



JUST WHAT THE DOCTOR, LOBBYISTS, PROTESTORS AND POLITICIANS ORDERED: THE HEALTH CARE REFORM DEBATE?

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Employers around the country are closely examining the confounding yet fascinating debate over health care reform being played out in Washington DC. The high costs of the health care and the uniquely American system of employer-provided coverage have formed the perfect storm involving government intervention and private enterprise in which the lives of millions hang in the balance. Some advocates argue for a single player system, others prefer a public option, and some even prefer the status quo. Yet, there are other critics of the current system who see a need for co-ops and others who believe that health savings accounts are the way to go. This article serves as a guide through the minefield that is the health care reform debate for companies wondering what is to come.

THE WAY THINGS ARE

The crux of the health care discussion comes down to competition; is there enough of it or should the government enter the marketplace to ease and better control costs? The competitiveness of the private market varies by state. According to the American Medical Association, the larger more densely populated states have the most choices of health insurance coverage. The leading insurance providers cover 24 percent of California, 26 percent of New York and 30 percent of Florida. However, in nine states a single insurer covers 70 percent of the aggregate population. In Alabama, one insurer covers 83 percent and in Hawaii, 78 percent are covered. And in 17 other states, one insurer covers over half of the population.

"The only way to help your health is to eat what you don't want, drink what you don't like and do what you'd rather not."

-- Mark Twain

Robert Zirkelbach, America's Health Insurance Plans (AHIP) spokesman, said there is plenty of competition because "in the top 40 metropolitan areas, there are eight or more health plans in every one of them. Both the

Federal Trade Commission and the Department of Justice have reviewed this and found that health insurance plans operate in a highly competitive market. Physicians' offices contract on average with a dozen health plans."

Employers face limitations in choices. Brad Herring, health economist for Johns Hopkins Bloomberg School of Public Health, told the NYTimes "a large employer can self-insure" by collecting premiums, paying out for medical claims and generally using a commercial insurer to administer the program which supplies a network of doctors and hospitals without financially underwriting the coverage. Herring said this includes half of all Americans with private insurance.

However, small businesses purchase coverage through insurers who are regulated by each state. They are unable to shop across state lines. Congress has not yet indicated that it is willing to alter the law to allow insurance companies to roll out interstate operations.

According to the American Medical Association, there have been 400 corporate mergers among insurance companies over the last twelve years. One insurance company covers 34.2 million people while another covers 29.5 million

according to second-quarter statements. Wendell Potter, CIGNA's director of communications said "the largest seven insurers cover more than 100 million people, a third of the market." Zirkelbach of AHIP countered that "hospital consolidation has driven up prices... in the last 20 years, benefit costs have risen 8.7 percent" correlating with the rise of premiums. However, Zirkelbach does caution that, "A new government-run plan would significantly disrupt the coverage that people currently rely on."

WHAT'S AT STAKE

According to the US Census, 85 percent of the country had some form of health insurance in 2007. More than two thirds of those had coverage through an employer. Medicare and Medicaid cover the elderly, disabled, veterans, as well as children and low-income people. 45 million people lacked health insurance at a specific time during the year but were not necessarily uninsured for the entire year. 9 million of the uninsured were not American citizens but the bureau's "Current Population Survey" does not collect information on the legal status of noncitizens. 12 million low-income uninsured people – mostly children and parents – were not enrolled in public programs for which they qualified, according to the National Institute for Health Care Management Foundation. One third of uninsured were moderate or high income individuals who are deterred by high premiums. Many others are shut out because of pre-existing conditions. Young adults, 19 to 29 years old, were 29 percent of the uninsured and had the highest uninsured rate of any group.

THE PUBLIC OPTION

The public option is the most controversial facet of the health care reform debate. Many oppose it, some favor it and want it phased in, others want reform without the option and there are those who want it immediately introduced to the market. Those who favor a public option need to mollify moderates while at the same time making sure it is not vitiated by a health cooperative. While the two party political parties have definitely gone their separate ways over this issue, the party in power has split between a public option and a health care cooperative. Nancy Pelosi, speaker of the House, said "We agree with the president

that a public option will keep insurance companies honest and increase competition."

However, some congressional officials believe that the public option could "fade if any legislation ultimately provides universal health coverage." House Democrats favor the public option but may be convinced to back a comprehensive bill that does not include it if there's a "victory" in achieving health care reform. Critics of the public option believe that it represents a federal takeover of the health care industry while supporters maintain it will foster competition with and among private companies.

