



FAQ Supplemental: Runaway Health Care Costs

Why are health care costs rising and how can single payer “bend the cost curve?”

High administrative costs and excessive - even ridiculous - prices under the current system are themselves symptoms of the increasing commercialization of health care and the growing dominance of private firms in health care delivery and financing. Cutting administrative costs and mandating reasonable pricing would result in very large one-time savings and allow an affordable transition to comprehensive coverage of the un- and under-insured, but without other cost control mechanisms these savings would soon be eaten up by continued health care inflation.

Over the longer term, the keys to savings lie in improved health planning implemented through control of capital spending, as well as limitations on market incentives and limitations on for-profit involvement in health care delivery.

Health planning is needed to assure that investments in expensive new technology meet needs, but do not exceed them. It is the only proven means to limit the excessive and dangerous interventions that drive up costs and lower quality. It is the salutary alternative to the current strategies of case-by-case review by HMOs, or the potentially disastrous incentives offered under capitation arrangements.

Limits on for-profit ownership and on the excessive compensation of health care executives are needed to dull the incentives for institutional gain at the expense of system-wide performance. For-profit hospitals and dialysis facilities paid by Medicare have higher costs and lower quality than non-profits. Eliminating them is key to “bending the cost curve.”

Why not make people who are higher risk pay higher premiums?

Experience-rated insurance requires higher risk people to pay higher premiums. This approach says that people who have had cancer in the past, or who have chronic conditions like diabetes and hypertension, or who have had dangerous exposures to substances like asbestos, must pay more because they are at higher risk of using health services. Experience rating allows insurance companies to cherry-pick the healthiest people and either refuse to insure the sickest or, what amounts to the same thing, charge prohibitively high rates. This approach makes no sense. The whole point of insurance is to spread the risk so that everyone is covered. If you raise premiums - and thereby exclude from coverage those people unfortunate enough to be sick - you defeat the point of both insurance and the health care system. Genetic conditions, childhood diseases, accidents, injuries, and income distribution (or how much equality there is in a society) play a much bigger role in people’s health than “individual lifestyle” factors. And we know

that even for motivated patients, alcohol and tobacco cessation are difficult, and medical weight loss nearly impossible. We need public health, primary care, and education programs to try to prevent disease, but punishing patients once they are ill is inhumane and counterproductive.

Community-rated health insurance is the socially fair approach. It spreads the risks evenly among all the insured. It removes the punitive element. It does not discriminate against the very sick, nor against those of us who are at higher risk because of our age (say, over 50) or our gender (reproductive-age females have higher health expenses than men, for obvious reasons).

Health care should be organized as a public service, like a fire department. A health system organized as a business is discriminatory and accountable to no one. At some point in our lives, all of us will predictably need health care. Hence, health insurance is unlike any other form of insurance; we all are involved.

How will we keep costs down if everyone has access to comprehensive health care?

People will seek care earlier when chronic diseases such as hypertension and diabetes are more treatable. We know that both the uninsured and many of those with skimpy private coverage delay care because they are afraid of health care bills. This will be eliminated under such a system. Undoubtedly, the costs of taking care of the medical needs of people who are currently skimping on care will cost more money in the short run. However, all of these new costs to cover the uninsured and improve coverage for the insured will be fully offset by administrative savings.

In the long run, the best way to control costs is to improve health planning to assure appropriate investments in expensive, high-tech care, to negotiate fees and budgets with doctors, hospitals, and drug companies, and to set and enforce a generous but finite overall budget.

Will bundled payments and “paying for value” in health care reduce costs?

Bureaucrats at CMS are fixated on the meme that we can reduce spending by paying for the value of health care rather than the volume. They have been disappointed with models such as accountable care organizations, and they are now turning to MA-CRA and its alternative payment models (APMs), with a renewed surge of interest in bundled payments.

The concept behind bundled payments is that, by assigning a single fee to a given intervention such as a joint replacement, you will motivate physicians to not spend money on portions of the care that are not really necessary. Medicare, as the payer, gets the advantage of a discounted price, and the physicians and hospitals

get to keep whatever they save beyond the discount.

Does this really reduce volume? The joint replacement will be done regardless, so what volume will be reduced? Doing only a cursory pre-op exam, missing the ejection murmur and omitting the pre-op cardiac consult? Send a patient home earlier when it is possible that the post-op status might not be fully stabilized? Cut back on rehabilitation, risking a less favorable long-term outcome? These might reduce volume, but they certainly bring into question quality and thus value.

Now they want to pay a set bundled payment for a heart attack. The clinical course of a heart attack is highly variable and could involve only a few or a great many interventions. Under a bundled payment, the physicians and hospital are bearing the risk of the high costs of a potentially complicated, protracted course. Isn't it the role of the insurer, in this case Medicare, to pool risk? Shifting that risk to the health care delivery system creates the potential for either a reduction in important beneficial health care services, or exposing the delivery system to potential monetary losses and the risk of insolvency - neither of which are desirable.

