Medicare Parts A, B, and D services to another organization called a Health Maintenance Organizations (HMO), or Physician Service Organization (PSO) for a contracted fee. With this method, Medicare locks in its cost, patients receive additional benefits and limit their cost. Healthcare providers who provide healthcare within this model benefit by providing efficient, excellent and preventive care. If patients practice healthy lifestyles, if health plans promote good health and if providers support patient efforts to maintain their health, the system works.

Depending upon the geographic location, the amount paid by CMS to the health plan is $5,000 to $7,000 a year. That total care is for everything: hospital, medication, surgery, home health, dialysis, immunizations, laboratory work, MRIs, CAT Scans, etc. The availability of this health plan to its membership is based upon the health plan's ability to provide care for all participants within the constraints of the fee paid by CMS to the HMO.

There are strict regulations on Medicare Advantage plans but essentially approved services and rules of eligibility for certain services are the same as for Medicare Part A, B and D. The principle behind Medicare Advantage (MA) is that with care and attentive management of patient care, the cost of care can be decreased while maintaining the quality of that care. The cost of care is expected to be driven down by the health plan, provider and patient working together to decrease the increase in the overall cost of care.

Over the past seven years (2011-2017) the Centers for Medicaid and Medicaid (CMS) has decreased the reimbursement to MA plans by four percent a year for a cumulative decrease of twenty-eight percent. Along with the tax imposed by the Affordable Care Act, extreme pressure has been put on MA Plans.

Interests of Patients. Providers and Health Plans

It is here where the interests of patients and plans merge. Both want patients to receive excellent care and both want the health plan to survive. It is possible for the interests of both to fail if the patient demands care which is not necessary, or if the health plan attempts to limit access to needed care.

It is here where the patient should be interested in the well-being of the health plan. If the health plan, provider and patient work together to provide all care which the patient needs and at the same time eliminate unnecessary and excessive utilization, then this system will work. If the health plan does not provide access to care or if the provider does not provide excellent care or if the patient demands unnecessary tests, procedures or care, then the system will fail.

We will continue this discussion next year with the examination of the difference between "rationed care" and "rationed care."