Is the Government Really Trying to Reform Healthcare?

An Ordinary American's Perspective #2

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Introduction:

Since the 2008 elections, President Obama has indicated that he has a mandate to "fix" the apparent healthcare crisis. The mantra from all in favor of "reform" is that our expenditures on healthcare are too high (16% of GDP) and 46 to 50 million (less than 10% are "uninsured" for more than 2 years) are "uninsured". In addition, President Obama has been campaigning that the "government" reform will reduce costs, improve quality of care and improve access to care. If you believe all this, I have a bridge in Brooklyn that I would like to sell you too. Don't get me wrong here because I also believe that costs are too high, but I disagree that a centralized government-run program can get the job done.

I have been involved with the healthcare business since 1967. I also believe very strongly that our Founders got it right when they set up our Republic. The Founders were careful to draft a Constitution that limited government involvement with our lives. They were students of human behavior for 5,000 years, and understood that centralized governmental power is very dangerous to our individual freedom, liberty and prosperity.

I am a 1967 graduate of the College of William & Mary. My wife and I are most fortunate to have three lovely children, good health, good friends and family and enjoy life in America. On most political issues, you would consider us to be of the conservative persuasion.

Historical Perspective:

President Lyndon B. Johnson established the Medicare and Medicaid programs in 1965 with his Great Society legislation. The first beneficiary to receive benefits in 1966 was former President Harry S. Truman. The two programs today cover about 88 million Americans split 50/50 with another 12 million Americans covered through other government programs, such as Department of Defense, Veterans, etc. Private insurance is provided to 179 million Americans through their employer and as individuals (18 million) so the Public sector now provides 25% coverage while the private sector is at 75%. The Public (25% of individuals covered) sector represents 45% to 50% of the payments made to providers primarily because they cover an older population.

Since the introduction of Medicare and Medicaid, the consumer price index (CPI) for healthcare has exceeded the general CPI index. The only exception to this trend is a few years in the early 1990's when HMO's had their highest market percentage. Because the "government" provides about 50% of the medical payments, they have "squeezed" Doctors and Hospitals to the point where the reimbursements to Hospitals are 30% less than private insurers and are 20% less than private insurers for Doctors. As a result, there has been significant cost shifting to the private sector where 75% of the insured market pays more than their fair share of the cost of healthcare.

The Rationale for Healthcare Reform:

Our government can not afford the healthcare it has promised millions of Americans. The new "buzz" word in Washington DC is to "bend the spending curve" and reduce healthcare costs to 12% of GDP from the current 16%. It is assumed that there is 4% of wasteful spending in the system, such as fraud, over utilization of tests (defensive medicine), inefficiencies, etc. It is argued that we don't get our money's worth as a nation, because when measured against other countries our morbidity factors are not that much better. In fact, some studies suggest the US healthcare system is underperforming when compared to other countries. An expression has been coined: The US Healthcare System—Best in the World, or Just the Most Expensive?

Another issue driving Healthcare Reform is the "46 to 50 million uninsured" in the United States. America has a healthcare crisis is the battle cry from all who seek a government run healthcare program. The drum beat has been incessant for years. There are some that think we have a Constitutional right to Healthcare Insurance.

Myths versus Facts on Healthcare Reform:

Myth #1: America has a healthcare crisis. No, we don't. 46 to 50 million people lack insurance. Of the remaining 85% of the population, or 258 million people, polls show high satisfaction with the current coverage. In deed, a 2006 poll by ABC News, the Kaiser Family Foundation and USA Today found 89% of Americans were happy with their own healthcare. As for the estimated 46 to 50 million not covered by health insurance, 20 million can afford to buy it, according to a study by former CBO Director June O'Neill. Most of the other 27 million are single and under 35, with as many as a third illegal aliens. When it's all whittled down, as few as 12 million are unable to buy insurance—less than 4% of a population of 305 million. For this we need to nationalize 17% of our nation's $14 trillion economy and change the current care that 89% like?

Myth #2: Uninsured's do not have access to healthcare. Yes, they do. Many institutions in the US will first treat you before they ask if you have insurance coverage. Many Hospitals and Doctors will work with individuals to help patients meet their obligations. In addition, many organizations provide significant charitable medical treatment when patients can not pay.

