COULD HEALTHCARE BANKRUPT AMERICA?

Over the years, we have all listened to presentations at local, state, and national meetings about socio-economic issues involving medical health care delivery in the United States. Many differing opinions have been voiced in the ensuing discussions; whether we want left or right wing social re-engineering of our medical care, I think we all recognize that changes must be made that lead to improvement of our health care delivery and to place it on a sustainable financial basis. There is no doubt that the US has the world's most skilled doctors, nurses, and its finest hospitals. Yet, most Americans think our health care system is still broken and the reason is simple; the US leaves its citizens to the mercy of an expensive, patchwork system where some get great care and others get little or none at all.

So….could health care really bankrupt America or is this just a theoretical question? Should we as consumers really be concerned or is the country as a whole at risk? Let's begin by looking at health care consumers. 62% of all bankruptcies in America are linked to unpaid medical bills while about 69% of these individuals had health insurance. According to a CNN article, there was a 50% increase in "medical bankruptcies" from 2001 to 2007 related to unpaid medical bills, loss of income and insurance coverage due to an illness, copayments and deductibles, or simply uncovered services. How can this happen? Gerard Anderson, a health care economist at John Hopkins explains the obvious and says, "All the prices are too damn high." If you have not read the March 4, 2013 medical report in Time magazine by Steven Brill, "Bitter Pill, How outrageous pricing and egregious profits are destroying our health care," I would encourage everyone to do so!

And now for the country…. according to the Congressional Budget Office, in 2012 health care totaled almost $3 trillion or just under 20% of our GDP, with Medicare costing 560 billion and Medicaid costing 480 billion. The remaining $2 trillion was paid by private insurance companies or individuals without insurance who paid some portion of the bills not covered. This amounts to almost $8508 per person for health care. Did the Affordable Care Act have a measure to reduce health care costs? While Obama claims "yes", touting insurance company rebates on insurance over charges, the answer remains a "no". An estimated 15 to 30 million

people will be added on to Medicaid and the rest of us are mandated to obtain health insurance or pay a fine, passing on even more potential profits to the insurance carriers. Will our insurance premiums go down? Again the answer is "no." Mandated no copay preventative care and coverage for preexisting conditions will force health insurance premiums upwards. According to the Kaiser Foundation, the average premium for employer sponsored health care for a family of four was $15,745 in 2012. A report this year by the Society of Actuaries indicates insurance companies will payout an average of 32% more under Obamacare on individual policies which spells a likely increase in health care premiums. A recent Robert Wood Johnson Foundation report documents that employer sponsored health care in 2011 covered just 62% of workers compared to 74% in 2000; the biggest factor in this decrease was the increase in cost! Unfunded health care entitlements run the risk of destroying us financially. According to the CBO, a typical middle class family retiring in 2010 is on track to receive $387000 in Medicare benefits for a pay in of only $156000. That clearly is unsustainable. Adjusting for overall inflation, Medicare spending per beneficiary rose more than 400% from 1969 to 2009 while inflation adjusted premiums on private health insurance for each insured increased an astounding 700%. Neither program has done an adequate job of controlling costs.

Did the ACA of 2010 accomplish any good changes? While insurance maybe available to millions more Americans, it does little for cost control or the prices we pay. The best provisions include prohibitions on exclusions for preexisting conditions, restrictions on co-pays for preventative care, and the end of annual or life time caps on payouts. It restricts abusive hospital bill collecting and mandates insurance carriers to explain their policies in plain English and allows for more appeals. Insurers must also limit the ratio of premiums spent on administrative costs compared to medical costs, referred to as medical loss ratios (MLRs) and if excessive must refund a portion of the premium.

