

Opinion

When Does Reality Set In? When It Happens to You

In March 2009, when discussing the protocols designed to prevent wrong eye/wrong IOL surgery, I opined in this column that I had considered such precautions unnecessary, or at least frivolous, until I came close to committing such an error myself. It was one of those “Now I get it” experiences.

This month, I have a different sort of epiphany to report. I was one of those 70 percent of Americans who was reasonably secure with their own personal medical insurance. You know, one of the people that President Obama is trying to convince that such security is misplaced because that kind of insurance is likely to be unaffordable, or unobtainable, in the future. Still, I wasn’t anxious to scrap what I had in the civic spirit of health care reform.

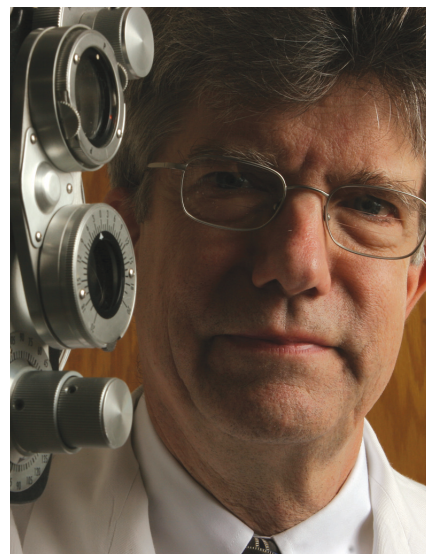
Then, in mid-July I received a letter from my insurer. “Dear Subscriber,” it began. How refreshing, I thought, to get a letter from them that didn’t begin with “Dear Provider.” But my good feelings were soon washed away as it continued, “We have decided to cancel your insurance and disband the group under which you are insured . . . You have two weeks to apply for an individual policy” (at twice the rate and half the benefits), “or you will have to complete a health questionnaire and be subject to disapproval.” I reread the letter several times, and there was not a single word of explanation of why

this action had been taken. Since I have friends on the “inside,” I learned that my group (all physicians and their families) had experienced a million-dollar obstetrical-neonatal claim. Instead of spreading the risk of such a rare event across their universe of insureds, the company chose to attribute the adverse event to our group of 300, thus rendering the group unratable and expendable.

Like most physicians, before this happened I had little love lost for private for-profit insurance companies. As mostly public companies, they are forced to file annual statistics with the Securities and Exchange Commission. One statistic, deliciously entitled “Medical-loss ratio,” describes the percentage of premium revenue that is “lost” paying for care. In each of the past eight years, PricewaterhouseCoopers’ Health Research Institute has fixed that number across the health insurance industry between 80 and 83 percent. In other words, 17 to 20 percent goes to administrative costs and profits. By contrast, Medicare spends 2 percent on administrative costs, and, of course, nothing on profit. My billing people tell me that they spend per claim about twice or three times as much time on private insurance fighting denials than they do on Medicare or Medicaid, so there goes a few more percent. And then there are the scurrilous, obviously unconfirmed reports by disgruntled ex-employees of insur-

ance companies’ claim departments that they were expected to fulfill a quota of denied claims. Also, it was some genius in the private insurance world who reasoned that a b.i.d. medication would need 62 pills *or eyedrops* per month and *no more*, never thinking that it’s easier to hit your mouth with a pill than your eye with a drop.

Before my insurance cancellation letter, I was willing to look the other way. After all, this is America, and we are capitalists, and everybody has the right to make a profit. But since then, I’ve begun to realize that if losing excellent existing medical coverage could happen to me, it could happen to anyone. Now I get it.



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