HEALTH CARE REFORM IN PERSPECTIVE

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Overview

Health care in the United States represents a $2.3 trillion expenditure and encompasses 16% (or 1/6th) of the total economy. Out of a total population of 308 million, about 15% or 45 million residents, lack health insurance. Some observers view adequate health care as a fundamental right while others believe it should be earned in the competitive market place where citizens must compete for jobs in order to provide their families with food, shelter and clothing.

In any event, there is widespread agreement that the overall delivery system for health care in the United States is dysfunctional and in major need of reform. In addition, curbing the runaway growth rate of costs (not to mention fraud and defensive medicine) is imperative. And, of course, something needs to done about the millions who are uninsured -- but at reasonable cost to U.S. taxpayers. This paper will try to put a few of these issues in perspective.

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This paper is incomplete because Health Care legislation was passed while I was in the middle of writing it. Therefore I have stopped working on it and will present here some of the random thoughts I was gathering for organization into a coherent "report" on the subject.

Some of the information still has relevance since there is quite a move afoot to repeal, reform or challenge the constitutionality of what has been passed.

Meanwhile, key features of the comprehensive legislation that was approved on March 21, 2009 are summarized in the attached article, "For Consumers, Clarity on Health Care Changes," that recently appeared in the The New York Times, as well as a summary description of the plan's main features that appeared on the web site of the House Democratic Majority Leader's web site.

HEALTH CARE REFORM IN PERSPECTIVE

Introduction

Without a shadow of a doubt, *for those who can afford it,* American doctors, hospitals and pharmaceuticals provide the best medical care an injured, afflicted or diseased individual can obtain. In an ideal state, moreover, everyone in America would receive the best health care that money can buy regardless of their age, health status, gender or wealth.

However, there is a slippery continuum regarding health care in the U.S. Thus, as a practical matter, due to major income inequality and a competitive free market in medicine, some lives are treated as more important or worth saving than others. For example, if every American were given the same health insurance, and quality of treatment, President Obama receives thousands of lives could be saved but the cost would be far greater than the $2.3 trillion (or $7,300 per resident) our country already spends on health care.

Of course, no such dream world exists – except for the likes of Bill Gates' and Warren Buffett. Thus, just as night follows day, anyone with *a life threatening condition* who receives less medical care than the best care money can buy runs the risk they will die sooner rather than later. For example, consider the stark contrast in outcomes given an expenditure of $0, $300 or $300,000 to treat the same medical condition. Needless to say, there are hundreds of situations (within this range of extremes) occurring daily due to gaps between the cost of optimal care and a patient's ability to pay for it.

Indeed, this form of *price rationing* is quite common in the United States since 15% of the population struggles on without health insurance. Most want it but cannot afford it, while others simply refuse to buy it. Then there are the unfortunate one's who are denied insurance because of a chronic condition.

Areas for Reform

There are a number of practical as well as philosophical issues that need to be addressed by health care reform. Chief among these are the following (not necessarily in order of priority):

- 15% of the population, or about 45 million, has no insurance.
- The inability, or unwillingness, of countless companies to provide health insurance because of its cost.
- Inequity of the 100% tax exemption for employer provided health insurance that is not available to those who must buy their own insurance.

- Guaranteed Issue and Guaranteed renewal. Both of these features raise overall premiums but guarantee one can obtain insurance regardless of a pre-existing condition or a decline in their health status.

- Community Rating which causes overall premiums to rise but equalizes premiums across the insured population regardless of age, gender or health status.

- Annual and lifetime caps on the maximum benefits a policy will provide over a specified period of time. The elimination of caps causes overall premiums to rise.

- Great variation in health insurance mandates within the states. Thus mandates broaden coverage but increase costs and limit consumer choice. This is especially true because it is unlawful to buy health insurance across state lines

- A health care delivery system based on "fee for service" instead of on overall patient outcomes, resulting in unnecessary or redundant procedures.

- The exorbitant cost of medical malpractice insurance due to widespread litigation and occasionally "out of control" juries, resulting in legislation of award caps in some states.