There are many ill conceived features of the ACA; states now have the ability to "opt out" of increasing their Medicaid rolls as well as establishing state insurance exchanges so it is unclear with the "insurance mandate" exactly how many people now uninsured will actually be covered. As of July 2013, 23 states and the District of Columbia have agreed to expand their Medicaid enrollment; 18 states have initiated their insurance exchanges and 26 more have asked the federal government to set up their exchanges. States that neither expand their Medicaid nor set up exchanges, run the risk of destabilizing their private insurance

companies with massive premium increases secondary to “cost shifting.” Because of the ACA, employers may also reduce their employees to part time work, to avoid paying for their insurance or may chose to pay the $2000 yearly fine rather than an insurance premium to cover employees. To finance the ACA, there are new taxes on medical devices, tanning salons, a supplemental tax on wealthy individuals and investment income, and a $95 or 1% of adjusted income per person “fine” for not obtaining health insurance.

The ACA should increase access to health insurance coverage but still does not establish universal coverage. Under universal health care, everyone has coverage to obtain health care but it does not necessarily mean that the government always pays for that coverage. Most countries around the world with universal health care use a combination of public and private coverage. With socialized medicine, the government runs and delivers the entire system, providing services from doctors, hospitals, and other facilities such as PT, and pays for all those services in a manner like the VA system. In a “single payer” system everyone gets coverage which is paid for by the government but the providers and facilities are mostly private services, not owned by the government.

While these benefits were touted to improve health care overall, the ACA’s failure to address tort reform and defensive medicine, manage health care’s big money wasters, and exclusion of a means to really control health care’s rising costs related to drugs, technology and chronic illness, are major omissions. Our continued rise in health care cost is clearly unsustainable. We all recognize that many more changes must be made that lead to improvement of our health care delivery and to make it fiscally stable.

While tort reform has generally been in the domain of the states, national standards could be established with caps on non economic “pain and suffering”. A CNN Money report from 2009 documents that defensive medicine, such as doctors ordering tests or procedures not based on need but on concern over liability, resulted in an estimated 210 billion waste of health dollars. The ACA of 2010 does encourage doctors to practice “evidence-based” guidelines as a way to cut back on unnecessary tests, but most think that capping malpractice awards would be more beneficial. In addition, each state should set up panels to review every medical lawsuit filed to determine whether it is meritorious or not. Many states are now requiring medical experts to be board certified, to only testify in their specialty, to only testify in the states in which they practice, and to have been in practice at the time the law suit was filed. Nationwide television ads,

placed by attorneys trolling to solicit patients for their "class action lawsuits" should be outlawed. These are all measures that will clearly decrease the number of frivolous suits.

Inefficient claims processing wastes health care dollars estimated at over 200 billion. Every insurance company has its own forms and completing their paper work takes time from patient care. Just standardizing forms and improving technology has the potential to save money. Experts have said electronic records have the potential to save billions of dollars by more efficiently sharing information. Fraud has cost both Medicare and private insurers over 100 billion in recent years; it is felt that electronic records may be able to detect spurious patterns in billing more rapidly than paper billing thereby reducing fraud. And it is not just billing that results in fraud. The TV show "60 Minutes" reported in December 2012 that many hospitals have admission quotas to fill beds from the ER; this may be up to 20% of private patients and up to 50% of Medicare patients evaluated. ER doctor's performances were graded on reaching these quotas. Medical errors cost the industry about $130 billion each year; computerized order entry for drugs and the use of electronic health records would help insure that patients receive the correct medicine and dosage. A recent study found that as many as one in three hospital patients are harmed by the care they received. These mistakes don't just cause pain and anguish but add billions paid unnecessarily by insurers, families and the government because of prolonged hospital stays to manage the complications.

