Healthcare and Access:

Regional Solutions for a National Challenge

Part One of a dialogue on healthcare in the Southern California region

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Access to Healthcare is a Challenge that will not lend Itself to a Simple Solution

Comprehensive Healthcare reform is a complex issue, especially when viewed on a national scale by those seeking one-size-fits-all solutions. The problem is indeed one of national concern that necessarily relies on federal funds and resources. But unfortunately, with such entanglements come the inevitable federal bureaucracies, guidelines and regulations.

What part should be played by state, regional and local agencies—and what is to become of individual responsibility? Is there room in these grand federal schemes for the empowerment of patients, for innovations such as regional healthcare cooperatives, and for the development of localized wellness and prevention strategies?

Nobody doubts that individuals living healthier lifestyles and having regular medical checkups can make their small contribution to the overall healthcare solution. But, healthcare programs offer few incentives for individual responsibility other than imposing surcharges based on age, or rejecting patients with pre-existing conditions.

❁ A Culture of Wellness

If we look to the state, regional and local level, there are programs that could be implemented to help bring down the overall cost of healthcare, but once again, there are few if any incentives. The notion of good health alone tends not to resonate with healthier individuals—at least not enough to get them to use greater care. Even in cases where free and subsidized healthcare is available, as in California's Healthy Families Program,[1] parents don't have the information, or are not taking the time to enroll their children.

Opponents of a comprehensive federal system argue that the solution cannot lie in another bloated government bureaucracy—with organizations far removed from local communities—organizations that are insensitive, unintelligible and politically inaccessible. Federal programs such as Medicare[2] do fill a critical need, but tend not to be cost-effective or efficient in the delivery of services. They are a constant source of frustration for patients. Socialized programs in the UK and Canada are also controversial, with substantially longer waiting lists and more limited access to technologies and procedures. Some would call this "rationed" healthcare, which of itself is a de facto means of cost control. Where healthcare is delayed, there is a greater chance of saving money if maladies resolve themselves. There is also a greater possibility that it will lead to more serious problems or even death.

❁ Status of the Healthcare Debate

In the broadest sense, healthcare can be broken down into four major categories: 1) healthcare costs, 2) cost to the system of uninsured patients, 3) the system for delivery of healthcare, and 4) public health and policy considerations.

The cost of healthcare is increasing at a rate doubling the increase in the Consumer Price Index. It is consuming a larger and larger percentage of personal income. The current slice—now at 16-17 percent—could easily go to 25 percent or more. In today's economy, a typical family of four pays about $15,000 per year for insurance. Yet, the comprehensive component of medical care—including primary care, x-rays, lab tests and outpatient care—only accounts for $800-$1,000 per year per patient. The remainder is consumed in a variety of other expenses, many of which are unrelated to patient health.

❁ Hospitals under Siege

Hospitals have four basic lines of business. Medicare and Medi-Cal[3] are steady and consistent, but unfortunately the reimbursement does not cover the costs, producing a negative cash flow for the hospitals and providers.

The third group is the uninsured, the ones most likely to be in need of care. They represent a tremendous drain on private hospitals who are often required to care for them without reimbursement. Typically they show up at an emergency room for treatment and cannot be denied, even if their problems

1 Healthy Families is low cost insurance that provides health, dental and vision coverage to children who do not have insurance today and do not qualify for no-cost Medi-Cal.

2 Medicare is a social insurance program administered by the United States government, providing health insurance coverage to people who are aged 65 and over, or who meet other special criteria.

3 Medi-Cal is California's Medicaid program, public health insurance for low-income individuals including families with children, seniors and persons with disabilities. It is financed equally by the State and federal government.

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are not emergency in nature. Under federal law, EMTALA,[4] anyone presenting themselves at an Emergency Room has to be treated. While this is a very responsible approach for an advanced society such as ours, unfortunately there is no provision for reimbursement or allowance for hospitals to terminate care. Hospitals receive no payment for these patients and are forced to cover these unfunded mandates from other sources. The costs to subsidize the non-paying and underpaying patients adds significantly to the burden of hospitals and to the overall cost of healthcare.

