The for-profit health insurance racket: From HMOs to “Value-based care”

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The killing of United Health Care CEO Brian Thompson by a gunman motivated by anger over the denial of health services by giant corporations has unleashed a flood of popular outrage on social media. There have been hundreds of thousands of posts denouncing the daily actions of profit-driven corporations to deprive working people of the health care which they need.

One of the principal techniques employed by the American medicine-for-profit system is to expand and extend the process of getting approval for necessary care, with the cold-blooded calculation that faced with interminable wait times and endless paperwork, many patients will simply forgo treatment that would cost money for the insurance companies. In the worst case scenario for the patients—or the best case, in terms of corporate profits—the patients will die before receiving care that is “too expensive.”

The policy of deliberate delay is generally disguised behind a display of concern, which is perfectly sincere on the part of doctors, nurses and other health care workers. But it hardly applies to insurance companies, which, like all capitalist enterprises, exist to generate profits for their shareholders and high salaries to their executives, regardless of the wider outcome of their operations.

When a person with an ailment seeks medical treatment, he or she may assume the doctor, clinic, or emergency department decides what services they need to find out what’s wrong so they can be treated. Do they need an X-ray, CT scan or MRI? Should they stay overnight in a hospital because of chest pain? Can medication help?

However, the American medical system has travelled a long way from a simple consideration of health issues. If you ask today who decides what health care services you need, the answer may include:

· The federal government, including Congress and the Centers for Medicare and Medicaid Services (CMS)
· Employers
· Insurance companies
· Private equity firms
· Drug companies and pharmacy benefit managers
· Health care business consultants

With advances in science and technology, and an aging population, the cost of health care keeps rising. National health expenditures grew 7.5 percent to $4.8 trillion in 2023, equaling $14,423 per person and 18.3% of Gross Domestic Product (GDP). When the media, politicians, or government agencies create plans to cut healthcare spending, they don’t touch the profits of pharmaceutical companies, hospitals, investors, and nursing home owners, or the salaries of the CEOs. The main goal is to create ways to cut services for the working class, while mouthing their concerns for patients, “patient care” and the “patient experience.” The result is that as health care spending increases, the health of the US population continues to decline.

The health care industry has perennially blamed doctors for the high costs of medical care, since doctors were paid for the health care services provided to the patient under a fee-for-service arrangement. The Blue Cross Blue Shield Association put it this way: “The traditional fee-for-service system rewards doctors and hospitals for the volume of care that they provide rather than the quality of care. That means doctors are paid more for seeing more patients and performing more services, such as tests and other procedures, even if the treatments they provide patients are ineffective.” So goes the argument to blame doctors.

The federal government, particularly the Centers for Medicaid and Medicare Services, has been at the forefront of the push to cut medical care for the working class. The federal government’s goal of reducing heath care expenditures is two-pronged: to control how much health care patients get, and to shift the cost of healthcare onto the patients.

Health care as a commodity

Limiting access to care began with the creation of Health Maintenance Organizations.

In 1973, the Nixon administration enacted the Health Maintenance Organization Act and authorized $375 million to help set up and expand HMOs. The act required employers with 25 or more employees to have an HMO option if they offered health insurance coverage.

HMOs are a type of managed care health plan financed by an insurance company. The HMO has a network of health care providers that treat a patient population for a capped cost (called capitation). This arrangement gives an incentive to the health care professionals to spend less than they are being paid for health care services. The primary care physician usually must approve all care—thus the reference to the primary doctor as a “gatekeeper”—and may need to give the patient a referral before he or she can see a specialist.

The HMO Act exempted these plans from state laws that kept medical decisions in the hands of doctors. As a result, medical decisions could now be made by insurance companies and government agencies. The act also allowed HMOs to be for-profit, opening the door to for-profit health insurance.

Many patients with HMO insurance, therefore, questioned their doctor’s and insurance companies’ motives when they were denied care, so HMOs have become unpopular. In 2023, only 13 percent of workers were enrolled in HMOs.

Other ways to limit the use of health care were introduced in the 1990s. Harvard Business School professor Regina Herzlinger promoted the benefits of “consumer-driven” health plans. Health care was put under the “consumerism” umbrella.

In the past, health plans offered by employers to workers defined the benefits that the insurance covered, such as doctor visits, surgeries, etc. To have access to the benefits employers and employees pay toward the premiums for the insurance plan. With “consumer-driven” or “consumer-

directed" health plans common these days, workers must choose from among high-deductible plans, meaning they have to pay thousands of dollars for medical services before the insurance company begins paying.