- Over spending on unnecessary procedures associated with defensive medicine in order to avoid (or to prevail in) medical malpractice suits.

- Extraordinary costs (emotionally and financially) often associated with end of life care -- especially when assessments entail severe pain, lifestyle issues and living wills.

- Health care rationing (or the inability to get optimal medical treatment) can occur for a variety of reasons. However, the main culprit is usually affordability.

Socialized Medicine – How Serious is It?

The Federal Government does not own the means of production for health care but it does have responsibility for paying for about half of it through Medicare, Medicaid, and the VA. Likewise, citizens are taxed at progressively higher rates in order to provide free (or inexpensive) care to the indigent. The inability of the poor to pay for emergency room care also results in cost shifting by hospitals onto those who are covered by insurance. Meanwhile it should be admitted up front that the practices of Community Rating, Guaranteed Issue and Guaranteed Renewal seek to socialize costs of health care for the greater good.

In an inherently mixed economy such as ours, however, it shouldn't be necessary to condemn such activities as inherently bad merely because of a quasi relationship with socialism. Indeed, we live in a society where 47% of the population doesn't pay income taxes and homeowners (with or without offspring) are required to pay substantial

property taxes in order to provide 12 years of education for all. Thus, the education is "free" regardless of the size of one's family or the amount of taxes one pays – if any. (Needless to say not all observers have a passive attitude about the specter of "creeping socialism" referred to in the above paragraphs.)

Closing in on the Problem

Here is a short list of the rich and famous for whom health care in the United States is unmistakably the "best in the world:" President Obama, Harry Reid, Mitch McConnell, Nancy Pelosi, John Boehner, Mitt Romney, Sarah Palin and the CEO's of Wellpoint, Aetna, and Humana among many others. Not only do these individuals pay no more than 25% of the cost of their Cadillac insurance policies but they can easily afford any co-payments that arise. At the opposite extreme are 45 million uninsured Americans who depend for their token health care on the generosity of the nation's hospital emergency rooms.

These institutions of last resort are only moderately reimbursed by the indigent populations they serve. In their self defense, therefore, the hospitals raise prices sharply on those who have insurance. This, in turn, causes the insurance companies to raise premiums on everyone else. As if this thimble game were not convoluted enough, moreover, hospital charges for the uninsured are much higher than for those who carry insurance! All this is because the insurance companies are able to bargain with the hospitals for discounts leaving the uninsured to pay at much higher rates.

Medicaid and Medicare were introduced in 1965 when, relatively speaking, health care was still in the dark ages by current standards. Thus in 1965 total spending on health care in real (or constant $2005) dollars stood at $0.211 trillion and represented 5.8% of real GDP in that year. Moving forward to 2008, by contrast, total health care spending was $2.3 trillion or 16.2% of real GDP. *Incredibly, then, over this 43 year period health care spending increased by 9.8 fold while GDP* ***only*** *increased 3.7 fold.*

Meanwhile, Medicare and Medicaid ushered in a new era in which many Americans began to embrace the view that protection of one's health should be treated as a "fundamental right" rather than as a privilege for the well to do.

The following pages contain some key statistics on health care in the United States derived from data online at the Kaiser Family Foundation website. In all cases figures are for the latest year available. Before turning to these Exhibits, however, it may be useful to summarize a few of the highlights from them. To start we find that while 15% of the population is uninsured 52% get coverage from their employer while 5% buy their own insurance in the private market.

Since race often comes up when discussing health care, we will not blink from addressing it here. Whites, as it turns out, comprise 65% of the total U.S. population but only 46% of the uninsured population. About 43% of Medicaid enrollees are white as are 78% of those enrolled in Medicare. On the other hand, blacks comprise 12% of the U.S.

population and 15% of the uninsured. Blacks also comprise 22% of Medicaid recipients and 10% of Medicare's beneficiaries.

For 2004, the latest year available, we find that the average per capita expenditure on health care in the United States stood a $5,283. Highest per capita spending occurred in the Dist. of Columbia at $8,295. Among the states, Massachusetts came in first at $6,683 in while Utah ranked last at $3,972.

