

Health Care Reform: Separating the Wheat from the Chaff

By
Andrew Kurz*
Miles J. Zaremski**

It is time to hit the reset button---not on legislation---but on all the disparaging rhetoric surrounding it. Denigrating a position or viewpoint one knows nothing about or is premised on incorrect "facts" makes it harder to adopt positions that best serve what Americans need and really want. It is also more difficult to garner broad support from the general public if one succumbs to only what special interests desire.

The shot across the bow sent Democrats by the voters of Massachusetts with the election of Scott Brown can have many meanings, but one in particular has to be striking: politicians in Washington are not getting things done to help us outside the beltway. A clear message from the Massachusetts' electorate was that it is just as easy to remove an elected-official, as it was to vote that individual into office.

Americans are rightly upset with Washington, and certainly with good reason---particularly with health care reform, and other major pieces of legislation. So little gets done, and when something is finally accomplished, it generally contains much unneeded and unnecessary pork.

We are here to focus strictly on explaining health care reform issues that make sense to all parties. The focus is *not* on the current state of legislation, on Congress, or on the President. We begin with the premise that accessing and affording health care in this country is truly broken. On that, there is universal agreement. Most would also agree that *basic* health care is a right for all Americans, not a privilege or responsibility---although a measure of personal responsibility is

certainly involved. The authors also have the luxury of being “outsiders” and are not otherwise bound by having to politically compromise. We can look at the best of what both sides of the aisle have offered that every American can readily understand and assimilate into their own experiences and household needs.

We offer a couple of other observations before we do. Of the 2,000 pages in either the present House or Senate bills, less than 20% of them are concerned with much discussed reforms to private health insurance. The remaining portions improve Medicare and Medicaid, and as well public health and the workforce. Those changes are extremely important to bending down the cost curve for a segment that consumes about 50% of all health care dollars. Ironically, for those who believe that reform is socialism, these programs are **already** *government* managed or sponsored.

Health care is cast in terms of *affordability* and *accessibility*. Affordability is typically cast through the prism of a health insurance policy since that is how and where the majority of Americans receive their care. Main Street also knows that what they pay for insurance is out of sight---sending thousands into bankruptcy, and, for millions, effectively denying them any insurance coverage at all. For the overriding majority of the uninsured, insurance premiums either would consume far too much of their income, or they are locked out because of some pre-existing condition. So health care reform, at least for starters, is health insurance reform.

Insurance reform has three fundamental goals or objectives: lowering costs, increasing availability, and maintaining or improving quality. While there is wide agreement on these goals, there remains less agreement on how to achieve them. When reviewing the paths to achieve each of these “end points”, the question is,

whether they lead to progress toward achieving them (goals) or whether the means to get there are simply different paths with no discernible difference in outcome.

The strength of any analysis must focus on the former, as we now do.

ISSUES ON WHICH THERE IS BROAD AGREEMENT

The following objectives of which we speak have no adversary, though politics has a habit of tinting some folks' glasses.

1. **Accessibility:** Broad agreement exists that insurance policies should (a) *not* exclude pre-existing conditions; (b) *not* allow cancellation of an existing policy owing to a medical condition; (c) guarantee issuance and renewals; (d) extend dependent child coverage to 26 years; and (e) allow cancellation only premised on non-payment of premium or fraud in the procurement of a policy.

2. **Affordability:** Broad agreement also exists that insurance policies should (a) *not* set lifetime or annual limits on benefits; (b) set reasonable annual limits for cost sharing, *i.e.*, deductibles and co-pays; (c) *not* allow pricing differentials based on sex; (d) set reasonable restraints on age-related differentials; and (e) create a national high risk reinsurance pool to protect insurers from the few enrollees who incur extremely high cost medical treatments.

(3) **Quality:** Broad agreement also exists that insurance policies should (a) *not* require cost-sharing for basic, preventive health care services, though not necessarily for visits beyond recommended check-up intervals; (b) require an essential benefits package that covers all basic health care needs and allows comparison based only on price and service; (c) standardize forms in order to reduce paperwork and inefficiency in processing claims and enrollment; and (d)

further the work of computerizing necessary medical information without running afoul of privacy laws.