Myth #3: Over 50% of households who file for bankruptcy do so because of medical costs. Not true. Historically, medical costs have been a factor in bankruptcies 17% of the time. The 17% statistic has not varied much over many decades.

Myth #4: Government-run healthcare produces better results. Again, not true. In countries with nationalized care, medical outcomes are often catastrophically worse. Take breast cancer. According to the Heritage Foundation, breast cancer mortality in Germany is 52% higher than in the US; the UK's rate is 88% higher. For prostate cancer, mortality is 604% higher in the UK and 457% higher in Norway. Colorectal cancer? Forty percent higher in the UK.

Myth #5: Healthcare reform will save money. Not according to the current CBO chief, Douglas Elmendorf. The Obama health plan, being written in Congress by Democrats, is estimated to cost between $1 trillion to $3.6 trillion—costs that are "unsustainable". None of the Bills before Congress include Tort Reform. Providers practice "defensive medicine" because of fear of being sued which encourages utilization. It is estimated that health insurance premiums would have dropped 20% if Tort Reform in 2005 had been adopted by Congress.

Myth #6: Only the rich will pay for reform. Not a chance. President Obama claims that only millionaires will pay a 5.4% surtax, but workers who decline to participate will pay a tax up to 2% of earnings. And small-businesses must pony up 8% of their payrolls. With the additional payroll tax, employers will be less likely to hire workers. Today's 9.5% jobless rate may become a permanent feature of our economy—just as it is in Europe where nationalized healthcare is common.

Myth #7: Wellness and coordinated care will produce enormous healthcare savings. No way. Wellness programs have been with us since 1974 with the creation of HMO plans, and the private sector is already handling coordinated care. Communication and data integration has improved dramatically in recent years. On average, 95% of an individual's healthcare expenses occur in the last month of their life. This is the 800 lb gorilla in the room.

Myth #7: Profits earned by a healthcare company are bad. No they aren't! Profit drives innovation and invention which improves our healthcare and its delivery. A centralized government-run healthcare plan operates inefficiently and wastes money and resources through graft and corruption. You could look at profit as a cost, but I like to think of it as a great motivator for good problem solving.

Myth #8: The government can negotiate better pricing for Prescription Drugs—just like Canada and other nationalized health countries. Yes, but you may not like the results. The U.S. has access to new and more effective drugs than foreigners. Since 1994, U.S. Patent Citations for pharmaceuticals is 75% and 90% for biotech versus the rest of the World. When drugs are purchased with an insurance card, you have benefited by significant discounts made to the various insurance companies or managed drug companies. The disparity is minimal. Part D, prescription drugs, of Medicare involves

the services of competing private companies and has worked out better than regular Medicare as to pricing and quality of responsive services. If you have no insurance, the drug industry has a number of programs that can help you pay for drugs you can not afford.

Myth #9: Is the simple answer for healthcare reform to mimic successful health organizations, such as The Mayo Clinic, Geisinger Health System, The Cleveland Clinic, etc.? Maybe. Healthcare is a local business. Each of the best-in-class medical organizations has a unique culture with local roots and local accountability. Within the Medicare system, these organizations tend to have lower cost healthcare with higher quality outcomes. Another common characteristic is that they all operate with significant charitable care, and some attract foreign patients who are willing to pay full retail for their treatment. Sweden has recently decided to “de-centralize” their nationalized healthcare administration to more local “medical councils” to try to improve treatment and reduce costs. After decades of experience, they have learned that healthcare can not be managed effectively with a centralized government-run health plan.

Myth #10: President Obama has been promising that Healthcare Reform will: 1. Lower Costs. 2. Improve Quality. 3. Give More Accessibility. The likely results will be: 1. Higher healthcare costs rather than lower. 2. Quality of care will be lower not higher. 3. Care will become less accessible not more.

