Non-Partisan CBO Estimates of Health Care Reform

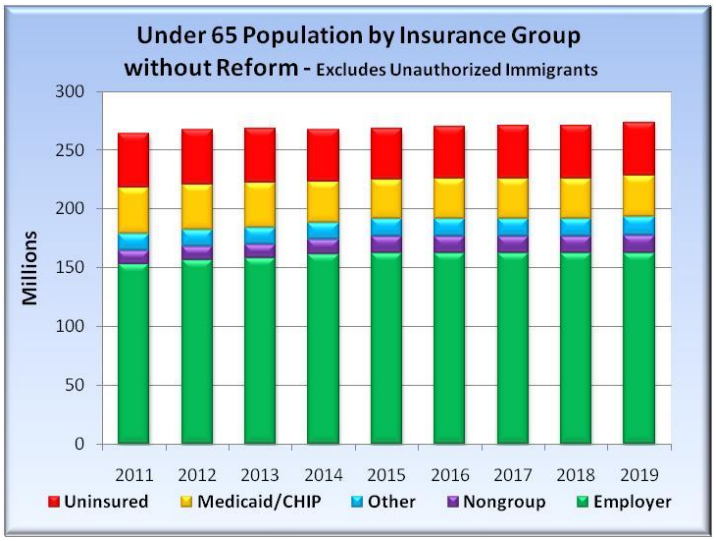
SUMMARY

Few doubt how unsustainable current medical trends are. With medical inflation consistently outpacing the CPI, health costs will continue to take a greater share of the economy. Private insurers claim they can solve the problem with reform but without a Public Option. History suggests this is a dubious claim at best. Looked at from multiple angles, private insurers are not likely to succeed. Profits gains have far exceeded key indices, medical loss ratios have gone way down while costs have gone way up, competition is diminished by concentration of major insurers, and tort reform complaints carry little water.

DISCUSSION

The graph below shows CBO projections of under 65 population by insurance group. The top, red bars are the uninsured that continue to grow each year. While insurance through employment is fairly consistent, greater employee cost sharing is an increasing burden.

Neither the Senate nor House reform proposals provide financial support to unauthorized immigrants. When analyzing various effects of reform, this group has no effect. For data consistency for both before and after reform, unauthorized immigrants are not included in the populations. Removal lowers uninsured population between 5 and 8 million over the 10 year period.



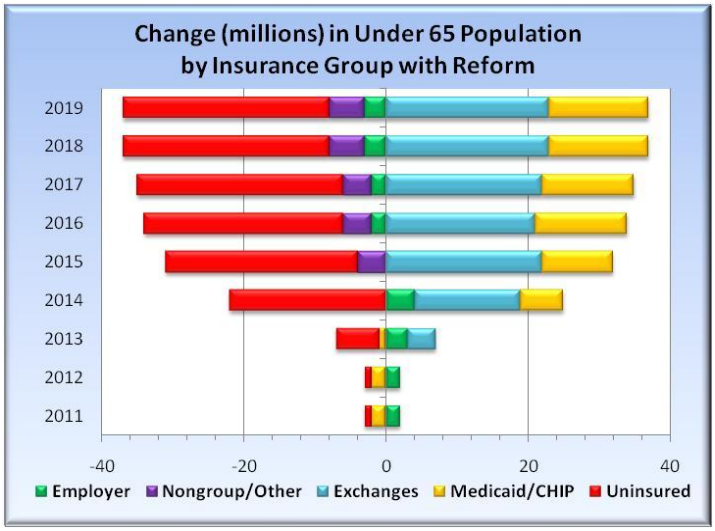
Source: CBO, Oct 7, 2009 letter to Senator Baucus

While the country may be coming to some agreement that reform is needed, differences exist on how to achieve reform. Health Insurers want to have participation mandatory which is a valid point. Except they have offered no other steps on how to reduce costs and are against Public Option that would offer real competition. However, they would be beneficiaries of millions of new customers.

Those customers would come from those currently uninsured, or insured through individual and employer groups. In the graph next column, CBO assumes reform includes an Exchange that would shift nearly 40 million from uninsured, individual and employer groups (left side of graph) to Medicaid and the Exchange (right side). Note that not all the movement is to the Exchange. A large number of uninsured poor would switch to Medicaid. Still, the Exchange is expected to grow quickly to nearly 25 million. This group is the target for private insurers and Public Option.