Perhaps an even more important issue is the fallacy that you can bundle most care and thus make strides in bending the cost curve. Think of the current proposals to bundle coronary artery bypass grafts and to bundle care for a heart attack - one might work some of the time, but the other has outcomes that are too variable. Now think of other hospital admissions - such as workup of a protracted fever, diagnosis and management of an HIV positive patient who has symptoms of a potentially serious but undiagnosed complication, or perhaps a child with fatigue and weight loss. The costs and outcomes are highly variable. How can you bundle those? Or think of the multitude of patients presenting in a 10 minute office visit with a set of complex clinical symptoms that would require extensive workups. How do you bundle those?

To get to the goal of 50 percent of Medicare payments being tied to APMs, you are going to have to figure how to bundle the large numbers of common clinical presentations, like the sore throat that turns out to be due to acute leukemia, or the routine family planning visit for a patient who feels ill that day and turns out to have diabetic ketoacidosis, or the chronic headache patient who has a focal motor seizure in front of you during the visit. What would otherwise be routine medical visits are often not bundable but are better handled on a fee-for-service basis. That makes the point that most health care is provided in a relatively fixed volume. It is really difficult to reduce the volume for patients who actually need care, and that's almost all patients. Besides, in most instances we really don't know how to measure value and convert that into a fixed fee. Volume is relatively fixed, and value is what we all strive for anyway.

Since it's really cost that we are concerned about we should move forward with reform that has been proven repeatedly to slow the rate of health care inflation - a single-payer national health program. Politicians need to abandon their false meme that single payer is "not feasible." What isn't feasible is expecting to fix our dysfunctional health care financing system with "bundled payments."

Answer contributed by PNHP senior health policy fellow Dr. Don McCann

How will we keep drug prices under control?

When all patients are under one system, the payer wields a lot of clout. The VA gets a 40% discount on drugs because of its buying power. This "monopsony" buying power is the main reason why other countries' drug prices are lower than ours. This also explains the drug industry's staunch opposition to single-payer national health insurance.

What impact would single payer have on physician incomes?

Canadian physicians have done well under their single payer system, as documented in a recent, careful study. In addition, streamlined billing under single payer would save U.S. doctors vast amounts in overhead, and free up additional physician time to see a few more patients. Hence, even if doctors' gross incomes declined slightly (a questionable assumption if they're freed up from insurance paperwork and able to devote more time to patient care) physicians' average take home incomes wouldn't change under single payer. Of course, some doctors' incomes would go down - e.g. those who currently enjoy a particularly rich payer mix. On the other hand, some would see an increase - e.g. those currently caring for many Medicaid or uninsured patients.

Answer contributed by PNHP co-founder Dr. Steffie Woolhandler

What will happen to malpractice costs under national health insurance?

They will fall dramatically, for several reasons. First, about half of all malpractice awards go to pay present and future medical costs (e.g. for infants born with serious disabilities). Single payer national health insurance will eliminate the need for these awards. Second, many claims arise from a lack of communication between doctor and patient (e.g. in the Emergency Department). Miscommunication/mistakes are heightened under the present system because physicians don't have continuity with their patients (to know their prior medical history, establish therapeutic trust, etc.) and patients aren't allowed to choose and keep the doctors and other caregivers they know and trust (due to insurance arrangements). Single payer improves quality in many ways, but in particular by facilitating long-term, continuous relationships with caregivers. For details on how single payer can improve the quality of health care, see "A Better Quality Alternative: Single Payer National Health Insurance." For these and other reasons, malpractice costs in three nations with single payer are much lower than in the United States, and we would expect them to fall dramatically here. For details, see "Medical Liability in Three Single-Payer Countries" by Clara Felice and Litsa Lambkros.

What impact would single payer have on taxes?

Currently, about 65% of our health care system is financed by public money: federal and state taxes, property taxes, and tax subsidies. These funds pay for Medicare, Medicaid, the VA, and coverage for public employees (including police and teachers, elected officials, military personnel, etc.). There are also hefty tax subsidies

to employers to help pay for their employees' health insurance.

Under the single-payer system created by H.R. 676, the Expanded and Improved Medicare for All Act, the U.S. could save an estimated \$617 billion annually by slashing the administrative waste associated with the private insurance industry (\$504 billion) and reducing pharmaceutical prices to European levels (\$113 billion).

Health care financing in the U.S. is regressive, weighted heaviest on the poor, the working class, and the sick. With the progressive financing outlined for H.R. 676, 95 percent of U.S. households would save money according to an analysis by professor Gerald Friedman.