Since hospital ERs are mandated to treat all patients regardless of insurance status, visits are increasing! However, the ER should not be used be used as a family clinic; despite this, more and more insured and uninsured patients are trying to obtain their primary care in ERs which wastes perhaps 14 billion each year. Going to your own doctor for a strep throat costs $65-75 while in the ER a similar visit may cost between $600-800 per patient. Currently, experts state that 30-40% of all ER visits are unnecessary. ERs, hospitals, and doctors cover their costs of treating the uninsured by cost shifting to paying patients. Cost shifting is also occurring because of decreased reimbursements from Medicare and Medicaid, resulting in a record number of doctors across the country not accepting new Medicare and Medicaid patients. In 2012, 9539 doctors opted out of the Medicare program.

Up to the current time, a lack of guaranteed health care for all Americans has resulted in America having relatively poor health compared to other developed

nations. The just published National Research Council report documents that the US ranks last or close to last in nine key benchmarks; those are infant mortality and low birth weight, injuries and homicides, teenage pregnancies, sexually transmitted diseases, prevalence of HIV and AIDS related illness, drug related deaths, obesity, diabetes, heart disease , chronic lung disease and disability. In the past, the World Health Organization has documented similar findings but their data has been disputed and criticized for its methodology. In a group of comparable "high income" democracies, the US tied Hungary and Slovakia with the highest infant mortality at 29th in 2007; the US ranked 34th in life expectancy in 2012 but was first in per capita health care expenditure. Is that really a bad thing? The US ranks first in prostate cancer survival, second in breast cancer survival, and ranks near the top for survival rates for colon and rectal cancer. Our health care system is the "most responsive" in patient confidentiality, consumer preference, short wait for elective procedures, and is first in medical technology availability. However, our health care expenditure in 2012 was over $8500 per person while the cost in Japan, Germany, England, and France was less than half as much. Still, most Americans are "satisfied" with their personal health care. The hubris of Americans claiming we have "the best health care system in the world" is truly shocking; America denies health care to more people than any other developed country on earth!

Could we learn something from other countries? Canada reformed its medical system beginning in the 1960s to a single payer that requires all persons be fully insured. Their system is a mix of public (70%) and private (30%) funding, with most high end services delivered by private providers. Although the system is not as responsive as the US, the "overall health service performance" from the World Health Organization ranked Canada 30th and the US 37th. This includes a measurement of achievement in the level of health, as well as the fairness of financial contribution and access to care. 92% of Canadians were satisfied with their care and did not want a system similar to the US. The US spends much more money than Canada, on both a per capita basis and as a percentage of GDP. Life expectancy is longer in Canada than the US and the infant mortality rate is lower but this may be due to different racial make ups of the countries and to the 30% US obesity rate that reduces life expectancy by 6-7 years. Switzerland and the Netherlands adopted universal health coverage in 1996 and 2006 respectively. Their systems have many features in common with an individual mandate, standardized basic benefits, a tightly regulated insurance market, and funding

schemes that make insurance affordable for low and middle income families. Their yearly costs are about half of the expense of the US.

Where do our health care dollars go and why is it so expensive? The CBO defines administrative costs as any expenses that insurers incur that are not payments for health care services. This includes marketing costs, expenses for claims review, taxes, and profits. Administrative costs for Medicare average 3-5% (the US government states 2%) while private health insurance averages between 15-20%. Some organizations such as Forbes and the Heritage Foundation argue that calculating administrative costs as a percentage of total expenses is misleading, making it only appear that Medicare is more efficient, and that the cost per beneficiary should be considered. Others point out that Medicare treats people who have many more health problems than the general population, and therefore the cost per beneficiary is misleading. Statistics aside, experts recognize that our mixed public-private system creates excessive overhead costs and that the large insurance company profits and CEO salaries all fuel health care spending. In 2011 the CEOs of the seven largest publically traded health plans collectively made 87 million dollars. Insurance company product design, underwriting, lobbying, and marketing all contribute to that sum. Kaiser Foundation Health plans, which are non profit, average 7.2% overhead which then goes into supporting their health care infrastructure. A recent study shows Medicare averages 4.7% versus private insurance at 14.8%.

