

Health Care Reform - Cost Containment and Recovery

by Sten from Maine

As with Vic Berez, I have been following the debate on the overhaul of the nation's health care system (thank you, C-Span). What follows are comments concerning the current system and some thoughts gleaned from my travels that relate to our current practices and future cost-containment, as thoughts for your consideration and further discussion. The narrative looks at two issues:

1) Does the current system need reform?

2) Should the activities we engage in that increase the cost to the nation be the source of cost recovery?

As background: I am a retired engineer who, in over four-decades in the practice of my profession around the world has had the opportunity to closely observe health-care systems in other countries. I have observed some national health care systems that provide services whose level of excellence offer models from which we can learn. I have observed other national health care systems that are disasters and can be pointed to as arguments against the existence of any national program.

I have no professional connection to the medical or health care or related industries other than as a patient. My view of the subject is biased by over 50 years of my personal experience as a consumer with medical professionals, drug companies and insurance companies.

Does the current system need reform? During the debates in the Congress on this program, I heard Senator McCain argue from the floor of the Senate that it was important that any action taken not endanger the nation's health care system, which he characterized as "the best in the world." As an engineer, I was taught that any statement of fact must be supported by repeatable measurements. In considering what measurements would support a statement of fact about the quality of the nation's health care system, two come immediately to mind: (1) average life span, and (2) infant mortality rates. As I look at the worldwide statistics on those two measurements, I find that the United States does not rank first in the world in either category nor would it qualify for either a silver medal or a bronze medal. Therefore, I must conclude that our system is not the best in the world. However, we do rank first in cost-per-person for health care. Therefore, we can state that our system, while not the best, is the most costly.

During the debates there were voices calling for delay so that there is time to get it "right." Now the same voices are calling for "repeal and replacement." As an individual who was born before World War II, I recall President Truman's efforts to find a solution to universal national health care. Those members of Congress and industry opposed to his effort at the time argued that a national health plan was a complex subject and government needed to move slowly to avoid risk of failure. I would assume that a half-century of study and the lessons learned from, and the model provided by, the Medicare program would suffice to allow the Congress to move forward at this time. In my view, after more than a half-century of study "the need to move slowly" doesn't sell. How long should we have to wait? If you cannot find "perfection" in 50 years, why not move forward with what we know now? I expect our elected representatives to work within the system, to value coalition and compromise, and to aim for achievable goals, not perfection.

Comments on *ObamaCare*: To begin, no one should expect the President and Congress to enact perfect legislation on this issue on this attempt. It is logical that any legislation passed will require future changes to cope with new conditions, better understanding of the nation's needs, and future changes in technology and practice. The only set of laws that has ever been placed before humanity

that was perfect, and, therefore, worthy of being cast in stone, was the 10 Commandments. Given the recent history of inflation of costs for health care, system changes are obviously required, and this is an issue whose time has come.

I admit the current law is not perfect, but I would argue it is the necessary first step on the path to correct many of the problems we now face in providing health care for most of our citizens. It institutes changes that will avoid the collapse of the entire system due to overwhelming costs which will continue to increase if no changes are instituted. Any legislation that accomplishes that deserves our strong support. Failure to pass this legislation would have only convinced the insurance companies and other opponents that they can continue to manipulate the House and Senate for their own financial benefit at the expense of the health and financial well-being of our citizens.

While the term *ObamaCare* is currently used by opponents to demean the current plan, I would argue that a decade from now, it will be held as a term-of-praise.

Cost containment and recovery: Concerns about the national budget deficit and projected cost to taxpayers for universal access to health care indicate any further increases to the national deficit must be avoided. Prior to the signing of what some refer to as the *ObamaCare* bill; over 45 million Americans were without coverage. The issue is how do we, as a nation, find a way to provide as close to equality of access to medical care for all of our citizens without increasing insurance rates to the point they are not affordable? The key will be finding ways for cost containment and cost recovery.

The suggestions that follow are based on the premise that sources to be considered for cost containment and recovery are those products, services, and practices that place increased burdens on the health care system and which are “voluntary” in nature.

I am a firm believer that each of us must be willing to accept responsibility for any decisions we make as individuals for the activities we engage in. I also don't understand why taxes or fees on the causes of poor health which are voluntary can't be levied. I believe that if everyone is to be allowed the freedom of living the lifestyle they wish, they are also responsible for covering the cost of that lifestyle and not burdening their fellow-citizens with that cost.

