

Healthcare Reform Overview

Presented by

David Burress

President, Ad Astra Institute of Kansas

Presented to the

**The Unitarian Fellowship of
Lawrence**

1263 North 1100 Road, Lawrence, Kansas

September 20, 2009

David Burress

- Research Economist
- Retired from KU's Institute for Policy and Social Research in 2004
- Focus on public economics, regional economics, benefit-cost analysis, law and economics
- Founding president of Ad Astra Institute.

Ad Astra Institute of Kansas

Mission:

A broad-spectrum progressive think tank

- 501(c)(3) nonpartisan nonprofit since 2005
- Membership organization
- Scope: Kansas state-wide policy research
 - Objective but value-driven policy analysis
 - Political strategy analysis
 - Communication analysis
- Goal: pragmatic progress for ordinary people

AAI's political niche

- Strategy: fill the Kansas policy research gap
- Other Kansas think tanks --
 - Market fundamentalist tanks: distorted ideology
 - Academic and legislative tanks: non-advocacy
 - Single issue groups: loss of big picture
 - Executive policy shops: Governor sets the goals

Topics

- The state of US medicine:
 - Two sectors
 - Three catastrophes
 - Three kinds of reform
- Insurance reform goals
- Insurance reform mechanisms
- Cost containment and quality improvement reform goals

Three catastrophes

As compared with other industrialized countries:

- **Uninsurance:** US is the only country with massive health care deprivation
 - due to absence of national health care
- **Cost:** US health care costs twice as much as in other countries
 - due public policy failures
- **Quality:** US health care is near the bottom in average quality and outcomes
 - despite cutting edge research and care

Percentages of GDP

COUNTRY	System type	Total health care expenditure	Out-of-pocket user fees	Direct cost of insurance administration	Per capita healthcare expenditure
USA	Mixed	15.3%	1.7-2.0%	1.2%	\$6,401
Australia	Single payer + supplem. insurance	9.5%	1.2-1.9%	0.3%	\$3,128
Canada	Single payer	9.8%	1.2-1.5%	0.4%	\$3,326
Germany	Social insurance funds	10.7%	0.8-1.4%	0.6%	\$3,287
United Kingdom	Socialized medicine	8.3%	0.50%	0.3%	\$2,724
Data year		2005	c.1996- 2005	2005	2005
Sources	[1]	[2]	[3]	[4]	[5]

Performance measures

COUNTRY	Deaths amenable to healthcare per 100,000	Same day appointments for serious primary care	Access restricted by cost during year	Overall performance ranking/ 1=best	Adult tobacco use
<i>USA</i>	110	46%	37%	6	16.9%
<i>Australia</i>	71	63%	26%	3.5	17.7%
<i>Canada</i>	77	32%	12%	5	17.3%
<i>Germany</i>	90	58%	21%	2	24.3%
<i>United Kingdom</i>	103	57%	8%	1	24.0%
Data year	2002-2003	2007	2007	c. 2005	2004
Sources	[6]	[6]	[6]	[6]	[5]

Two sectors

- Health care finance
 - raise funds
 - patient interface: determine services
 - provider interface: make payments
- Health care delivery
 - recommend goods and services
 - provide goods and services to patient

Three types of reform

- Health care finance
 - insurance reform
 - currently the main topic in Washington
 - also the main topic of this talk
- Health care delivery
 - quality reform
 - cost containment reform
 - The two are closely connected. Bad medicine is expensive.

Health insurance theory

or

Why does private insurance stink?