However, the primary factor driving up health care costs over time is new technology and prescriptions drugs, which may extend and improve the quality of life, but often with very high cost. The research identifying the human genome has opened “Pandora’s Box” for development of drugs directed at specific genetic defects and cancer specific genes. The 1983 “Orphan Drug Act” has facilitated the development of drugs to treat rare conditions, giving biotech companies increased patent protection and exclusive marketing. According to Forbes, there are now 9 drugs on the market that cost more than $200000 per year to administer. For example, gene therapy for lipoprotein lipase deficiency, a heredity disorder, will be available in Europe this summer with a yearly price for treatment of $1,000,000 per patient. The drug Solaris, eculizumab, a monoclonal antibody, is available to treat paroxysmal nocturnal hemoglobinuria (incidence of PNH is 1 per million) and atypical hemolytic uremic syndrome, affecting a total of about 2000 patients world wide. This drug alone will earn it’s maker, Alexion Pharmaceuticals, 1.5 billion dollars in 2013 on the cost of $440,000 per patient for

a year. Even now, many cancer drugs now cost between $2000 to $12000 per month. In addition, we have protected drug company profits at the expense of every American on prescription medications. Recently, the US Supreme Court agreed to decide whether a pharmaceutical company should be allowed to pay a competitor millions of dollars to keep a generic copy of a best-selling drug off the market. As you can imagine, these pay-for-delay deals are win-win for drug companies but lose-lose for consumers and tax payers. The availability of state of the art technology and research for new drugs increases health care spending, not only because the development cost of these products must be recouped, but also because they generate consumer demand for more costly services, even if they are not necessarily cost effective. These treatments rarely cure the cancer and may only extend the patient's life a few months. Health economists estimate that advances in medical technology may add 40% per year in annual costs; medical industries are making billions each year promoting these advances, even if some are not cost effective compared to older treatments. We are going to have to carefully assess the acute needs of a few patients versus the wider interests of society in spending health care dollars.

Technology has now given us the ability to replace many different joints. Total knee replacement surgery was initiated in 1968 and the procedure has undergone multiple improvements since its inception. Currently, total knee replacement cost in the US is $45,000-$75,000 at a typical hospital. Originally, this surgery was intended for elderly patients with advanced osteoarthritis but with our "baby boomers" destroying their knees earlier and earlier, the indications for surgery have changed. Now, patients in their 40-50's are having surgery despite the fact that most implants have only a 10-15 year life span. The chance for a second surgery in these individuals is high and complications are even higher! In 2011, 644,000 knee replacements were performed in the US and it is estimated that by 2020, 2,500,000 will be performed. While this operation has generally improved the quality of life, are all of these replacements truly necessary? It has become the largest fee generator for orthopedic surgeons.

In addition, tax free employer sponsored health benefits have contributed to rising costs; since the consumer does not have to pay directly for his healthcare, there is virtually no incentive to even consider the cost of treatment. Under tax reform, congress will probably take a long look at the benefit of the tax-free status of employer health insurance which is the single biggest tax break the government allows. The CBO estimates that if this was eliminated it would bring

in an additional $150 billion. While it is unlikely that this will be totally eliminated, making this a fixed sum "tax credit" such as $2500 to $7500 deduction against your tax liability, depending on family size, will almost certainly be considered. Price transparency would make consumers more aware of what the actual cost of a medical procedure was going to be. Many experts feel that competition for medical treatment will reduce costs but, in general, this has not worked because the consumer-patient does not actually pay for the medical services.