<u>The Public Plan is Central to all Three Bills before Congress:</u>

According to President Obama, we need a Public Plan in order to keep the insurance companies “honest” and competitive. The “Public Plan” means Medicare for young people. Will it be a level playing field? The “Public Plan” is exempted from three significant requirements:

1. No reserves required to be set up by the Federal Plan—worth about 20%
2. No State premium tax paid—worth about 2%
3. No State mandated benefits covered by Federal Plan—cost varies by State, 10% to 20% estimated

A study by the Lewin Group estimates that 120 million people would lose their private coverage and enroll in the public plan (most would get dumped into the Public Plan by employers)

The Kennedy Bill and the House Energy and Commerce Committee Bill are the blue prints for healthcare reform. It has the following implications:

1. $ 1 Trillion in New Taxes
2. Health Insurance coverage will be mandatory
3. Employers will be required to contribute
4. Washington will decide what type of plan you must buy

If there is a mandate that everybody must have health coverage, then some governmental body must necessarily have the authority to decide when the mandate has been met. This body or Congress will be the target of lobbyists and special interests—trying to get coverage for everything from acupuncture to in vitro fertilization. In addition, end of life planning will be dictated by the system which will introduce significant moral contradictions into our society. Who decides when the costs are too high to live?

What does this mean to ordinary Americans?

1. You will likely lose the coverage you now have
2. You will be required to buy insurance in an "exchange" or "gateway" created and regulated by government
3. Ultimately, you will not be able to buy insurance anywhere else

How will the Public Plan Bend the Cost Curve or Reduce Costs?

The Obama Administration has indicated that Wellness programs, Disease Management and Medical Home can have a significant impact on costs. The Administration is long on unrealistic projections, but short on understanding human behavior. For example, promoting wellness is a big theme with the "Public Plan", but premiums can not be based on any health characteristics. So, if someone who is over-weight and smokes will have the same health insurance cost as the individual who does not smoke and goes to the gym everyday; therefore, there will be little economic incentive to change behavior. By the way, wellness programs were introduced to us by HMO plans in 1974. So far, Corporate America has had marginal success in generating cost savings by changing employee health behavior. It is a long term proposition. Disease Management is about telephone outreach by nurses to help patients comply with their doctor's prescriptions and behavior modifications. Medical Home promotes home treatment where possible with community support services. By the way, prior to the adoption of Medicare, most people died in their homes rather than the hospital.

Another irony is that Congress proposes cost savings for Medicare by arbitrarily reducing the funding for Medicare Advantage Plans. Medicare beneficiaries can choose to participate in plans that are outsourced to private sector healthcare companies. Aetna, Blue Cross and United Healthcare are a few examples. The companies usually offer some added features like wellness, disease management, and coordinated care through their managed HMO or POS (point-of-service) plans. Isn't this what our government is talking about doing with their Public Plan option?

The "dirty" little secret is that cost control will emanate from healthcare rationing! The Bills introduced in Congress are very similar to other nation's national healthcare plans. What is the experience of countries with national health insurance? In general terms, it takes about 3 decades to destroy your infrastructure, i.e. hospitals, medical equipment, medical personnel, etc. For example, the availability of MRI's in the USA per 1,000,000 people is 89 while it is 17 in Canada and less in Britain. So the government sets up health boards to determine who gets treatment. Britain's Health

Board has a rule: spend no more than $35,000 to save a year of life. In fact, the World Health Organization indicates that 25,000 Britons die every year because they do not have access to cancer drugs available in the US. As a result, a two tier health system is developing in Britain: one for the wealthy and privileged class, all others must use the "national" healthcare plan. Canadians will have no place to go when their healthcare treatment is delayed or denied if the US moves to Nationalize Healthcare Insurance.

Understanding Healthcare Reform:

There is some rationing of healthcare now, just ask someone who has gone from a private insurance program to coverage under Medicaid. The expansion of eligibility for the S-CHIP program had some children covered by their parents' employer sponsored program become eligible for medical coverage with Medicaid. Because Medicaid reimbursements are less than Medicare, fewer doctors will accept those patients or will require a long wait for care.

The government can not implement their true cost control strategies until they Nationalize Healthcare Insurance. The strategy requires getting people out of their private health insurance plans into a government plan. The government already pays 45% to 50% of health care costs, but can not impose rationing until there is one government plan.