Medicaid enrollment as a percent of a state's total population stood highest in California, at 29%, while Utah ranked lowest at 11%. Medicaid spending per capita in 2006 stood at $4,575 on average in the U.S., with Rhode Island at $8,082 and Alabama ranked last at $2,206.

Meanwhile, Medicare enrollment as a percent of a state's total population was highest in West Virginia at 20% and lowest in Alaske at 11%. Medicare payments per capita averaged $7,439 in the U.S. in 2006 while the Dist of Columbia came in highest at $9,154. Among the states, Louisiana ranked highest at $8,659 and South Dakota ranked lowest at $5,640.

Turning to mandated medical procedures and services required to be included in all health insurance policies issued within a state, we find the average state had 42 medical mandates in 2009. Rhode Island was the most prolific with 70 mandated procedures while Idaho was last with only 13.

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Exhibit 1
Key Statistics on Health Care in the United States
(Source: Kaiser Family Foundation)

Sources of Health Care Coverage (2008)

Provider	% of U.S. Population
Employer	52
Uninsured	15
Medicaid	14
Medicare	12
Individual	5
VA /Other	1
Total	100

Distribution of the Uninsured by Ethnicity (2008)

Ethnic Group	% of the Uninsured Population	% of U.S. Population
White	46	65
Hispanic*	32	16
Black	15	12
Other	7	7
Total	100	100

Health Care Expenditures Per Capita (2004)

Region	Amount	Rank
United States	$5,283	
Dist of Columbia	8,295	
Massachusetts	6,683	2
Main	6,540	3
New York	6,535	4
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Idaho	4,444	49
Arizona	4,103	50
Utah	3,972	51

*Of the approximately 49 million Hispanics in the U.S. it is estimated there are 12 million in the country illegally or about 4% of the U.S. population.

Exhibit 2
Key Statistics on Medicaid in the United States
(Source: Kaiser Family Foundation)

Medicaid Enrollment as a Percent of Total Population in the Region (2006)

Region	% Enrolled	Rank
United States	20	
Dist of Columbia	**28**	**2**
California	29	1
New York	27	3
Mississippi	27	4
//		
Virginia	11	47
New Jersey	11	47
New Hampshire	11	47
Nevada	11	47

Medicaid Payments per Enrolee (2006)

Region	Amount	Rank
United States	$4,575	-
Dist of Columbia	**8,484**	**1**
Rhode Island	8,082	2
New York	7,927	3
New Jersey	7,869	4
//		
Georgia	3,296	49
California	2,740	50
Alabama	2,206	51

Distribution of Medicaid Beneficiaries By Ethnicity (2008)

Ethnic Group	% of All Medicaid Recipients	% of U.S. Population
White	43	65
Hispanic	28	16
Black	22	12
Other	Z	Z
Total	100	100

Exhibit 3
Key Statistics on Medicare in the United States
(Source: Kaiser Family Foundation)

Medicare Enrollment as a Percent of Total Population in the Region (2008)

Region	% Enrolled	Rank
United States	15	-
Dist of Columbia	13	44
West Virginia	20	1
Main	19	2
Pennsylvania	18	3
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Texas	11	49
Utah	10	50
Alaska	8	51

Medicare Payments per Enrolee (2006)

Region	Amount	Rank
United States	$7,439	-
Dist of Columbia	9,154	1
Louisiana	8,659	2
Maryland	8,535	3
New Jersey	8,512	4
//		
New Mexico	5,652	49
Montana	5,650	50
South Dakota	5,640	51

Distribution of Medicare Beneficiaries By Ethnicity (2008)

Ethnic Group	% of All Medicare Recipients	% of U.S. Population
White	78	65
Black	10	12
Hispanic	8	16
Other	5	7
Total	100	100

Exhibit 4
Health Insurance Mandates in the United States (2009)
(Procedures or Services that Must be Included in all Policies in the State)

Region	Number of Mandates	Rank
Average for USA	**42**	-
Rhode Island	70	1
Minnesota	68	2
Maryland	66	3
//		
Utah	23	48
Alabama	21	49
Idaho	13	50

Source: *Health Insurance Mandates in the States 2009*
By V.C. Bunce and J.P. Wieske

Summary of Health Care Reform Legislation

How the Plan Works

Gives millions of Americans access to affordable insurance choices just as big businesses have—through a new competitive health insurance market that keeps costs down.