Virtually every other industrialized country worldwide has health care inclusive of the above provisions. These nations also provide universal coverage, exceeding the 95% range. While all such programs operate differently, all have a private marketplace component and deliver health care at half the cost and with about the same average quality as the U.S. Moreover, while the U.S. leads other nations in some criteria used to judge access and affordability, it lags in other criteria. One measure where our country lags is the number of patient visits. Our falling down on this measurement is oxymoronic to the claim that the US has the best health care system while citizens elsewhere wait an interminable amount of time to see his or her physician.

ACCESSIBILITY ISSUES ON WHICH THERE IS LESS AGREEMENT

While Medicare at 55 has been proposed to increase accessibility, the three major avenues to increase accessibility have been: (1) a public option; (2) lifting the antitrust exemption; and (3) allowing insurers to sell health insurance across state lines. We address the latter three now.

PUBLIC OPTION: Arguments favoring a public option are that it would be a non-profit insurer with the sole goal of providing basic insurance while incurring minimum overhead. This should bend prices down which also improves affordability. Arguments against a public option are that it adds government insurance into the mix, pulling business and profit margins away from private insurers. It is fair to note that private insurers did not object to government

insurance for seniors – Medicare –which took the lion’s share from private insurers, though the private market still operates within segments of these programs.

ANTI-TRUST: The second method for increasing access through competition is to remove private insurers’ anti-trust exemption. This exemption allows insurers to not only collude on setting premium prices, but also to monopolize markets of whatever size. Both promote concentration, less competition, and higher prices.

SALES ACROSS STATE LINES: The third method is for insurers to sell across state lines. There are two ways to achieve this. The first alternative is leveling the playing field with a uniform set of rules that a national exchange would establish, similar to what CAFE mileage standards do for car manufacturers when mandating “corporate average fuel economy” that apply in all states. A national exchange is the health equivalent for enforcing uniform standard rules. The other alternative is to use the credit card “model”, where different rules apply to different policies depending upon the insurer’s home state. The question becomes, would the public prefer insurers to act more like credit card companies (banks) with no federal intervention, or to participate on a level playing field with federal enforcement?

AFFORDABILITY ISSUES ON WHICH THERE IS LESS AGREEMENT

TORT REFORM: High on the list for many is tort reform, though neither pending bill in Congress includes this. Typically cast in terms of placing caps, or ceilings, on non-economic damages, it is an element of the health care reform debate that has gained attention in many quarters. Many states already have such reform, but this would be a federal cap. The argument in favor of caps on these damages is that there would be less defensive-medicine, overall health care costs would drop

significantly, and doctors would find their malpractice insurance premiums lowered. The argument against caps is that there is minimal relationship between caps on these type damages and premium charges, or health care costs. Opponents argue that premiums increase more as a result of insurers' not obtaining projected financial returns from investments while "defensive medicine" has more to do with generating income than avoiding liability.

If the theory is correct, *viz*, that a cap on damages will reduce health care costs, consider establishing a 3-5 year period with a federal cap of, let's say, \$1.0M on non-economic damages and that would not pre-empt states which have such ceilings in effect. If utilization drops significantly indicating less defensive medicine, then such caps could become permanent; if not, then the federal cap would sunset.

AFFORDABILITY CREDITS: Affordability credits are a sliding scale subsidy for individuals and families earning less than some multiple of the federal poverty level (FPL). The House suggested an upper limit of 400% of FPL while the Senate proposed less. To fund affordability credits (the premium subsidies), a tax could be levied on individuals with adjusted gross income exceeding \$250K (\$500K for families), and taxing plans with "Cadillac" benefits. Rather than setting a flat rate, a fairer method would be to use regional cost bases, and to tax only the amount exceeding some percent of average, basic, benefits by region. Arguments for and against affordability credits tend to center on the method of funding. The two above are funding options under consideration.

