Risky Business: Profitizing Health Care

The United States has struggled with the effects of for-profit health care for decades. The country has never embraced access to health care as a basic human right. I say this because we don't guarantee heath care for everyone. It has always been a patchwork approach:

- There is the Indian Health Service that provides care for indigenous people living on reservations.
- There is the Veterans Administration that provides care for individuals who served in World War II, the Korean Conflict and most who serviced in Viet Nam. In more recent years and conflicts the VA has set limitations for veterans receiving care based on when they served or whether their health care needs are service related.
- Medicaid is designed to provide care for the poor, but while it is a federally mandated program, it varies from state to state who is covered and what services are provided.
- Medicare provides care for people over 65 and those with disabilities, but it is not free. Recipients have to pay a premium to cover outpatient care and physician services.

Obviously, there are tremendous gaps in this patchwork. While most children are covered, people who are able-bodied and under age 65 are expected to provide for themselves. They may have an employer who provides them with insurance, but this is less and less common. More and more people have to purchase their own insurance on the Marketplace. There is no standardization or basic set of benefits each policy must provide. People often don't realize what is covered or not covered until they need care.

In the United States we know some 26 million people or 8% of the population are uninsured. That says nothing about how many are underinsured, having insurance but unable to afford the copayments and deductibles.

45,000 people die each year as a direct result of not having insurance. The US lags behind other wealthy nations in treatable mortality. More people die from treatable problems for which they fail to get the care they need when they need it.

In the past 20 years we have watched the aggressive privatization of Medicare through a program called Medicare Advantage. It is a privately administered program that has been successful in enticing senior citizens to enroll in this program instead of traditional Medicare. These plans selectively target healthier and thus less costly patients. Even when they enroll seniors with chronic diseases, the structure of Medicare Advantage Plans make it more complicated to access more expensive care. Unlike traditional Medicare, more Medicare Advantage Plans require prior authorization for expensive tests, treatments, and medications.

The federal government bases the amount of funding provided to insurance companies paying for the care of Medicare recipients on the cost of care for the average Medicare patient. As a result of the targeted enrollment of the healthier Medicare recipients, studies suggest these plans were overpaid by between $88 and $140 Billion. Medicare Advantage programs have an overhead of 12.8%, whereas traditional Medicare has an overhead of 2.8% and Canadian Medicare has an overhead of less than 2%. When I refer to overhead, I mean dollars not spent on the delivery of health care. These are dollars that, as a result administrative excesses, were not available to provide care for sicker patients who may have needed it.

In 2023 more than half of all Medicare recipients enrolled in Medicare Advantage Plans. The problem with people enrolling in these plans and then realizing the plan may not serve their best interests is that by the time they realized they have a problem they aren't guaranteed the right to go back to traditional Medicare. Once a patient has been in a Medicare Advantage plan for 12 months, they are not guaranteed coverage in traditional Medicare Medigap policies. These policies are designed to cover potential out of pocket expenses that come with Traditional Medicare such as deductibles which are usually 20% of medical expenses and medications. If they can get coverage, the insurance company is allowed to charge them a higher rate if they have any diagnosed medical problems.

Medical illness or medical debt is the most common cause of bankruptcy in the United States today and has been for many years. We don't protect people from losing their home or all their assets because of medical debt, which one would think is the role of health insurance. The majority of people who declare bankruptcy as a result of medical debt have insurance at the time of the illness. Over 40% of Americans between the ages of 19 and 64 years of age have medical bills or medical debt. 15% of Americans in that age group had to change their way of life to pay medical bills.

If there is a lesson for the rest of the world to learn from the United States it is the lesson of avoiding the private insurance industry. The insurance companies have a fiduciary responsibility to make as much money as possible for their shareholders. They determine which patients have access to what care. There is an inherent conflict of interest here.

While there will always be limitations on how much money is available to spend on health care, society should be making the decisions on what care to provide for the population, not the market. Decisions need to be made based on societal need, cost effectiveness and population health, not profits and financial yields. We know that increased administrative spending results in decreased utilization of health care and that is the engine that drives for-profit health care.

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