- Medical care is a necessity
- Health insurance is a necessity
 - since few can afford major medical events
- Insurance = a “risk pool”
 - everyone pays in
 - people draw out when they need health care
 - the larger the pool the better it works
 - SINGLE PAYER(=1 single risk pool) works best
 - that usually means government is the insurer

Health insurance theory continued— “adverse selection”

- Why insurance companies race to the bottom
 - avoiding claims is the key to profits
 - cherrypicking: insuring only those who least need it (& fragmenting the risk pool)
 - companies that do the best cherry picking charge the lowest premiums
 - that puts other people into a more expensive risk pool
 - that drives up premiums for those who most need insurance

How insurance companies avoid claims

- They “cherry pick” and provide “phantom insurance”:
 - Underwriting (i.e., refusing to cover sick people)
 - Marketing only to well people or healthy groups
 - Exclusions: pre-existing conditions, etc.
 - Copays, deductibles, etc.
 - Maximums and coverage limits
 - Arcane procedures & opaque contracts
 - Rescissions (dropping your policy when you make a claim because of “false data”)
 - Arbitrary claim rejections, stonewalling, etc.

Avoiding claims is hugely expensive

- Medicare spends 2 or 3 % of your money on administrative costs to keep you covered.
- Private insurance companies spend 10% to 30% or more of your money to keep you from being covered.
- They do it to maximize profits.
- Ironically, their actual profits are a relatively small share of your money (typically 2 to 4%)!

Health insurance theory continued– regulating doctors

- Doctors determine needed care
 - suppliers create their own demand, hence:
- Competition for patients doesn't regulate doctors.
- Private insurers don't regulate doctors enough, due to:
 - conflict of interest--increasing medical costs means increasing dollar value of insurance
 - coverage denial easier than regulating doctors

Health insurance theory continued— “moral hazard”

- (Positive) moral hazard:
 - patients allegedly consume “too much” health care when insurance pays for it
 - the conservative argument for high copays
 - it isn’t true—doctors set what patients consume
- (Negative) moral hazard:
 - patients consume too little health care due to out-of-pocket expenses
 - lots of evidence that this happens
 - this is why we need FULL insurance

Insurance reform

- Major issues:
 - Coverage
 - universal care, affordable care, insurance hell
 - Industry structure
 - single payer, public option, private insurance, regulation
 - Funding
 - taxes, mandates, premiums
 - Impact on deficit
 - cost containment, government vs social cost

Some types of coverage

- Universal full coverage
 - All medically necessary care is provided with no out-of-pocket costs
- Universal coverage
 - All medically necessary care is available with limited out-of-pocket costs
- Affordable health care, affordable insurance
 - Good insurance is available at a price that (government says) you can afford, with subsidies
- Affordable health care plus mandates
 - Employers must provide and/or individuals must purchase
- Insurance hell
 - Age 50-64 or pre-existing condition or poor and seeking individual insurance.

What is so important about universal coverage?

- Ethics: health care is defined as a right
- Community: we are all in this together
- Revenue sufficiency: since you can't opt out, you can't easily avoid contributing
- True insurance: complete assurance you will still be covered next year, as will your family
- Full insurance: protection against medical bankruptcy

Affordable health insurance

- “Affordable health insurance” is something of a weasel phrase. It does NOT mean “universal health care.”
- It applies only when people are making choices about what insurance to purchase.
- Full universal coverage means there is no purchase choice.
- Even if it is “affordable” (according to the government), some people won’t buy it and won’t be covered.
- How good is the insurance?

Affordable health insurance plus mandates

- This phrase is almost an oxymoron. If the mandates are truly enforced then affordability doesn't really come into it.
- Massachusetts has this kind of plan.
- Nevertheless, 5.4% of Massachusetts residents are not covered by any health insurance [7]. Mandates need not lead to universality.

Congressional plans— coverage

- Obama and all committee plans call for affordable insurance plus mandates.
- The House and probably the Senate will allow a vote to substitute a full coverage single payer plan. It will almost surely fail.
- The devil in the details: how good is the insurance?

Industry structure

- Single payer
 - 1 risk pool covering all medically necessary care
- Mixed affordability system
 - single payer Medicare/Medicaid for some, regulated and subsidized private insurance for others
- Public option
 - mixed affordability system plus a government plan that competes directly with private insurance
- Deregulation
 - let private insurance companies run wild

Single payer is the gold standard for administration

- Single payer has the lowest administrative costs.
 - The cost savings from eliminating private insurance would more than pay for covering the uninsured.
- Single payer is the only way to get true universal coverage.
- Single payer is the only way to insure equality of coverage for everyone.
- Single payer does well in polling
 - except inside the beltway.
- Single payer is the best basis for cost containment.