Congress has already identified areas where this approach might be applied:

1) If I decide that I want to smoke tobacco, then I should be willing to pay for the increase in health care costs brought about by my personal practice, and taxes on tobacco products should be appropriate to cover increased national health care burdens caused by tobacco consumption. The increased taxes on tobacco have already created a reduction in tobacco consumption, improving the health of Americans and lowering the potential for future costs.

2) Indoor tanning has been shown to cause skin-cancer. As with tobacco consumption, a tax on these services will hopefully reduce consumption, but if it doesn't, it will help to pay for the increased costs of health care.

3) Cosmetic surgery that is not associated with correction for injuries or deformities should be taxed. Again, these surgeries are not necessary and sometimes resulted in infections and other side effects that place additional burdens on the health care system. A tax may deter individuals from having unnecessary surgery, but if not, will help to pay for the increased burden on the health care system.

Using the same logic, other areas might be considered:

4) Over 20% of America's children fall into the obese category. One source of this obesity has been traced to consumption of sugared beverages. A recent study found that increasing the price of soft drinks by 10% led to a 7.8% decrease in consumption. Taxing soft drinks would lower the rate of obesity (and associated diabetes) while supplying funds to treat those who suffer.

5) My doctor has suggested I drink one or two glasses of red wine each day. A 5% federal tax on alcoholic beverages won't preclude me from enjoying my wine, but it may impact the intake of someone who is consuming two six-packs of Guinness and a bottle of Jamison a day and will help pay for that individual's liver transplant down the road. I would argue a 5% tax on alcoholic beverages would not bring serious economic harm to someone who has one or two drinks per day, while heavy consumers would be contributing to the cost of their recovery programs.

6) Trans-fats in food products appear to reduce cost of production and extend shelf-life of the products in which they are used while shortening the shelf-life of the consumer. Trans-fats in foods should be outlawed, but given Congress's reluctance to do so, taxing these products at the manufacturing source or at the point of entry into this country will reduce their cost-effectiveness, hopefully reduce their use, and if not, supply the funds for treatment of the cardiovascular wreckage they cause. (As with tobacco, tax levels of 100% or more should be considered.) If these taxes reduce consumption, all parties derive a benefit.

7) There are many medications, both prescription and over-the-counter drugs, that produce side-effects that increase the burden on our health-care system. Even relatively harmless, over-the-counter medication for pain relief such as acetaminophen has been shown to cause damage to internal organs when taken over a long period of time. I would argue that a tax of 5% to cover the cost of the additional burden would not significantly impact the demand for these products but would help cover the costs of their impact on the health care system.

8) Obesity is a costly problem. Check out your local Wal-Mart, which charges more for plus-size or "extended-size" garments than for regular size garments. (T-shirts selling for \$6.00 for "regular" sizes are \$2.00 higher for X, 2X and 4X sizes.) An added cost on plus-size garments would help fund the additional burden placed on the health care system by people who are plus-size. We don't appear to object to this practice by Wal-Mart, so why wouldn't it work for America?

Based on personal experiences, I learned:

9) On the subject of co-pays: For five years, I "commuted" to a research project at the University of Lund in Sweden. It is my understanding Sweden originally planned a national insurance system that did not require co-payments. Since all medical care was "free", they found that individuals made appointments for the most trivial matters, even just when they were bored and needed to talk to someone, situations in which, previously, they did not seek professional medical services. The system was swamped by these appointments, delaying access to medical care by individuals who were truly in need. The Swedes revised their plan to include co-payments to avoid abuse of the system.

Those who argue that a co-payment requirement might prevent an individual who was economically disadvantaged from receiving necessary care should find inclusion of a voucher-plan acceptable. Vouchers to cover the co-payment could be offered for those who could not afford a co-payment. (Vouchers for care by specialists would require the approval of the individual's primary care provider.) Co-payments have been proven to reduce the impact on the national budget and deter abuse.

The Swedish experience shows that any plan that does not provide for a co-pay (and I suggest a co-pay that is at least 10% of the cost) will increase the cost and burdens on the system. I would argue that plans that cover co-pays should be taxed to recover the additional cost of unnecessary care.

10) The cost to the government of supervision of the new system should be considered. I do not understand why the current law provides for different classes of insurance plans. I suspect that with over 2000 pages to work with, the lobbyists have certainly woven into the paper exemptions for the firms or industries that pay their salaries. I see opportunities for some insurance companies and health care providers to continue operating as they do today, gleaning immense profits, with insurance companies denying care when it is most needed, luring its customers into a sense of false security until they actually require help, creating plans that allow for technicalities that make it possible to deny liability or curtail payment, and health care providers recommending services that are not required, while making it difficult for any supervising government agency to hold them accountable.