An insurance "co-op" would provide coverage and be controlled by its members. Administrative costs should be minimized because the co-ops would be nonprofit. They would compete with private insurers but would need enough members to have power to negotiate prices with doctors and hospitals. According to Farhana Hossain and Robert Pear of the New York Times, co-ops will need 25,000 members to be viable and 500,000 members to negotiate effectively.

The public option is in trouble because the "Gang of Six" does not favor it. The "gang" comprises six senators on the Senate Finance Committee who are writing the most pivotal pieces of the health care bill. Senators Max Baucus, Democrat of Montana, is the committee chairman and Charles Grassley, Republican of Iowa, is the ranking member and they have worked closely together in crafting the proposed legislation.

OTHER REFORM IDEAS

President Obama wants to slow the growth of health care spending and expand health insurance coverage. The goal is to find billions of dollars of savings in Medicare by reducing payments to hospitals. Moving Medicare away from fee-for-service methods towards quality of care includes greater use of technology, better management of chronic diseases and more attention to preventive care for long-term savings. Including the expansion of Medicaid, the overhaul is expected to cost \$1 trillion over the next 10 years.

The proposals would trim Medicare payments provided for most services in order to “incentivize” hospitals to be more efficient. More than \$150 billion over 10 years would be cut from federal payments to private health plans that cover 10 million Medicare beneficiaries which the current administration considers to be unwarranted subsidies. According to the New York Times, the president hopes to make up for the costs by limiting itemized deductions like charitable deductions and mortgage interest for the wealthy but has met resistance from Congress.

THE SWISS MODEL

Liberal columnist and Nobel Prize winning economist, Paul Krugman has highlighted Switzerland’s health system as an admirable model to follow in his essay, “The Swiss Menace.” According to Krugman, in the UK, the government runs the hospitals and employs the doctors through its National Health Service (NHS). In Canada and France, the delivery of care is “in private hands” but government pays most of the bills. Finally, the third way involves using private insurance companies to achieve universal coverage by utilizing regulation and subsidies. That is how Switzerland does it; “everyone is required to buy insurance, insurers can’t discriminate for pre-existing conditions and lower-income citizens get government help.” Krugman does advocate the public option above and beyond this route because he believes the government would make the system cheaper.

THE DEFICIT DILEMMA

On the other hand, health care reformers on the other side of the political spectrum from Krugman express caution. John Mackey, CEO of Whole Foods, contributed his thoughts and concerns to the Wall Street Journal. In his piece, “The Whole Foods Alternative to ObamaCare”, Mackey warned against entitlements that would balloon the nation’s budget deficit. His argument is that the country should move “toward less government control and more individual empowerment.” He followed with eight reforms.

1. Encourage creation of high-deductible health insurance plans and health savings accounts (HSAs) – Whole Foods

pays 100% of premiums for workers on the high-deductible health plan and also provides up to \$1800 per year in deposits to Personal Wellness Accounts for workers to spend as they choose. Money not spent can be rolled over each year and grow over time.

2. Equalize tax laws – Employer benefits are fully tax deductible but individual health plans are not and Mackey asserts this is unfair.

3. Repeal state laws prohibiting insurance companies from crossing state lines – Health insurance should be portable and would foster competition and lower prices.

4. Repeal government mandates on what companies should cover – The mandates have increased insurance costs by billions.

5. Enact tort reform to end ruinous lawsuits – Doctors are forced to pay high insurance costs which are passed on to the rest of us.

6. Make costs transparent – People buy other goods and services and know the costs breakdown, why not for medical care?

7. Medicare reform is necessary – Mackey asserts that Medicare is headed towards bankruptcy and that reforms are needed for patient empowerment, choice and responsibility.

8. Revise tax forms to encourage voluntary donations for those who need care – Tax deductible donations would help millions who aren’t covered by Medicare or Medicaid.

CONCLUSION

The problems are massive, the proposals are voluminous, but the answer is elusive. No one has the magic bullet to fix the health care system but there are plenty of opinions on what should not be enacted. Just as deciding which doctor is best for your family, the prescription for the medical industry as a whole is a personal decision too. Lobbyists, politicians, doctors and patients are working together to forge compromises and consensus. Hopefully, the correct decisions lie somewhere in the countless debates that have echoed around the country. In the meantime, the best way to decide what is best for health care reform is to be as well informed about the issues as possible.

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