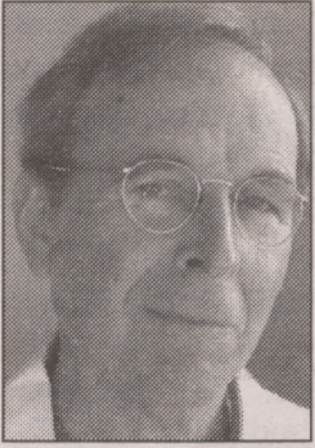


Health Care Reform without Tears, Part 3: Private health insurance

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Part two of this series left readers with the unhappy prospect of an Affordable Care Act (ObamaCare) failing to achieve universal access, lower costs or better health. What about our private health insurance industry? Many individuals and organizations advocate unfettered competition among insurance companies on a nationwide basis, releasing them from the jungle of regulation created by 50 individual states. Free market competition brought down the costs of flat-screen televisions. Can't it do the same for health care?

There is some foundation for this position. After all, most central Europeans finance health care with private insurance companies and their health is better than ours while spending half of what we do.

The flaw in this proposition is in vocabulary. European "Private health insurance" resembles American "Private health insurance" the way European football does to American football. Different games, different goals, different rules.

Yes, European health insurance companies both compete with each other and provide better care at lower prices than American companies do. However, they operate under regulations both alien and unacceptable to American insurance companies.

Europeans created rules to achieve specific goals: provide access for every citizen no matter how sick, or poor, or unemployed; reduce total costs; and improve everyone's health. And European companies succeed.

Americans designed their health insurance rules to achieve what any business in America wants to achieve: to enable insurance companies to make as much money as possible. And, to be honest, American insurance companies succeed. But our rules are different and our goals are different from Europe.

Here are the European rules. Remember none apply to American companies.

(1) An insurance company can charge whatever it wants for a policy, but it must sell it at the same price to everyone regardless of health.

(2) Insurance companies cannot refuse a policy to anyone, sick or healthy. As the Good Book says, "Ask and it shall be given." No exceptions.

(3) Insurance companies cannot drop a patient for any reason, not even failure to pay – the government will make sure premiums are paid. Patients, on the other hand, can change insurance companies at any time without notice. If your client gets one grumpy customer service agent, she takes her business elsewhere.

(4) Every policy must cover every treatable disease. No patient can inadvertently pick a policy

that risks bankruptcy or death if they acquire a treatable disease. Supplemental policies may offer additional benefits, like single hospital rooms, cosmetic surgery, or experimental drugs. Patients can always get more than they need for basic health care, but they can never get less.

This next rule only applies in a few countries.

(5) If the government discovers that an insurance company still manages to cherry-pick healthier patients, the company pays a premium to subsidize companies with sicker patients.

Within these constraints, how can European insurance companies compete? There's not much wiggle room: lower premium prices, added benefits, and improved customer care.

If you were an American insurance executive playing by American rules, how would you compete in the US? Remember, no insurance company makes money selling policies costing more in health care than are collected in premiums.

Offering comprehensive coverage at affordable prices to sick patients who will need expensive care is the highway to bankruptcy.

You would compete by playing it safe.

(1) Pay expert medical underwriters high salaries to predict which patients will cost the most money. Then avoid those patients. The extra costs of underwriters can be passed on to patients by increasing policy prices.

Pricing your policies as high as possible is an excellent way to avoid sick patients. With our health care access determined by income, health follows wealth. If only healthy people can afford your policy, you have elegantly eliminated the most expensive patients to insure.

(2) Carefully craft benefit packages to reduce your financial liability. Remember most patients (and physicians for that matter) are incapable of deciphering what their policy will really pay for.

(3) Discourage policyholders from seeking health care by passing as many costs on to patients. High deductibles, high co-pays, and restricted benefits do the job quite nicely.

Remember most American workers change insurance companies every six years. It makes no sense for an insurance company to invest in preventative care if the savings ten years later accrue to a competing insurance company.

(4) Delay or deny payment to providers as long as possible. After all, you've got the premium money as soon as it is paid; the longer you hold on to it the more investment return you accrue. If you exhaust the patience of the provider long enough, they may even give up without any payment at all. That's money in the bank.

These practices sound cruel, and they may be. However, in contrast to Europe, our rules align business interests against patients and providers. Competition rewards those insurance companies who avoid the sick, pass the most expenses onto patients, and deny both care and payment.

Insurance CEOs who place their clients' medical interests ahead of their company's financial interests will, at best, be fired or, at worst, be arrested for violating their fiduciary obligation to make the interests of their owners paramount.

Removing regulatory barriers to allow free exercise of these rules is thus unlikely to promote better access, reduce costs, or improve health.

One last industry protest: Passing costs to patients (also colorfully known as "cost-sharing," "skin in the game," and "catastrophic-only insurance") makes patients savvy consumers of health care and decreases their health care costs. Is this true?

The experience of European health care systems reveals the opposite. Europeans see their physicians two to four times as frequently and spend more time in the hospital than we do. At first glance they appear to be consuming more care than Americans do. Yet these non-US patients spend half as much as we do for health care and enjoy better health outcomes.

Now it gets easier to understand why health care economics drive us to distraction. Health care does not follow conventional rules of supply and demand. Health care needs do not change when health care costs increase. However much we might covet flat-screen televisions, everyone has a minimal need for health care. But once that need is addressed, we have little incentive to consume more. Few people look forward to painful procedures or hospital food.

European health insurance companies have much to teach us. If our goal is to provide better care to more people for less money, we must apply the three rules of health care financing, noted in the first part of this series and used successfully in every industrialized country other than ours.

(1) Include everyone, even the sick.

(2) Encourage patients to seek care by lowering or removing deductibles, co-pays, and excluded conditions.

(3) Finance health care with publicly accountable, transparent, not-for-profit agencies.

With considerable disappointment, we must acknowledge neither the Affordable Care Act nor our American health insurance industry will pull our health care system back from the brink of destruction. But, as promised, the next and final part of this series will present refreshing news, that we can still create a cost-effective health care system in Oregon.

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