My concern with keeping insurance companies honest is based on personal experiences. As one example, in 1970, one of the members of my family was diagnosed with cancer. Surgery and a course of radiation treatment were prescribed. The treatment plan was approved by my medical insurance carrier, and we proceeded. After the bill (for the successful treatment) was submitted, the insurance company refused to pay, claiming that Sloan-Kettering (the premier cancer-treatment facility in the world) was not on their list of approved cancer treatment centers. It took six-months of legal effort to get them to pay.

11) The cost of access to medication in this country is one area of cost reduction that requires consideration. Studies indicate the major cost component for medication in the U.S. is the cost of marketing, with the expense of marketing far exceeding the investment on development and the cost of production. “Marketing” includes the necessary cost of providing information to medical care professionals, but to a greater extent, the cost of television and print and other media advertising.

This advertising has an additional negative effect, in that, individuals are moved by the advertised claims to demand a prescription from their doctors for new drugs that often do not perform as well as older, less expensive medication or convinces too many people that they suffer from diseases that they do not have.

As reported in *TIME* (*TIME Magazine*, January 11, 2010, p.18): “By 2008, for example, GlaxoSmithKline was selling over \$1 billion worth of Paxil a year to the Japanese, who didn’t know they had a problem with depression until drug marketers informed them.”

My personal experience from purchasing the same medication in Europe and America (a 400% mark-up in the U.S.) suggests that the formula for determining the price of a medication for sale in the United States differs from the formula(s) used for other parts of the world, and begs the question: “Why should Americans pay a premium?”

I would argue that the cost of medication could be greatly reduced and the public health would be improved by eliminating the ability to advertise prescription medication to the public. Since the probability of Congress passing such a restriction is small, a tax on advertising of prescription drugs to the general public (but no tax on the costs of providing information directly to medical care professionals) to cover the additional costs to the health care system might be a workable alternative.

12) Reimbursement to health care professionals for services in many nations is carefully controlled by fee structures established by their governments. In each case, the fee structure is designed to control costs, and the recipients of the fees have no choice since acceptance of the fee structure is often a requirement for them to maintain any necessary licenses to practice.

I was told by citizens of other nations in which I worked where the structure is extremely punitive that some health care professionals had taken to requiring a cash “gift” prior to providing services. This gift was above the fee provided by the national plan and, my understanding was, not reported. However, without the “gifts”, health care professionals could no longer afford to provide services.

I have seen statistics that indicate that up to 40% of the cost of medical care is related to “paperwork”. By introducing a national, standard electronic patient care reporting and service fee recovery system, the cost of medical care could be dramatically reduced, and at the same time, the level of safety increased through the availability of electronic access to patient records.

Any reduction in fees for services by health care professionals should be related to the reductions in cost of delivery of those services. Health care professionals should not be punished by carrying the burden of the need to balance the budget.

Another possibility for future consideration would be to have the government agree to reimburse health care providers (i.e. doctors, nurses, etc.) for their educations, since the cost of acquiring those educations and payment of the loans that resulted must be recovered when the individuals engage in practice.

Some of those who oppose the current attempt to reform the system have argued that there will not be a sufficient number of primary care providers (family doctors) to cover the additional number of Americans that will be included. A program that would reimburse 10% of the cost of an individual’s education for up to 10 years in each year in which the individual engages in a family practice would probably attract a sufficient number to meet the nation’s needs. Specialists could also be compensated, but since they attract a higher income, the rate and percentage of reimbursement could be lower.

13) Universal availability of electronic access to patient records implies that the nation has in place an adequate broadband communications structure. As of 2008, the United States ranks 20th in the world in broadband penetration and 17th in the world in average advertised broadband speed. (The average rate for the United States is 9.6 Mb/s as compared to nations such as France at 51.0 Mb/s, South Korea at 80.8 Mb/s, and Japan at 92.8 Mb/s.) This is a related problem that must also be resolved.

14) Competitiveness between a government plan and private insurers: I have seen statistics indicating that the overhead costs for providing healthcare insurance by private companies, including marketing costs, amount to between 20 and 40% of the total cost, while the overhead on the Medicare program is less than 4%. The argument is that a government plan, having lower overhead costs, would undercut private plans and drive private industry out of business. Given the importance to each individual of access to affordable health care and current costs of care and of insurance, a reduction in cost to the consumer of over 20% is a hard problem to set aside. A government plan could serve as a role-model for private corporations to follow to improve their efficiency.