In countries like Canada and Britain, the government decides how much doctors are paid. The average doctor earns less than a good plumber. In countries with nationalized healthcare, the government uses waiting lists to ration care. The government decides how long you must wait for treatment. People can wait months for a hip replacement or cancer therapy. The most effective drugs are not available because they are too expensive. Finally, older patients and the disabled are often denied treatment.
Why doesn't the government believe in:

1. Economic incentives
2. Markets
3. Entrepreneurship

Advocates of the government healthcare reform don't believe that healthcare costs can be controlled by giving people the right economic incentives.

They don't think doctors should be paid for outcomes, not the amount of services they provide.

They don't believe healthcare consumers should be rewarded for shopping for better prices or questioning unnecessary tests.

They don't believe hospitals, insurers or drug companies should be allowed to make profits for their investors.

They don't believe market competition and pricing controls costs, even though the real price of laser eye surgery and medical imaging has fallen due to competition.

They don't believe innovative entrepreneurs can find more efficient ways to deliver healthcare, such as over the Internet or through walk-in clinics.

An observation about "third party" payers (government, employer groups, and individual insurance) of our healthcare costs: The patient has little input to the process which has created a sense of entitlement on behalf of patients. Patient expectations can also impact how many diagnostic tests might be performed because someone else is paying for it. The patient doctor dialogue rarely gets into the trade-offs, because the patient has no "skin" in the game and the reimbursement formulas incent the doctor to produce volume.

Consumer Driven Healthcare is designed to have the patient pay some of the initial costs (still no cost for preventative care) such as a $1,200 deductible along with some co-insurance. In addition, the patient would be provided some "health" coaching such as decision support, education, behavior change, advocacy, etc. These plans are typically supported with Health Savings Accounts (HSA's).

<u>The Politics of Healthcare Reform:</u>

President Obama is a product of Chicago politics where they know how to work the system for political leverage. For example, the special interest groups that they will try to "buy" off are:

1. Medical Associations
2. Hospitals
3. Drug Companies
4. Large Health Insurers
5. Large Companies & Business Roundtables

Representatives of the Obama administration will meet behind-closed-doors—carving up the spoils that will flow from healthcare reform. All are negotiating the "terms of their surrender". The only groups not represented behind closed doors are: **Patients!** No one is representing the interest of patients in these deliberations.

The 7th Principle of our Founding Fathers was: **The proper role of government is to Protect Equal Rights, not provide equal things.**
Why the Founders made European Theories Unconstitutional. Samuel Adams said the ideas of the welfare state were made unconstitutional:

> The utopian schemes of leveling (redistribution of ownership of all the means of production and distribution), are as visionary and impracticable as those which vest all property in the Crown. These ideas are arbitrary, despotic, and, in our government, unconstitutional. This section quoted from: <u>*The 5,000 Year Leap: A Miracle That Changed the World*</u> by W. Cleon Skousen

We are not a nation that looks to our central government for solutions, but rather to the innovation and ingenuity of its people.

Thomas Jefferson often said: In order for our Republic to survive, it is important that the people of The United States of America be:

- Educated
- Moral
- Engaged

Our Republic needs all its citizens to be educated and engaged in the Healthcare Reform debate. Get involved!

I would appreciate hearing from you. Here is my email address: rowen@benefitinsurancegroup.com

The organizations that I felt had the best information on Healthcare Reform are:

- Investors Business Daily www.investors.com
- Liberty Counsel: Analysis of HR3200 Health Care Reform Bill www.liberty.edu/media/9980/attachments/healthcare_overview_obama_072909.pdf
- Milliman Research Report: Imagining 16% to 12% (February 2009)
- National Center for Policy Analysis www.ncpa.org
- The Heritage Foundation www.myheritage.org
- The Lewin Group www.lewin.com

The first edition of An Ordinary American's Perspective #1: World Forum on the Future of Democracy;

http://www.benefitinsurancegroup.com/Private/FOD.pdf

This edition of An Ordinary American's Perspective #2: Is the Government Trying to Reform Healthcare?

http://www.benefitinsurancegroup.com/Private/HC.pdf