The final category are those patients who pay individually or through their employers for private health insurance provided by firms such as Anthem/Blue Cross or Kaiser. Even this pool of patients can create headaches for providers. The bargaining power of a handful of huge insurance companies in each state is substantial, and hospitals and healthcare providers are often forced into contracts that lock-in operating losses. These costs add to the burden of healthcare delivery and represent an estimated ten percent hidden tax.

In some cases hospitals have been muscled out of the traditional system entirely, many opting instead to only provide boutique medical services in categories that allow enough margin for profitability. This means limiting access, in most cases eliminating the burden of providing trauma care, and avoiding the exposure that comes with operating an ER.

With hospitals' average operating margins being negative, they are left to make up shortfalls through foundations and other resources. Very few are profitable.

Insurance as a Business

If we accept the premise that insurers are in the health *insurance* business, that means they are *risk* based. They take the risk and insure against their customers becoming ill—primarily against the fear that customers have of catastrophic illness. Accordingly, they cannot be expected to take on poor risks, or to charge the same premiums for a healthy 30-year old as they would for an unhealthy 65-year old.

The business model is different in the health *maintenance* business. In this model the focus is on keeping individuals healthy and out of the doctor's office. Patients pay a fixed premium to join a health maintenance pool and access a comprehensive, but limited array of care. This approach is usually characterized by lower deductibles and co-pays, with patients shopping for immediate return on their invested premiums. Unfortunately, these routine day-to-day matters may not be an area where insurance can be applied most efficiently—where a vast bureaucracy stands between doctor and patient even in matters of primary care, consultation and checkups.

4 The Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd, EMTALA) requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay. There are no reimbursement provisions. As a result of the act, patients needing emergency treatment can be discharged only under their own informed consent or when their condition requires transfer to a hospital better equipped to administer the treatment.

The goal in health maintenance should be to keep as many patients at the primary care level for as long as possible during their lifetime. On the service delivery side, a balance must be struck between the costs of regular preventive care and early diagnoses, and the much greater costs of advanced conditions that result from neglect and avoidance.

Most health plans and health insurance policies are hybrid versions of the two models. It may be beneficial to look at unbundling traditional coverage and services and consider possible variations and cafeteria-style plans. Support is growing for bare-bones policies that only cover major illness and catastrophic losses. These would be coupled with large buyer pools guaranteeing contract rates to members, who then pay their own costs for primary medical care. Unfortunately, the morass of existing regulations may make implementation of such plans difficult.

Many object to private insurers because they make profits in the marketplace, but ultimately the same principles of solvency need to apply to government programs if they are to be sustainable. Business is business, and even in government, the laws of economics apply. If revenues don't meet expenses, they will cease to exist and be of no further use to anyone.

What is Driving up Costs

Private insurance costs are skyrocketing. New technologies and medications are a big part of these healthcare cost increases. Much of this is due to amortization of the R&D for advancements that are passed along to the healthcare industry and ultimately to the patients. "Wonder drugs" can be extremely expensive, and it is estimated that bringing a new drug to market today can range from $500 million to over $2 billion. But on the positive side, the sale of these drugs also generates capital that can be plowed back into more research, discoveries and innovation. If profitability is reduced, there is a very good chance that research on the next generation of pharmaceuticals will be reduced as well.

"We were not spending nearly as much on high-tech medical procedures in the past because there were not nearly as many of them, and we were not spending anything at all on some of the new pharmaceutical drugs because they didn't exist" opines economist Thomas Sowell in a June 2009 editorial. "We would like to have all these things without the rising costs that come with them. But only with medical care is such wishful thinking taken seriously, with government [giving] us the benefits without the costs."

The costs of acquiring and keeping pace with technologies such as imaging equipment can be staggering. Yet MRI, CT and PET scans have become routine elements of medical diagnosis. New surgical techniques, such as the use of stents and minimally invasive techniques: laparoscopic and arthroscopic surgery also signal new, higher "standards" of healthcare. With today's flood of information, consumers are instantly made aware of any new drugs or techniques that might remotely benefit them. With the inundation of advertising, pharmaceuticals and technologies are in high demand from the very moment they go to market.