It can be argued that the existence of what has been termed the “public option” could also be important to assuring that the insurance companies conform to the law. I understand there is strong

opposition to a public option. I would argue that such an option should at least be allowed on a state-by-state basis, since there are many states, such as Maine, where the distribution of population and the local average income may not attract true competition among private insurance companies. If a national program is not politically achievable, the choice of a public option could be left to each state.

I also see a national public option as an offering that might be found more acceptable a few years after the current proposed health care reform bill has been put into action, should it become evident that private industry had failed to meet its responsibilities.

Another possible solution would be to provide for a universal public option plan, which includes a mandatory co-payment structure, and to allow private industry to provide add-on plans that cover co-payments, as is currently found with the Medicare program.

Those industries that are fighting to maintain the status-quo should learn from the lessons of the automotive industry - manipulating the legislative process to avoid the challenges of today may lead to the complete elimination of your corporate existence in the future. The owners they represent would be better served by adapting to the changing world rather than denying its existence.

15) A universal requirement for every individual to carry health insurance creates a pool that results in lower costs to all, and by mandating payroll deductions to guarantee and confirm participation, the cost of individual billings and collection would be reduced for private insurers as well as the government. For those individuals who are self-employed or not employed, collection of the cost of health care premiums could be mandated and collected through modifications to the current *Estimated Tax for Individuals* collection system (Form 1040-ES).

16) Increasing Medicare taxable levels or income taxes: I recognize that providing care for most of our population will increase costs. I am past my 70th birthday living on social security and a pension, and I have no objection if a small increase in my taxes will secure the system. I certainly don't understand why those individuals and families whose income exceed \$250,000 per person per annum and businesses can't find a few more dollars to contribute to the well-being of their fellow citizens. A healthier pool of workers has been shown to result in increased productivity, lower absentee rates, and higher corporate profits. A moderate increase in income tax rate for individuals and businesses whose income exceeds \$250,000 would not be a restrictive burden and should be acceptable to those who will pay.

I worked as an engineer in the television industry and was well compensated. My work required me to travel, and I observed how other people lived throughout the world. I am grateful that I live in America. While I don't appreciate waste of my tax dollars such as on military equipment that doesn't meet functional requirements or bridges-to-nowhere, I have always been willing to pay what was due the government. According to data published by the IEEE, for more than the last decade of my career, my income placed me in the top 1% of my profession (albeit, not in the top 1% of the nation), and I paid income taxes accordingly. I didn't consider what I missed purchasing with the taxes that were taken, but, instead, focused on the life style provided by what remained, and noted that I lived better than 95% of the rest of humanity. I have access to clean drinking water, breathable air, good roads, and many other benefits that others are denied. I believed I should pay my share of the cost of those benefits and have always felt blessed.

I appreciate the fact that there will always be individuals for whom no amount of taxation will be acceptable. My work brought me into daily contact with individuals with multi-year, personal services contracts whose annual compensation was in the millions of dollars. I listened to some of

them complain constantly about their tax situation and other ways life was “cheating” them. They were always looking at the possessions and advantages enjoyed by others that they had not, as yet, acquired, rather than recognizing and extracting joy from the privileged life they led. I have heard highly compensated individuals argue that since their work provides jobs for others, they should not have to pay any income taxes. (I refer to such individuals as suffering from LHS - the Leona Helmsley Syndrome – “only little people pay taxes.”)

I believe that we each should pay for the benefits that we receive. People of higher income are obviously benefiting more than the average citizen from the economic engine that drives this country. If the United States were to be invaded, it would not be the slums of the poor that would be confiscated by the invaders for their own use; it would be the homes of the wealthy. I look at our tax rate structure as a “usage tax”; the more of the nation’s services I use, the more income I make, and the more material objects I own, the more I have to protect and the more I should contribute.

In summary, I would argue that a review of the history over the past half-century clearly indicates that this nation needs to create a new national health care environment that focuses on improving the quality and efficiency of health care, thereby, lowering the cost of health care in this country to reduce: (1) the probability of personal bankruptcy of individuals due to the cost of personal medical care, (2) its eroding effect on American businesses’ ability to compete in the world market, and (3) the rising deficits in the national budget.

There is still much work to be done in achieving desired cost containment, finding ways to pay for the new protections, and ensuring there will be adequate numbers of medical professionals to provide the services required. All of that work requires a framework on which to build, and the current health reform bill provides the foundation for that work to begin.

The intent of this narrative is to promote a response. I would be interested in comments by others. Send them to webmaster@inshadesofgray.us and they will be forwarded to me.