So why is it necessary to have a Public Option on the Exchange?

On its face, private insurers could certainly cover 25 million new enrollees without government involvement. But the catch is that the government IS involved because of another feature of reform.



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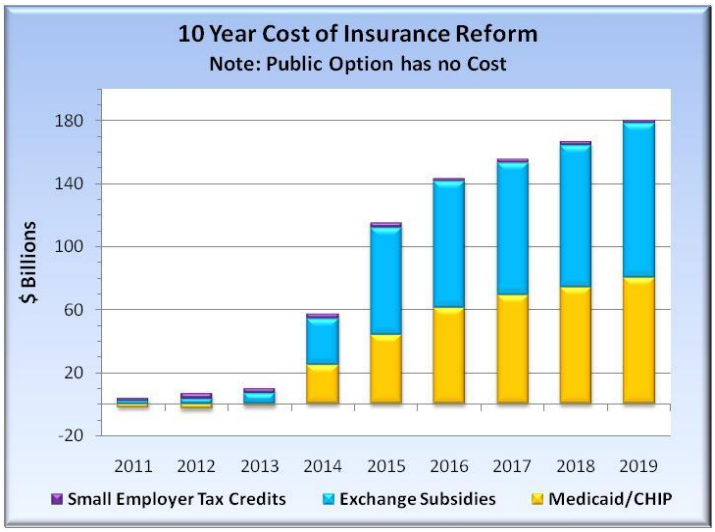
That reform feature is "affordability credits". Even those with insurance find their total health care costs consume so much of their income that they do not get needed care. Affordability credits help those with lower incomes pay premiums and shared health costs. The effect is shown in the chart below. Medicaid pays for the very poor while credits help less well off people in the Exchange.



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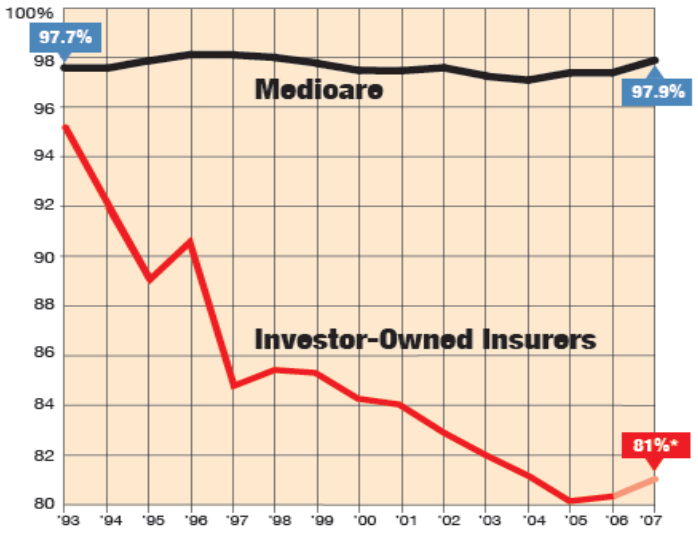
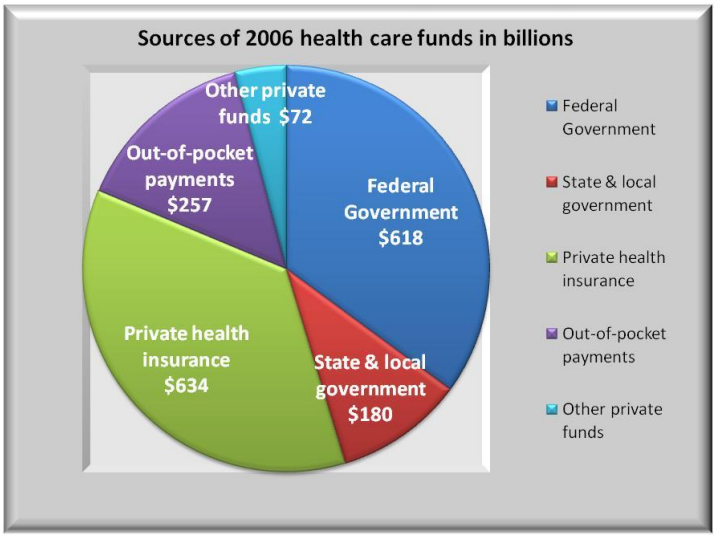
In short, the Government will be paying some $100 billion each year in credits to Exchange enrollees, much of it going towards insurance premiums. Will private insurers provide good value for this outlay? Their track record is not encouraging.