Holds insurance companies accountable to keep premiums down and prevent denials of care and coverage, including for pre-existing conditions.

Improves Medicare benefits with lower prescription drug costs for those in the 'donut hole,' better chronic care, free preventive care, and nearly a decade more of solvency for Medicare.

Immediate Benefits this Year

SMALL BUSINESS TAX CREDITS –35% of premiums this year, 50% in 2014
FOR SENIORS

CLOSING THE MEDICARE PART D DONUT HOLE—Immediate $250 rebate; next year, 50% discount on brand names; fully closed by 2020

FREE PREVENTIVE CARE UNDER MEDICARE—No copayments and deductibles

HELP FOR EARLY RETIREES—Temporary coverage for ages 55 - 64

For Those Privately Insured

NO DISCRIMINATION AGAINST CHILDREN with pre-existing conditions

BAN ON INSURANCE PLANS DROPPING YOU IF YOU GET SICK

BAN ON LIFETIME COVERAGE LIMITS

TIGHTLY REGULATES ANNUAL LIMITS ON COVERAGE UNDER NEW PLANS (all plans in 2014)

FREE PREVENTIVE CARE UNDER NEW PLANS

MORE FOR YOUR PREMIUM DOLLAR—Plans must put more of your premiums into your care; less into profits.

For Those Uninsured

COVERAGE IN HIGH - RISK POOL IF YOU HAVE A PRE-EXISTING CONDITION (discrimination ban extends to all adults in 2014 when Exchanges have been created, high - risk pool phases out)

EXTEND COVERAGE TO 26TH BIRTHDAY through parents' insurance

General Reforms

COMMUNITY HEALTH CENTERS—Investment to double patients served

MORE PRIMARY CARE DOCTORS—New investment in training

MORE REFORMS THAT BEGIN IN 2014

NO DISCRIMINATION AGAINST ADULTS WITH PRE-EXISTING CONDITIONS

BAN ON HIGHER PREMIUMS FOR WOMEN

PREMIUMS BASED ON AGE CAN ONLY VARY BY A MAXIMUM OF A 3 - TO - 1 RATIO

CAP ON OUT - OF - POCKET EXPENSES for private health plans

For Consumers, Clarity on Health Care Changes
The New York Times – By Tara Siegel Bernard 3-21-10

American consumers, who spent a year watching Congress scratch and claw over sweeping health care legislation, can now try to figure out what the overhaul would mean for them.

The uninsured are clearly the biggest beneficiaries of the legislation, which would extend the health care safety net for the lowest-income Americans.

The legislation is meant to provide coverage for as many as 32 million people who have been shut out of the market — whether because insurers deem them too sick or because they cannot afford ever-rising insurance premiums.

For people already covered by a large employer — most Americans, in other words — the effect would not be as significant. And yet, just about everyone might benefit from tighter insurance regulations.

“We think it’s a big step forward,” said Bill Vaughan, a policy analyst at Consumers Union. “It’s going to provide a peace of mind that many Americans who really want or need health insurance will always be able to get a quality product at a reasonable price regardless of their health or financial situation.”

There would be costs to consumers, too. Affluent families would be required to pay additional taxes. Most Americans would be required to have health insurance and face federal penalties if they do not buy it. And it is still unclear what effect, if any, the legislation would have on rising out-of-pocket medical costs and premiums.

But there is no question that the legislation should benefit consumers in various ways. Beginning in 2014, for example, many employers — those with 50 or more workers — could face federal fines for not providing insurance coverage. Several of the other changes would take effect much sooner.

Six months after the legislation is enacted, many plans would be prohibited from placing lifetime limits on medical coverage, and they could not cancel the policies of people who fall ill. Children with pre-existing conditions could not be denied coverage.