State and federal governments have become more and more aggressive in mandating what must be covered. "While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets." The Council for Affordable Health Insurance estimates that mandated benefits currently increase the cost of basic health coverage from a little less than 20% to perhaps 50%. These extended benefits and inclusions are championed by various healthcare providers and patient populations, all of whom want to expand the range of coverage and narrow what they pay for out of pocket. Unfortunately, forcing companies to load up policies increases the costs to the patient pool, and in the premiums insurers need to charge.

Hospitals that don't field the latest technologies run the risk of not being competitive, of losing doctors and staff, or in the worst case, risking lawsuits. Defensive medicine is an extremely large hidden cost, with an estimated 83% of doctors admitting to ordering extra tests as a precaution, solely to keep from being sued. Doctors practicing cost containment and efficiency do so at their own peril.

A Tsunami of Seniors

In the United States, and California in particular, there is a major bulge—the "Baby Boomers"—reaching that magic age where priorities change, with the quest for good health displacing other concerns, and where healthcare costs comprise an ever-greater share of individual budgets. This population bulge (1946-1964) is 18 years deep, with the average lifespan from age 60 to age 80 adding another 20 years. Thus, we have to prepare for a flood of demand that will last the next 40 years. How much of this will be market driven and how much will be government mandated programming? Judging by citizen sentiment and the current political debate, this is likely to be a question of degree, with no clear winners.

The Uninsured and Under-Insured

The uninsured and under-insured make up the most important pool of concern. There are many situations where workplace coverage is not possible or simply not provided, such as with the self-employed, occasional laborers, smaller businesses and part time employees. Monthly individual plans can run from $200 to $1,000 or more, and for families this can push beyond $1,500, even with high deductibles and co-pays.

This problem is compounded by changing economics and demographics as well, affecting an ever-greater percentage of the younger population. Healthy young people tend not to trouble themselves with fears of illness. And, by definition, the under-employed have little chance of being able to afford coverage for themselves or their families. Many self-employed individuals simply don't insure themselves or their employees, primarily because of budget constraints that are all too common in smaller companies.

How Costs are Being Controlled

As with any economic or social system, we can find solutions, or solutions will be forced upon us. In order to control costs, some businesses are dropping dependent and family coverage. Insureds are accepting higher co-payments and higher deductibles. It is not unusual to have $2,500 to $5,000 deductibles with the newer, consumer-driven health plans—and they often provide far fewer benefits. In the worst-case scenario, consumers are dropping coverage altogether, especially if they are under the illusion that they're not at risk for illness. This adds to the problem since insurance companies generally pool the premiums paid in, and benefits paid out, in order to determine rates. With the loss of the younger, healthier participants, the per capita costs of those remaining in the pool increases.

Ninety percent of larger businesses provide coverage compared to only 50% of smaller businesses. Overall in California, only about 50% of businesses provide coverage, and every year this is decreasing by one to two percent. The market is also hobbled by an inability to buy health insurance across state lines. This decreases competition and limits the creativity that insurers can use in underwriting and in their marketing strategies. Such arbitrary regulations rarely benefit the consumer.

We are faced with a number questions that will have to be answered: Can our society afford to provide unlimited care to every resident, and offer an ever-increasing array of technologies, pharmaceuticals and heroic procedures? If so, who pays, and what are the comparative roles of government, non-profits and the private sector? Can the healthcare industry as we know it, survive more unfunded government mandates?

As to solutions: What can be done on a state, regional or local basis to help decrease dependency on federal programs, diminish costs, improve access, and assure that efficient and appropriate healthcare will continue be available? Could regional health insurance cooperatives provide part of the answer?

We will explore more of the issues and approach some solutions—including regional strategies—in Volume II of these policy papers.

References

Core material for this series of policy papers was presented by Keith S. Richman M.D.; former member of the California State Assembly; EVP and former Chairman, Lakeside Community Healthcare. Supplemental material and editorial provided by: Robert L. Scott, Director, Mulholland Institute; San Fernando Valley Hospital Report, March 2004; The Council for Affordable Health Insurance; Thomas Sowell, Economist; The Reason Public Policy Institute; and The Valley Economic Alliance, Livable Communities Roundtable.