Health care costs fall into two categories: medical cost outlays and administration / overhead costs. In 1993, 95% of premiums went for medical costs at Investor-owned insurers as shown below. Over the next 14 years, this decreased to just above 80%, a shift of about 14% or one percent per year. Meanwhile Medicare administration and overhead costs have remained fairly constant through the period. While some may argue this is not a direct comparison, the fact that Medicare medical loss ratio stayed constant while investor-owned insurers drop significantly cannot be denied.



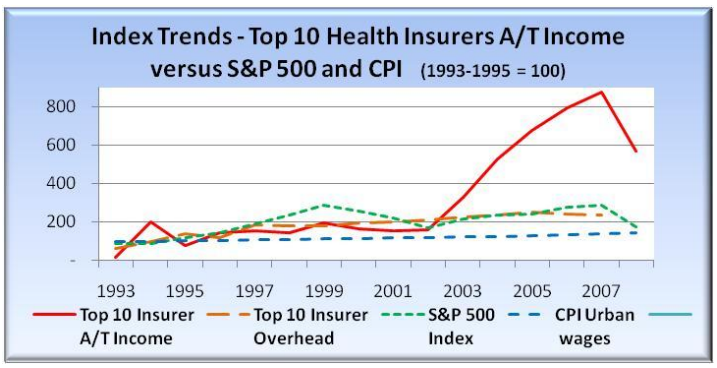
Sources: PricewaterhouseCoopers' Health Research Institute, and U.S. Center for Medicare & Medicaid Services

14% becomes urgent when you consider premium dollars as shown in the chart below. Private insurance runs over $600 billion. 14% of this is nearly $90 billion per year. Fortunately, one third of private insurers are non-profit. But that leaves some $60 billion added overhead including contribution to profits since 1993.



Source: Center for Disease Control – Health, United States 2008 Figure 19

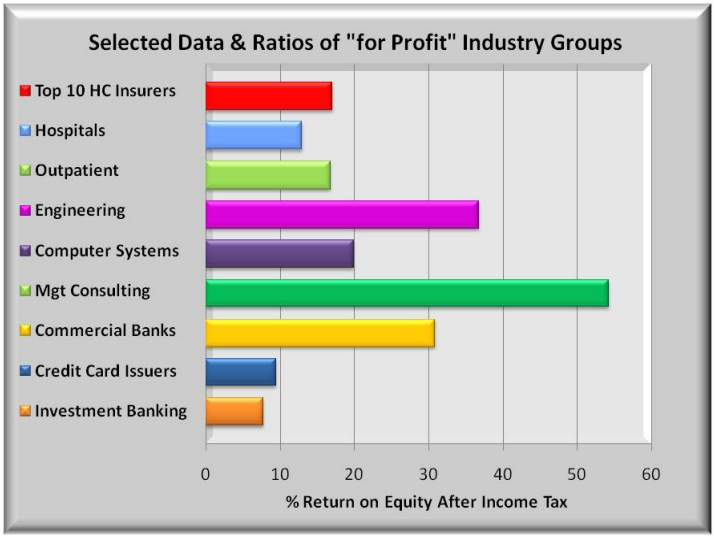
Profits did not grow to $60 billion, but they sure did grow as shown below, exceeding by a huge margin the S&P 500 and CPI for urban wage earners. All the growth occurred since 2002.



Sources: U.S. Dept. of Labor, Bureau of Labor Statistics, Standard and Poors, and Health Insurers' 10K's

Not only did investors do well, but so did executives and all at the expense of people paying for health insurance. 7 insurance CEO's drew nearly $70 million total compensation in 2008.