A *Health Affairs* column noted, "In our view, a narrow focus on consumerism is conceptually confused and potentially harmful. The consumer metaphor wrongly assumes that health care is a market in the usual understanding of that term, that the high cost of US health care is a function of excessive consumer demand, and that price transparency and competition can deliver on the promise of reducing costs or ensuring quality. Furthermore, a consumer metaphor places disproportionate burdens on patients to reduce health care costs, and it could erode professional obligations to provide appropriate and effective care" (Michael K. Gusmano, Karen J. Maschke, and Mildred Z. Solomon, March 2019).

"Value-based care"—but whose value?

Another idea was introduced in 2006. Michael Porter and Elizabeth Olmsted Teisberg outlined the concept of "value-based care" in their book *Redefining Health Care: Creating Value-Based Competition on Results*. They advocated a "health care system in which every actor is focused on improving value, as measured by health outcomes per dollar expended."

The CMS definition of "value-based care" is highly subjective:

> Value-based care is a term that Medicare, Medicaid, doctors and other health care professionals sometimes use to describe health care that is designed to focus on quality of care, provider performance and the patient experience. The "value" in value-based care refers to what an individual values most.

For the patient, of course, longevity and quality of life are uppermost. Likewise for health care professionals, who for the most part have entered and continued in this high-stress profession because they find delivering good care to fellow human beings highly rewarding. But in the case of for-profit corporations, which dominate the health care system, "value" is purely economic. So terminology which may seem entirely positive to patients and providers actually masks something very different: the drive by capitalist enterprises to cut costs and boost profits, at the expense of health and even life.

In 2010, Congress enacted the Affordable Care Act (known as Obamacare). Following its passage, value-based care programs grew in size and scope. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) tasked with designing, implementing, and testing care payment models to help lower health care spending for Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The ACA funded CMMI $10 billion for the years 2011 through 2019, and allocated another $10 billion for CMMI each decade thereafter.

Of the over 40 programs implemented by CMMI, one of the biggest has been the Accountable Care Organization (ACO). ACOs give health care providers incentives to reduce overall spending. Since the federal government introduced ACOs, CMS has implemented many ACO models. Insurance companies have done so as well, creating their own ACOs for their patient populations.

The federal government reduced Medicare and Medicaid reimbursement rates under the Affordable Care Act to move the health care industry away from fee-for-service. In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act to further speed up the adoption of value-based care. CHIP is the Childrens Health Insurance Program, under which the federal government gives matching funds to states to provide health coverage for lower-income families when they do not qualify for Medicaid.

The legislation created the Merit Based Incentive Payments System for doctors who provide "cost-effective" care. While declaring, with its usual verbiage, that the care should be "high quality," the goal is to give financial rewards for cost cutting.

While rates were reduced, CMS developed value-based incentive payments and alternative payment models to reward "affordable" care rather than the volume, that is, how much care was given to patients. However, many health professionals participating in value-based initiatives through CMS are not ready to do so. The increase in administrative reporting and data collection has resulted in financial penalties for many providers.

Other techniques of profit maximization

Health insurance companies have designed other ways to cut spending on health care with high-risk doctor's contracts. For example, in the fall of 2022, six physician groups signed full-risk reimbursement deals with Blue Cross Blue Shield of Michigan for the care of patients under its Medicare Advantage PPO and Blue Care Network Medicare Advantage plans. BCBSM is the state's largest health insurer. The contracts cover 670 primary care physicians in the state with 55,000 members under their care.

A full-risk arrangement puts financial liability on the doctor's practice in exchange for a larger potential reimbursement for providing what the insurance companies claim is high-quality care. When physicians meet outcome and cost goals for each patient, they get paid more by insurance companies. For doctors, the message is clear: the less you spend on patients, the greater your rewards.

Another cost-cutting device is a bundled payment methodology. It involves combining the payments for physician, hospital, and other health care provider services into a single bundled payment amount. This amount is calculated based on the expected costs of all items and services furnished to a beneficiary during an episode of care.

As one analyst describes it, "Payment models that provide a single bundled payment to health care providers can motivate health care providers to furnish services efficiently, to better coordinate care, and to improve the quality of care. Health care providers receiving a bundled payment may either realize a gain or loss, based on how successfully they manage resources and total costs throughout each episode of care. A bundled payment can create incentives for hospitals and physician group practices a provider or supplier to coordinate and deliver care more efficiently."

The combined effect of all these mechanisms is to drive profit maximization deeper and deeper into the structure of the health care system, perverting its essential human purpose—to use science and technology to extend and better human life—and transforming it into yet another means of extracting wealth out of the population and funneling it into the pockets of the super-rich.

As the experience of countless health care "reforms" over the past half-century have demonstrated, profit considerations are entirely antithetical to the operation of a health care system that maximizes human welfare and minimizes pain, suffering, uncertainty and the economic catastrophe that accompanies illness under capitalism.

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