Single payer, continued

“I want to cover everybody. Now, the truth is that, unless you have a single-payer system, in which everybody is automatically covered, then you're probably not going to reach every single individual” (President Barack Obama, 2009).

Congressional plans— industry structure

- Obama and all committee plans call for mixed affordable systems, either with or without a public option.
- The House and probably the Senate will allow a vote to substitute a single payer plan. It will almost surely fail.
- There will also be a vote to allow single payer plans at the state level. That has a good chance of succeeding.

Industry structure, continued: the public option

- Obama and most committee plans call for a public option.
- Sen. Baucus's Finance Committee plan has no public option.
- All republicans oppose a public option.
- A majority in both houses support it.
- Obama is wavering.
- Getting a public option depends on willingness to bypass the filibuster.

Industry structure, continued: insurance regulation

- Obama and all Congress committee plans call for strong limits on cherry picking and phantom insurance, and create regulated exchanges with standardized benefits.
- The insurance companies agree in principle, provided there is a coverage mandate for everyone.
- New regulations seem almost sure to pass.
- The devil is in the details.

Funding

- Money sources under consideration in Congress include
 - New and iffy cost containment schemes
 - A tax on insurance companies
 - A tax or deductibility limits on high-dollar insurance policies
 - Cost controls on drug prices
 - Removing subsidies to insurance companies under Medicare Part C
 - Purchase mandates

Impact on deficit

- Obama and Congressional leaders have promised no impact on deficit.
- That's measured by the Congressional Budget Office, which takes a dim view of Obama's cost containment claims.
- Because taxes are key, this will probably get settled secretly at the last minute in the conference committee.

Conservative snake oil

- Conservatives have pushed a number of alternatives that would make us worse off. Their ideas include:
 - Reduce state regulation (by allowing sales across state lines)
 - Speeds the race to the bottom
 - Replacing insurance for routine health care with medical savings accounts
 - Causes people to avoid needed care
 - Useless for poor people

Conservative snake oil, continued

- Taxing group insurance benefits
 - Forces people onto individual insurance, which is more costly and harder to obtain.
- Replacing the public option with coops
 - Coops are already possible. They rarely succeed.
 - Raising capital is a problem.
- Tort reform
 - Takes away recourse against malpractice.
 - Various reforms tried in about 40 states since 1986 haven't noticeably lowered medical costs.

The medical cost catastrophe

- 16+% of GDP is direct cost of health care
- Twice as high as other countries
 - For inferior care
 - Meaning at least 8% of GDP is being wasted
- Increases 1 percentage point every 3-4 years
- Major drag on economic competitiveness
- Indirect value of bad health care equals an *additional* 5 to 10% or more of GDP
- Bottom line: at least 1/7 of GDP is wasted

Sources of 8% excess direct cost in the US (as % of GDP)

my estimates

- 1-2% Excess bureaucracy [8, 9]
 - Private insurance company overhead ~1%
 - Providers' compliance costs ~1%
- 1% Inflated drug prices [10]
- <1% Simple fraud [11]
- ~4% Bad medical delivery systems [12]
 - Overtesting and overtreatment
 - Specific controllable medical errors
 - General lack of cooperation or orientation to quality
- 1-2% High doctor's salaries [13]

Summary of key upcoming decisions

- Allow state-level single payer?
- Public option? What are the details?
- Sources of funding
- Cost containment methods
- Details of regulations on insurance companies.
- Bipartisanship? probably a lost cause.

END

Comments or questions? Contact:

David Burress

President, Ad Astra Institute of Kansas, Inc.