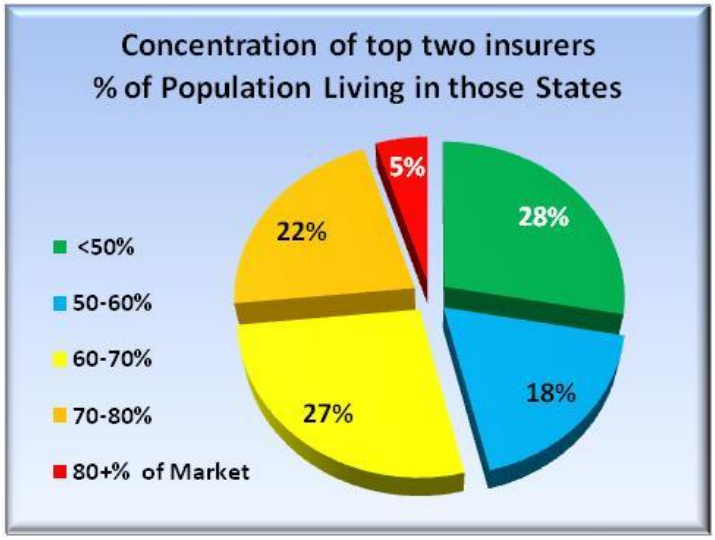
Still, Investor-owned insurers argue that their profits are a mere 3% of revenue. Another and better measure is Return on Equity (ROE) which is profitability based on investment. By this measure, health insurers are earning 17%. From the chart below some industries do have greater returns, but 17% should be nothing to complain about. The 10 insurers are even higher than credit card issuers.



Sources: 10K reports for top 10 Investor-owned Insurers and CCH Almanac of Business and Industrial Financial Ratios, 2009 Edition

Now high returns to executives and investors might have some justification if private insurers were successful in containing and bringing down the major component of health care – medical costs. Yet, year after year, medical costs outpace the CPI. One could almost argue that insurers "administer" health care costs rather than provide a value added "management" of those costs.

Competition often has something to do with companies holding down costs. In competitive markets, insurers need to maximize cost control efforts to maintain market share. But is there really competition? The graph below shows the market share of the top two insurers in each state weighted for population covered.

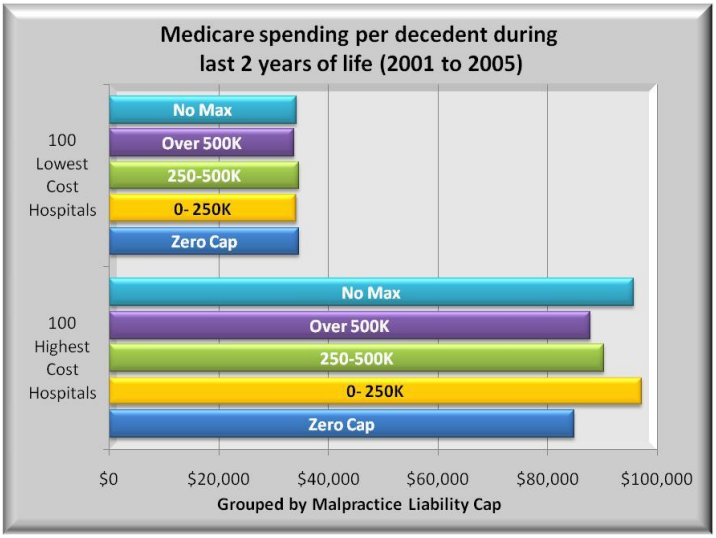


Sources: AMA, Consumer Union, Sector & Sovereign analysis

Over half the U.S. population lives in states where two insurers control over 60% of the market. That is not a good omen for competition. For instance, insurers claim that their market share allows them to negotiate lower rates with providers. It would not be fair to paint all insurers with the same brush. But a number of insurers have been found not to be driving down rates, but of negotiating with providers to NOT contract lower rates with their competition. Instead of reducing costs, these illegal acts increase medical costs compared to a truly competitive environment.

Insurers and others also argue that tort reform would bring down medical costs owing to current waste of defensive medicine. There is no argument about the waste. But is it due to defensive practice or simply practice? Data suggests that the latter is more prevalent.

The graph below, derived from Dartmouth College data, groups two sets of hospitals, the 100 highest cost, and 100 lowest cost hospitals for Medicare spending per decedent during the last two years of life. The bars represent average costs by states that have enacted tort reform setting caps on non medical damages. For the lowest cost hospitals, tort reform shows virtually no effect on hospital costs. For the highest cost hospitals, it is mixed. But there is no clear evidence that tort reform will substantially lower costs.