The following progressive financing plan outlined by Prof. Friedman would meet the specifications of H.R. 676:

- EXISTING SOURCES OF FEDERAL REVENUES FOR HEALTH CARE
- TAX OF 0.5% ON STOCK TRADES AND A 0.01% TAX PER YEAR TO MATURITY ON TRANSACTIONS IN BONDS, SWAPS, AND TRADES
- 6% HIGH-INCOME SURTAX (APPLIES TO HOUSEHOLDS WITH INCOMES > \$225,000)
- 6% TAX ON UNEARNED INCOME FROM CAPITAL GAINS, DIVIDENDS, INTEREST, PROFITS, AND RENTS
- 6% PAYROLL TAX ON TOP 60% OF INCOME EARNINGS (APPLIES TO INCOMES OVER \$53,000, TAX PAID BY EMPLOYERS)
- 3% PAYROLL TAX ON THE BOTTOM 40% OF INCOME EARNINGS (APPLIES TO INCOMES UNDER \$53,000, TAX PAID BY EMPLOYERS)

Of course, the biggest change would be that everyone would have the same comprehensive health coverage, including all medical, hospital, eye care, dental care, long-term care, and mental health services. Currently, many people and businesses are paying enormous premiums for insurance littered with cost-sharing through copayments, deductibles, and uncovered services, exposing patients to financial ruin in the case of illness or injury. Under H.R. 676, this cost-sharing would be eliminated.

What is PNHP's perspective on the Medicare crisis?

Medicare can only be saved by incorporating it in a single-payer program that would be very different than the current Medicare program.

Medicare benefits need to be greatly upgraded. At present, Medicare covers less than half of the total medical expenses incurred by its beneficiaries.

Medicare's payment policies for physicians, hospitals, home care, rehab, nursing homes, and HMOs are all deeply flawed.

Its physician fee schedule is wildly skewed toward specialist care and needlessly complex; it discourages salaried practice.

Its hospital payment system uses per-patient payments rather than global budgeting, and lumps together capital and operating payments – negating any real health planning possibilities.

Its rehab and nursing home payment methods are similarly complex, discourage health planning, and reward institutions willing and able to engage in financial scheming.

The home care payment system burdens nurses with extreme amounts of paperwork, rather than paying home care agencies lump sum budgets.

As long as Medicare is one among many payers it cannot achieve substantial administrative savings (in doctors' offices, hos-

pitals, and other facilities) and it cannot enforce the health planning changes needed to “bend the cost curve” over the long term.

In short, the only way to preserve Medicare is to replace it with a single-payer program with comprehensive benefits and effective cost controls (negotiated fees, global budgets, and bulk purchasing) – not just incrementally expand it to the whole population.

Answer contributed by PNHP co-founders Drs. David Himmelstein and Steffie Woolhandler

What proportion of health spending is for undocumented immigrants?

Very little. All foreign-born people, including immigrant workers who have legal status and who have lived in the U.S. for years, account for somewhat less than one-quarter of the uninsured, according to the Census Bureau. We do know that foreign-born people in the U.S. are, on average, healthier and utilize little health care (about half of the health care, per capita, of U.S.-born persons). Surprisingly this is true whether or not they have insurance. Immigrant children receive very little care, 74 percent less overall than other children. So, if the foreign born are less than one-quarter of the uninsured, only one-eighth of health spending on the uninsured is going to the foreign born, which translates into a tiny fraction of all U.S. health spending. In fact, most immigrants have health insurance coverage, and 30% of immigrants use no health care at all in the course of a year. Undocumented immigrants are politically marginalized and hence a convenient target, but they are not the cause of rising health care costs.

How much do private insurance companies spend on overhead and profit?

Private insurance overhead and profit, on average, fluctuates between 12% and 14% nationally. This figure is somewhat lower than the 16-20% at many of the big insurers because it includes self-insured plans of many big employers that have overhead of about 6-7%. On the other hand, overhead in the individual market is often substantially higher than 20%, and in some cases above 30%.

The estimate that total administrative costs consume 31% of U.S. health spending is from research by Drs. David Himmelstein and Steffie Woolhandler, published in the *New England Journal of Medicine* in 2003. The figure would undoubtedly be higher today. Insurance overhead accounts for a minority of total overhead. Much more occurs in physicians' offices, hospitals, and nursing homes - driven by our current fragmented payment system. The fact that insurance overhead per se accounts for a minority of the bureaucratic waste in the system explains why implementing a public option plan would not achieve most of the potential bureaucratic savings that can be realized through single payer. Even with a public option, hospitals, physicians and nursing homes would still have to maintain virtually all of their internal billing and cost tracking apparatus in order to fight with private insurers.