

## Health Care Insurance Reform: Putting Our Country First

Opponents of health insurance reform are berating proponents for health care reform over future cost increases. Opponents gleefully point to a \$1 trillion expenditure over the next ten years to cover an estimated 30 million uninsured U.S. citizens. According to the Congressional Budget Office (CBO), the health insurance reform plan will leave uncovered some 15 million uninsured. While the debate rages over future costs increases, opponents fail to mention that we, the U.S., spent \$1 trillion in increased health care expenditures between 2001 and 2007, or \$1.4 trillion in 2001 to \$2.4 trillion in 2007, a six year period of time. This is a staggering increase in health care expenditure for our country without reducing the number of uninsured and without improving health care outcomes, and causing the U.S. to be ranked 34<sup>th</sup> among industrialized nations.

National expenditure data by the CBO provides a compelling picture for a nation that is losing its competitive edge in world markets. In 1975, U.S. spent 8% of Gross Domestic Product (GDP) on health care and 16.2% of GDP in 2008 or \$7,421 per resident; This is the highest of all industrialized countries. Other industrialized countries spent less than 9% of GDP on health care in 2008. The cost per resident for an annual health insurance premium averaged \$12,700 in 2008. This is the amount that a health insurer charges an employer for a health plan covering a family of four. Included in this amount, workers contributed nearly \$3,400 or 12 percent more than they did in 2007. While workers contribution increased significantly, annual premiums for family coverage easily eclipsed the gross earnings for a full-time, minimum-wage worker (\$10,712). The average worker contribution that an employee pays to a company-provided health insurance has increased more than 120 percent since 2000. Average out-of-pocket costs for deductibles, co-payments for medications, and co-insurance for physician and hospital visits rose 115 percent during the same period. The rise in worker contribution can be attributed to cost shifting techniques, from employer to employee. Because of cost shifting and the inability to curtail health insurance costs, personal bankruptcies has risen to seventy percent (70%), and is due primarily to health care costs, particularly out-of-pocket expenditures. This extraordinary cost shifting techniques is also responsible for some 1.5 million families losing their homes to foreclosure every year due to unaffordable medical costs.

Every working U.S. citizen is paying the price for the spiraling cost of health care that is mired in political philosophy that subordinates the interest of the country to that of their political party's interest. In this regard, some citizens ask, "why the rush to reform health insurance coverage?" The rush is about a runaway health care

train that cost Americans \$13.8 billion per month. While congress is on vacation, we will have spent an additional \$14 billion dollars in increased health care expenditures.

To understand the political philosophies and positions, we should examine political statements and arguments:

1. *Socialism versus Free Enterprise Medical System*: unfortunately, health care is neither a product nor a commodity where you can apply traditional free enterprise practices, such as cost accounting, i.e., capturing the cost of raw materials, production supplies, and labor costs to determine competitive prices. Charges in health care, not prices, are socially generated from one social or demographic setting to another. Health care charges represent a fee for a service. In this instance, an asset value is not determined from a pricing structure. The end result is not competition (price), but rather income expectation.
2. *Public Option versus Private Health Insurance Plans*: The Public Option is not being proposed as an agency of government, but a health insurance arrangement with multiple private insurance plans that compete for new enrollees. This plan consist of basic benefits, such as provided under the Federal Health Benefits Program and includes pre-existing conditions. The Public Option Plan's health insurance premiums will be community rated, not experienced rated. The Public Option is fully funded from premiums paid by employers and employees. In this option, only individuals earning less than \$43,000 per annum and above Medicaid eligibility can qualify for insurance credits or subsidies toward the payment of premiums. Since the Public Option is community rated, Private insurance plans that use experience rating and exclude pre-existing conditions, will have a competitive advantage over the Public Option. Blue Cross and Blue Shield served for years as our nation's "Public Option." In this regard, they enjoyed special tax considerations as tax exempt companies. Only recently, we have witnessed a plethora of for-profit insurance plans generating huge profits by passing annual cost increases to employers and employees.
3. *Congressional Budget Office Assessment*: The CBO claims that none of the health care reform plans pending in Congress will control long term spending. The primary purpose of reforming health insurance is to provide more coverage to all citizens and slow the health care expenditure growth rate. If you compare spending increases over the past six years to the next ten years, spending increases will be reduced from \$166 billion to \$129.48 billion per year. In this scenario the CBO's assessment is incorrect. The CBO uses a set of assumptions to project future costs. Without testing their assumptions, it is difficult to refute their projections. However, it is extremely difficult to