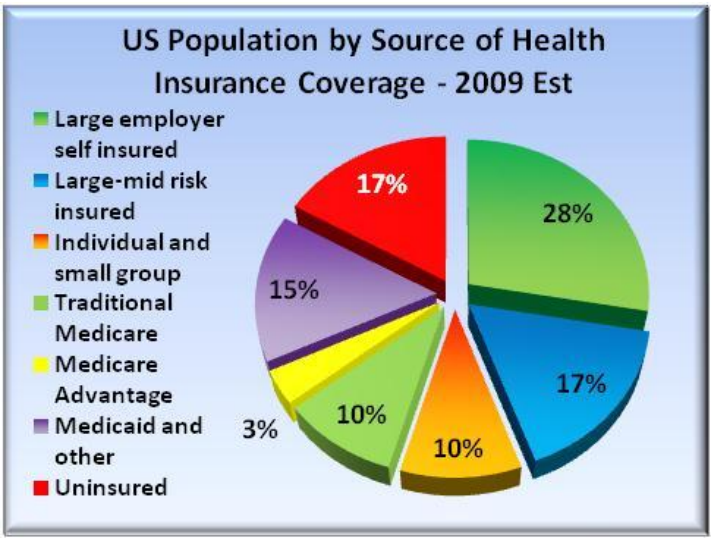
Source: Dartmouth_hosp_DAP_Hosp_HRR_ST_01_05.xls

So far, private insurers' track record suggests that left to the free market, they will not be very successful in lowering costs, either administrative or medical costs, with or without tort reform. It may be unrealistic to even expect investor-owned insurers to succeed given that their number one priority is to their investors.

Instead of using their actuaries to data mine patterns to help providers reduce costs, their efforts are focused on denying claims and raising premiums to high claims groups. Instead of returning surpluses to people paying premiums, they are buying back billions of dollars of their own stock to increase value to their shareholders.

Thus far the focus has been the cost of illness. Another aspect is the benefit of staying healthy. Corporations have had success in wellness programs. They not only reduce health care costs, but lower absenteeism. (http://www.uscorporatewellness.com/USCW White Paper 2009.pdf) Some insurers offer wellness programs, but they often include a health risk assessment on employees and that runs a risk that insurers may use that data in setting rates for the company: if towards lower rates, good. If higher rates, not so good.

Fortunately, large corporations are the biggest block of insured people, and their wellness efforts can have a broad effect. The graph below shows the U.S. population by source of health care coverage. Big business covers 45% of the population, 28% who self insure and another 17% who shift risk to insurers.

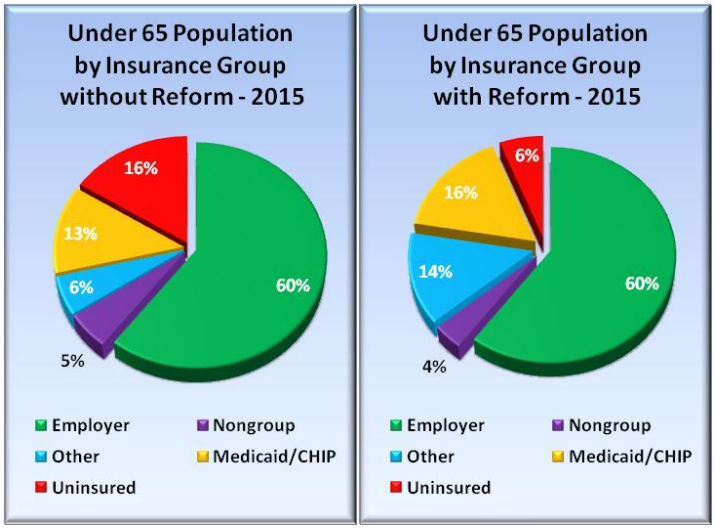


Source: CBO, EBRI, CMS, Goldman Sachs Research estimates

Groups at a disadvantage to big business include individual and small group business and the uninsured that together make up over a quarter (27%) of the population. If private insurers are unable or unwilling to lower administrative and medical costs for them, then the next best alternative is to offer a Public Option.

Without progress in both lowering administrative and medical costs, the affordability credit paid for by the government is going to cost taxpayers more than can be justified. The question is not whether a non-profit Public Option will succeed. The question is whether private insurers can succeed after years of failing to take the needed steps to contain costs.

The stakes are huge. CBO projects that with a Public Option, the insurance picture changes dramatically as the graph below shows. Medicaid grows a bit for the poorest, but the uninsured and non employer based population can look forward to more affordable insurance. Meanwhile the majority of the population is unaffected.



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