Am I Crazy?

Description

I have given the costs of healthcare some thought and I am coming to the conclusion that insurors/payers benefit when the total spend on services is higher. Am I wrong?

An article from Verywellhealth (VerywellHealth is a media brand of IAC that seems to be ad-supported) outlines the basic framework of how payouts for healthcare insurance work:

> â€œ. . . salaries are part of the administrative costs that health insurance companies are required to limit under the Affordable Care Actâ€™s medical loss ratio (MLR) rules. And so are profits.
>
> Under the MLR rules, insurers that sell individual and small group health insurance coverage must spend at least 80 percent of premiums on medical claims and quality improvements for members. No more than 20 percent of premium revenue can be spent on total administrative costs, including profits and salaries. And for insurers that sell large group coverage, the minimum MLR threshold is 85 percent.â€•

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However, an on-point article from NPR addresses exactly the question I am askingâ€“do insurance companies make out when the total healthcare spend goes up? In view of the fact that their gross margin is capped at a percentage of the total premium revenue, they make more when the losses (what they pay out for services to their insureds) are higher, because this gives them the opportunity to increase premiums in ensuing years.

> â€œYou would think that health insurers would make money, in part, by reducing how much they spend.
>
> Turns out, insurers donâ€™t have to decrease spending to make money. They just have to accurately predict how much the people they insure will cost. That way they can set premiums to cover those costs â€” adding about 20 percent for their administration and profit. If theyâ€™re right, they make money. If theyâ€™re wrong, they lose money. But, they arenâ€™t too worried if they guess wrong. They can usually cover losses by raising rates the following year.â€•

The NPR article is framed around a medical expense story in which a patient who the NYU Langone hospital charged $70,000 for a surgical procedure that included a one-night stay. After receiving the bill (for which he was 10% responsible,) he priced many of the elements of the procedure independently and found them provably excessive as compared with Medicare/Medicaid reimbursements.

I recently had outpatient surgery on my wrist that took about four hours end-to-end. My experience was, by and large, excellent. Really attentive and helpful staff, nice new facilities and no complications from pre-op to the OR to post-op to discharge. The hospital billed my carrier $32,000 and was paid about

$12,000. My end of that was about $1,200. Not so bad, I guess. However, I have private small-group insurance that costs me almost $20,000 annually with a $3,000 deductible and $6,000 out-of-pocket limit for my son and me.

Now, I know thereâ€™s a cost to maintaining the facilities and support staff for all of this but is $32,000 the right number? Itâ€™s hard for me to say, partly because itâ€™s nearly impossible to get quotes for what anything costs except by actually using the services, which is a little risky, I think.

We should also consider the price of pharmaceuticals. No one seems to care that much when some hideously overpriced prescription comes with a measly co-pay or is subsidized by the manufacturer. Your carrier is paying whatever you are not, less some negotiated discount that still leaves the prescription wildly overpriced and that all flows into the rate base on which payers make roughly 20% gross margin.

Everyone opposed to Medicare for All as socialized medicine views the existing system as market-based and believes that competition will intervene to hold down costs. One important aspect of markets is the ability to perform price discovery, transparency to which todayâ€™s health care payers and providers seem decidedly averse. I donâ€™t see where anything in the framework in which services are delivered and paid for disincentivizes gouging those who use or pay for them. Seems to me that the insurers have managed to insulate themselves from the actual costs of services quite nicely and itâ€™s us insureds that pay.

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The ACA is certainly better than nothing for the formerly uninsured that have managed to obtain coverage through it. The current administration would like to terminate it leaving those currently served by it with . . . nothing?

I, for one, am getting a little sick of the logical fallacies perpetrated by the healthcare and insurance industries. I have been very fortunate in my life to have had some of the best healthcare available and have not had to move into a refrigerator box on the street as a result. Nonetheless, what we have today is unsustainable and I am not hearing of any concrete plans to change it substantially.

The rest of the world has figured it out. We have to do better than this.

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