believe that the CBO's assumptions include a decrease in hospital costs (hospital costs account for 31% of all health care spending nationally). If the U.S. covers 30 million more uninsured citizens with a basic benefit plan, each enrollee or subscriber will be eligible for outpatient studies and preventative procedures. Increased insurance coverage for outpatient studies and preventative exams will significantly reduce excessive deaths and unnecessary emergency room visits, thus, a reduction in national hospital expenditures. While our national expenditures, prevalent rates, and health outcomes are poor, the State of Louisiana expenditures, health care quality, and outcomes are worse.

4. Impact of Restructuring Medicare Part D: Congressional proposals call for restructuring Medicare Part D. Unfortunately, proposals for restructuring Medicare Part D should be considered in a separate bill, not one that reforms health insurance. Reforming Medicare Part D should be considered in a cost containment bill. By reforming Medicare Part D, seniors will reap huge benefits from reduced prescription drug costs by allowing government officials to negotiate prices directly with pharmaceutical manufacturer and redistributing drug rebates. Savings from reduced prescription drugs will reduce the rate of health care spending.
5. Length of Health Insurance Bill: Opponents of Health insurance reform complain about the length of the legislative reform Bill (HR 3200) being 1,000 pages. After hearing this frivolous complaint, I reflected on entering graduate school, some of you may recall your professor telling you that the required reading was a minimum of 450 pages per night. This was not a question for democracy, but rather one's commitment for academic preparation. If you were unable or unwilling, you were summarily dismissed from the program. To encourage us in meeting required academic preparation, the professor reminded us that Harvard students were required to read 1,000 pages per night. Since our Congressional representatives have staff whom are required to read bills, I wonder why this seems to be such an arduous task for two or more people. If reading 1,000 pages will reduce the GDP rate for health care expenditure and prevents national bankruptcy, why not?
6. The Health Insurance Reform Plan will limit your choice of doctors: Unfortunately, doctor participation in any health insurance plan, including Medicare, is driven by payment incentives. By all accounts, our nation's doctors are not precluded from participating in any government sponsored plan unless there is a sanctioned against that doctor. However, many private insurance plans limit doctor participation based on medical certification and willingness to accept In-Network contracted rates. Regardless of a payment provision, or patient's lack of insurance coverage, all licensed doctors are required to meet a standard of care. Your doctor may choose not to

participate for a myriad of reasons, not because a health plan limits their participation.

After assessing the position of opponents to health insurance reform, none of them offer a single solution to curtailing the spiraling cost of health care and its impact on our nation's Gross National Product. Effective leadership begs for solutions, not rhetorical responses that divide its citizens along political philosophy. While free enterprise drives our nation's economy, a solution to the spiraling cost of health care and its impact on the nation's GDP will not be formed by private companies. Private companies are driven by profitability, not altruistic concerns for excessive spending. This is evident by more and more advertising designed to make Americans spend more on medicines without a complete understanding of drug efficacy.

If we fail to reform health insurance, our nation will spend 20% of its GDP on health care in the next few years. At this percentage of GDP, our nation will spend almost three times the amount on health care than we spend on national defense. Since freedom is not cheap, we should be extremely concerned about the impact such excessive spending has on the value of Gross Domestic Products and the potential for the dollar to be devalued. All of us who work in the health care industry must find ways to be more efficient and reduce the cost of health care. Since health care expenditures are volume driven, we need to find ways to reduce volume at every corner.

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