PURCHASE MANDATE: This provision mandates that all citizens purchase health insurance. Arguments in favor are that by adding millions of customers,

insurers would incur lower costs. First, overhead would be allocated over more policies creating unit savings. Second, with larger risk pools, the “risk margin” insurers require would be less, which should lead to lower premium prices.

Mandatory insurance would also have the salutary effect of reducing the number of those without insurance who rely on hospital emergency rooms for non-emergency health care---a very inefficient way to render treatment. Arguments against mandatory purchase includes whether such a requirement is constitutional, though it seems similar to employees “purchase” of Medicare insurance through wage withholding at work. Those who do not favor a mandate as well point to insurers’ gaining considerably in revenues, yet question whether or not insurers will increase premiums for any new insurance reforms, like no pre-existing condition barring coverage.

The only way a mandate works is if affordability credits are extended to millions of financially disadvantaged. Those affordability credits will come from government subsidies, and because taxpayers are responsible for these monies, many believe it fair to expect insurers to discount, or reduce, premium charges when setting rates. Insurers are not likely to do this voluntarily. Price controls are one way to restrain premium rates, but are not viewed as a long term solution. The best solution remains competition. This is why many argue that the anti-trust exemption must end, though they feel even that may not be enough; that stronger measures are needed. The current mix of for-profit and not-for-profit insurers has not been successful in restraining prices, and a government backed not-for-profit is needed. This thinking is the impetus behind advocating for a strong public option.

DISCOUNTED DRUGS: The final affordability issue would be to allow Medicare to negotiate drug discounts and to allow cross-border purchases. Arguments against discounting are that margins are needed for research into new drugs and that the quality of imported drugs cannot be assured. Arguments in favor of discounts are similar to the purchase mandate. The government handed big pharmaceutical companies \$Billions of new business with no risk. Many feel that the pharmaceutical industry should be forced to accept “discounts”. The current no discount policy has resulted in U.S. drug prices far above what pharmaceuticals cost in other industrialized countries. As for quality, many of the drugs purchased here are the very same pharmaceuticals that buyers in other industrialized countries purchase. Recall, too, that the Medicare drug program costing hundreds of billions of dollars was not funded, with the entire cost of the program being added to the federal deficit.

INTERIM CONSUMER PROTECTIONS WHILE REFORMS ARE IMPLEMENTED

Many of the above provisions cannot be implemented quickly. Some method is needed to restrain premium increases in the interim. To prevent health insurers from imitating credit card companies who increased rates before reforms became effective, a gatekeeper, whether through a national commission, state insurance commissions, percent increases imposed by statute, or another mechanism, ought to be in place from the outset of any reform enacted into law.

CONCLUSION

In less than ten pages, we have summarized the salient components of 2010 health care reform. What we have penned allows the reader to understand the core

provisions for any reform, pro and con. Moreover, the material described in the foregoing pages is a give and take where no one constituency will be entirely happy. But in order for every American to afford and access health care, each segment of our society must give up something that may have been sacrosanct to them. Such compromising also levels the playing field between corporate and Main Street America. If every “player” comes to the table called health care reform in good faith and acts fairly and openly, the nation as a whole will benefit. Partisanship only leads to what occurred in Massachusetts; we cannot afford to see this with efforts to reform health care any longer---our system is broken and on the brink of disaster.

© 2010 Andrew Kurz and Miles Zaremski

* Mr. Kurz is a former CFO for Blue Cross-Blue Shield of Wisconsin. He has been recognized and quoted for his analyses, statistical charts, and insights into how health care reform can come about. He is now retired in suburban Chicago and can be reached at agkurz@att.net.

** Mr. Zaremski is a health care attorney and author, with background in healthcare policy. He has counseled and represented Members of Congress, and is a contributor to Huffington Post on health care reform as well. His law firm is in Northbrook, Illinois; he can be reached at mzaremski@gmail.com.