And dependent children up to age 26 would be eligible for coverage under their parents’ plans — instead of the current state-by-state rules that often cut off coverage for children at 18 or 19.

And within three months of the law’s taking effect, people who have been locked out of the insurance market because of a pre-existing condition would be eligible for subsidized coverage through a new high-risk insurance program.

That special coverage would continue until the legislation's engine kicks into a higher gear in 2014, when coverage would be extended to a wider part of the population through Medicaid and new state-run insurance exchanges.

Those exchanges, or marketplaces, are meant to provide much more competitive, consumer-friendly online shopping centers of private insurance for people who are not able to obtain coverage through an employer.

In 2014, people with pre-existing conditions could no longer be denied insurance, all lifetime and annual limits on coverage would be eliminated and new policies would be required to meet higher benefit standards.

Even sooner, in 2013, affluent families with annual income above $250,000 would be required to pay an additional 3.8 percent tax on their investment income, while contributing more to the Medicare program from their payroll taxes. And eventually, the most expensive insurance policies would be subject to a new tax.

Here is a look at some of the main ways the health care overhaul might affect household budgets.

The Uninsured

Although most Americans who do not obtain health insurance would face a federal penalty starting in 2014, many experts question how strict the enforcement of that penalty would actually be.

The first year, consumers who did not have insurance would owe $95, or 1 percent of income, whichever is greater. But the penalty would subsequently rise, reaching $695, or 2 percent of income.

Families who fall below the income-tax filing thresholds would not owe anything. Nor would people who cannot find a policy that costs less than 8 percent of their income, said Sara R. Collins, a vice president at the Commonwealth Fund, an independent nonprofit research group.

EXPANDED MEDICAID More lower-income individuals under the age of 65 would be covered by Medicaid, the federal health insurance plan for the poor. Under the new rules, households with income up to 133 percent of the federal poverty level, or about $29,327 for a family of four, would be eligible.

EXCHANGES AND SUBSIDIES Most other uninsured people would be required to buy insurance through one of the new state-run insurance exchanges. People with incomes of more than 133 percent of the poverty level but less than 400 percent (that's $29,327 to $88,200 for a family of four) would be eligible for premium subsidies through the exchanges.

Premiums would also be capped at a percentage of income, ranging from 3 percent of income to as much as 9.5 percent.

EMPLOYMENT FLEXIBILITY The exchanges would also help people who lose their jobs, quit or decide to start their own businesses.

“If you lose your employer-related insurance, you will be able to move seamlessly into the exchange,” said Timothy Stoltzfus Jost, a professor at the Washington and Lee University School of Law.

Moreover, people of any age who cannot find a plan that costs less than 8 percent of their income would be allowed to buy a catastrophic policy otherwise intended for people under age 30.

Those With Insurance

EMPLOYER COVERAGE People who receive coverage through large employers would be unlikely to see any drastic changes, nor should premiums or coverage be affected. But almost everyone would benefit from new regulations, like the ban on pre-existing conditions that would apply to all policies come 2014.

There might even be cases where people would be eligible to buy insurance through an exchange instead of through their employer, Professor Jost said: those who must pay more than 9.5 percent of their income for premiums, or those whose plans do not cover more than 60 percent of the cost their benefits.

CHANGES IN MEDICARE One of the biggest changes involves the Medicare prescription drug program. Its unpopular “doughnut hole” — a big, expensive gap in coverage that affects millions — would be eliminated by 2020. Starting immediately, consumers who hit the gap would receive a $250 rebate. In 2011, they would receive a 50 percent discount on brand name drugs.

HIGH-COST INSURANCE Starting in 2018, employers that offer workers pricier plans — or those with total premiums of $10,200 or more for singles and $27,500 for families — would be subject to a 40 percent tax on the excess premium, said C. Clinton Stretch, managing principal of tax policy at Deloitte. Retirees and workers in high-risk professions like firefighting would have higher thresholds ($11,850 for singles, or $30,950 for families), pegged to inflation.

Although the taxes would be levied on the insurer, experts expect the assessment to be passed on to the consumer in the form of higher premiums or reduced benefits.