912 Holiday Drive

Lawrence KS 66049-3005

Email: david.burress@adastrainstitute.org

Web: www.adastrainstitute.org

Facebook: Ad Astra

Phone: (785)749-1218

FAX: (208)977-5833

Sources

- [1] Classified by the author
- [2] OECD (2006)
- [3] Calculated from OECD (2006), American College of Physicians (2008), and Anderson *et al.* (2002)
- [4] Calculated from OEDC (2006) and Commonwealth Fund (2008)
- [5] World Health Organization (2007)
- [6] Commonwealth Fund (2008)
- [7] Nardin et al. (2009)
- [8] Administrative overhead = 7.3% in US, 2% elsewhere (Commonwealth Fund ,2006). $(7.3\% - 2\%) \times (16\% \text{ of GDP}) = .8\% \text{ of GDP}$.
- [9] Providers compliance cost assumed equal to insurers overhead = .8% of GDP
- [10] Drug costs are 10% of US health care costs; 60% lower in countries that negotiate central prices; $60\% \times 10\% \times (16\% \text{ of GDP}) = 1\% \text{ of GDP}$

Sources, continued

- [11] Fraud estimated at 4+% of Government in funded medical programs, Medicare, Medicaid (Inglehart, 2009) .Rate is likely lower in other sectors. $4\% \times (16\% \text{ of GDP}) = .6\% \text{ of GDP}$.
- [12] Bad medicine: Medicare data showing regional differences (Gawande, 2009). Bad practice areas cost at least twice as much as good practice areas, yet have worse outcomes. Hence over half of medical costs are wasted. To avoid double counting, focus on medical costs after removing previous sources of waste: $1/2 \times (16\% - .8\% - .8\% - 1\% - .6\%)$ of GDP = 6% of GDP. Assuming that only 2/3 of this waste can be removed in practice suggests an available 4% improvement.
- [13] US Doctor's salaries total about 3% of GDP, while salary shares in OECD countries averaged up 1.4% of GDP (Reinhardt et al, 2002). The gap is 1 -2% of GDP.

References

American College of Physicians. 2008. Position Paper: Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries, *Annals of Internal Medicine* 148, pp. 55-75 (accessed January 30, 2009 at http://www.commonwealthfund.org/usr_doc/Survey_Schoen_2008intlhltpolicysurveyeightcountries_chartpack.ppt?section=4056)

Anderson, Gerald F.; Varduhi Petrosyan; and Peter S. Hussey. 2002. *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October (accessed January 30, 2009 at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221239)

Commonwealth Fund . 2006. *National Scorecard on U.S. Health System Performance, 2006*.

Commonwealth Fund. 2008. *National Scorecard on U.S. Health System Performance, 2008--Chartpack, Commission On A High Performance Health System*, July (accessed January 30, 2008 at http://www.commonwealthfund.org/usr_doc/Survey_Schoen_2008intlhltpolicysurveyeightcountries_chartpack.ppt?section=4056)

References, continued

Gawande, Atul. 2009. "Annals of Medicine--The Cost Conundrum: What a Texas town can teach us about health care," *The New Yorker*, June 1 (accessed June 26, 2009 at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all)

John K. Inglehart. 2009. "Finding Money for Health Care Reform — Rooting Out Waste, Fraud, and Abuse," *New England Journal of Medicine*, June 10, www.nejm.org (10.1056/NEJMp0904854)

Nardin, Rachel; David Himmelstein; and Steffie Woolhandler. 2009. "Massachusetts' Plan: A Failed Model for Health Care Reform," Physicians for a National Health Plan, February 18 (accessed April 9, 2009 at http://www.pnhp.org/mass_report/mass_report_Final.pdf)

Reinhardt, UE; Hussey, PS; and Anderson, GF. 2002. "Cross-national comparisons of health systems using OECD data, 1999," *Health Affairs* (Millwood), 21(3), May-June, pp.169-181 (accessed September 21, 2009 at <http://content.healthaffairs.org/cgi/content/full/21/3/169>)

World Health Organization. 2007. *World Health Statistics 2007*. (Accessed January 29, 2009 at www.who.int/whosis/whostat2007.pdf)

Organization for Economic Co-operation and Development. OECD Health Data 2006: frequently requested data. Accessed at www.oecd.org/document/



*Ad Astra
Institute
of Kansas*