The nature of health care in the US is changing in the face of chronic illnesses with obesity, diabetes, and cardiovascular disease, along with smoking related illnesses, all exploding. These are placing tremendous demands on delivery of health care and Center for Disease Control and Prevention, estimates that this now accounts for 75% of our national expenditures. A recent study showed that 1% of sickest patients spent nearly 30% of our health system's money, while the healthiest 50% of the population accounted for only 3% of overall medical spending. These high cost patients can be assigned health managers to try and reduce their maintenance. There should be an expansion of wellness programs which would provide financial incentives in an attempt to decrease the prevalence of these chronic and self destructive conditions. It is clear our population is aging, especially as baby boomers reach Medicare age, and the cost of care will rise dramatically. According the Wall Street Journal, 1 out of every 7 dollars spent on health care occurs in the last 6 months of life. While most Americans say every person deserves life prolonging care, can we afford it? This issue creates both a moral and financial dilemma. In addition, specialty care also drives up the cost more than primary care; more treatment by nurse practitioners and physician assistants would substantially lower costs.

So where can we find savings? We can invest in information technology (IT) and develop electronic record keeping. We can improve the quality of medical care by standardizing treatment, thus decreasing variation in medical practice and unnecessary treatment. Experts estimate that 30% of health care currently is not needed which would result in billions in savings. Another innovative idea is to for employers to "bundle" surgery costs for their insured by arranging treatment at only 5 or 6 hospitals across the country. This results in price stabilization and quality control with a lump sum payment for all services including surgical and hospital fees. Other changes that we should consider include an adjustment in provider compensation rewarding healthy outcomes rather than volume on a "fee

for service basis", which simply encourages more interventions. Medicaid and Medicare should consider a capitation program, where an annual payment is made yearly for comprehensive care. Most economists today agree that part of the solution to rising medical costs is having the consumer pay for a portion of their health care. This means more co-payments, higher deductibles, and possibly shifting premium costs to employees for spouses and dependents. To control insurance costs, some companies such as UPS, have initiated surcharges for unemployed spouses and are no longer covering a working spouse. Other companies are simply providing a "fixed dollar payment" for employees to buy their own health insurance.

We will never be able to control health care costs unless we increase the number of primary care physicians, decrease the number of specialists, fine tune technology, and then emphasize delivering affordable, quality basic medical care to those who now have none. We cannot continue to be mesmerized into extending each person's life until the "bitter end" through medical technology. Even adopting all these cost saving measures discussed in this presentation, only some which are in the ACA, we will still have millions uninsured and the cost of insurance will continue almost double digit increases yearly, far greater than our rate of inflation. At some point we should analyze whether or not the free market has reformed the cost and delivery of health care. If the problems persist, it may make sense to then consider a single payer defined benefit health care system, administered by the government, that would provide continuity of care that is not possible with all our competing systems. In a civilized society, all of its members should have access to medical care. It should be a program that offers a basic universal coverage to all US citizens. This would be administered via a health care tax or premium with government funding for low income families. The federal government needs to devise a solution to control health costs by regulation of fees of hospitals, doctors, pharmaceuticals and medical device manufacturers; however, no one can expect a "blank check" to receive all the health care that modern medicine can provide under a defined benefit plan. The attitude of Americans affects health care costs, in that most believe that if there is a treatment available, no matter what it costs and no matter what chance there is for a positive outcome, it should be made available.

We already have covert rationing in the health care market from both private insurers and the government. What is proposed here is an extension of this form of rationing to gain cost control. If individuals wanted additional coverage for

expensive surgeries such as organ transplant, complex cardiac and neurosurgery, some early joint replacement, and high end drug and chemotherapy, they or their employer would purchase them a supplemental insurance policy or simply have them pay for services in a manner like currently having cosmetic surgery. Doctors and hospitals could continue to operate as private businesses but we would then have a publically funded system for general health care delivery. If this was tightly regulated, it would eliminate the need for expensive insurance corporations, redundant paper work, underwriting, advertising, and multimillion-dollar CEO salaries and billions in profit. Our current free market system is extremely inefficient because of what economists call “transaction costs”, which are the costs of administering and coordinating a system that was designed to reduce access and limit care. Everyone eventually needs health care and it makes sense that a proactive system, involving all US citizens, healthy and unhealthy, would provide a better balance and enhance our society.

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