Moving toward universal access to healthcare (a market-oriented perspective)

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What is the Heartland Institute?

- The Heartland Institute is a national nonprofit research and education organization, tax exempt under Section 501(c)3 of the Internal Revenue Code, and founded in Chicago in 1984. It is not affiliated with any political party, business, or foundation.
- Heartland's mission is to discover, develop, and promote free-market solutions to social and economic problems.

Agenda

1. A quick history of health insurance
2. The role of tax policy
3. Healthcare spending in the U.S.
4. International comparisons
5. The case for consumerism
6. Market-oriented healthcare reform ideas
7. Concerns about Illinois Covered
8. Moving toward a "21st Century" system with universal access
9. Key questions to ask

1. A quick history of health insurance

- The first modern group health insurance plan was formed in 1929.
- Blue Cross and Blue Shield entities begin offering group health plans in 1932.
- Several large life insurance companies entered the health insurance field in the ‘30’s and ‘40’s.

1. A quick history of health insurance

- WWII wage freezes imposed by the federal government.
- Employee benefit plans proliferated in the ’40’s and ‘50’s. Strong unions bargained for better benefit packages, including tax-free, employer-sponsored health insurance.

1. A quick history of health insurance

- Social Security was expanded in 1954 to provide disability benefits.
- Medicare and Medicaid were implemented January 1, 1966 during the Johnson administration.
- ERISA, passed in 1974 as a pension reform bill, reinforces the employer’s role in providing health benefits.

1. A quick history of health insurance

- 1970s: Private health insurance moves toward comprehensive major medical insurance.
- The Federal HMO Act was legislated by Congress in 1973.
- PPOs, HMOs, and POS plans emerge during the ‘80s and ‘90s as the prevalent form of private insurance.

1. A quick history of health insurance

- By 2001 93% of private insurance was of the managed care variety.
- Over the last 5 years, trend away from HMOs toward CDHPs (consumer-driven health plans).

1. A quick history of health insurance

- In 1940 the total US population was 127 million. About 12 million Americans (9.4%) were covered by some form of private health insurance.
- In 2005 the US population was almost 293 million. At the time 248.1 million Americans (84.6%) were covered by some form of public or private insurance, and 44.8 million* (15.4%) were without.

Source: Census Bureau Revises 2004 and 2005 Health Insurance Coverage Estimates, March 23, 2007
http://www.census.gov/Press-Release/www/releases/archives/health_care_insurance/009789.html

1. A quick history of health insurance

- Sources of health insurance coverage:

Source	U.S.	Illinois
Employer	54%	59%
Individual	5%	4%
Medicaid	13%	10%
Medicare	12%	12%
Other Public	1%	1%
Uninsured	15%	13%

Source: Kaiser Family Foundation, Health Insurance Coverage of the Total Population, U.S. (2005), states (2004-2005)

2. Role of tax policy

- The biggest tax break that the American people get is the invisible tax exclusion that protects the value of health insurance premiums from their income at work.
- In the Administration's FY08 federal budget proposal the economic value of the tax exclusion for job-based insurance is pegged at $160 billion. Contrast this with the value of the deduction of mortgage interest, which is "only" $89 billion.

2. Role of tax policy

- President Bush proposed a "standard deduction for health insurance" in his 2007 SOTU speech. Families with health insurance would not pay income or payroll taxes on the first $15,000 in compensation; for singles, the first $7,500.
- The goal: Provide the same tax preference for health insurance for all Americans regardless of the source of their coverage.

2. Role of tax policy

- Another option may be to provide advanceable and refundable federal health insurance tax credits for lower-income individuals.
- Many make too much to be eligible for government health programs and cannot afford health insurance even if it is subsidized by their employers.

For more information on health ins. tax credits visit http://www.nahu.org/legislative/uninsured/credits.cfm

3. Health care spending in the U.S.

- In 2005 (the latest year data are available) total national health expenditures rose 6.9% -- two times the general rate of inflation.
- Total spending, public and private, was $2 TRILLION in 2005, or $6,700 per person, representing 16 percent of the gross domestic product (GDP).

3. Healthcare spending in the U.S.

- Do we spend too much? Who is “we” and what is the “right amount”?
- Data from around the world show that people tend to spend a bigger part of their incomes on healthcare as they grow wealthier. *(OECD 2004)* Health is what economists call a “superior good,” which means spending rises faster than income.
- Higher spending on healthcare is responsible for some part of the significant increases in lifespan and reduced disability during the past half century. *(Cutler 2004, Gratzer 2006)*

Source: “Ten Principles of Health Care Policy”, 2007, Heartland Institute

4. International comparisons

- In the U.S. we invest much more in saving prematurely born infants and extending the life of our elderly than do other countries. *(Wesbury 1990, Wennberg 2006)*
- Pregnancy, birth, and abortion rates among girls aged 15 to 19 are higher in the U.S. than in other developed countries. *(Singh and Darroch 2000)*
- Obesity rate for U.S. population aged 15 and older is nearly double that of Canada and substantially higher than other countries. *(Anderson and Hussey 2000).*

Source: "Ten Principles of Health Care Policy", 2007, Heartland Institute

4. International comparisons

- The U.S. spends more on its healthcare than other countries, although all countries are experiencing high rates of growth in their healthcare spending.
- Americans are wealthier than all but a small number of (small) countries, and the gap is growing larger over time.
- Americans’ healthcare needs and demands are different from those of other countries.

4. International comparisons

Does universal coverage = universal access?

- A lawsuit reached the Supreme Court of Canada in June, 2005. A Quebec businessman who waited 12 months for a hip surgery wanted to pay out of his own pocket to get it done in Canada but was not permitted. The Supreme Court agreed that the system wasn't working. In fact the full quote from the decision is as follows:
  - *"We conclude, based on the evidence, that prohibiting health insurance that would permit ordinary Canadians to access health care, in the circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with life and security of the person as protected by Section 7 of the Charter."*

4. International Comparisons

- Recently public opinion surveys were conducted in 26 single-payer countries. In 25, majorities of respondents identified health system reform in their countries as an "urgent priority."
- In Great Britain, in a November 2006 survey over half the respondents rated the NHS worse than in 1996.
- Isn't it comforting to know that we are not the only ones in the Western developed world who have problems with their healthcare systems?

Sources: The Stockholm Network, "Impatient for Change" (2004) and "Poles Apart" (2005) ; Nov. 2006 news article posted on www.inthenews.co.uk

4. International comparisons – life expectancy

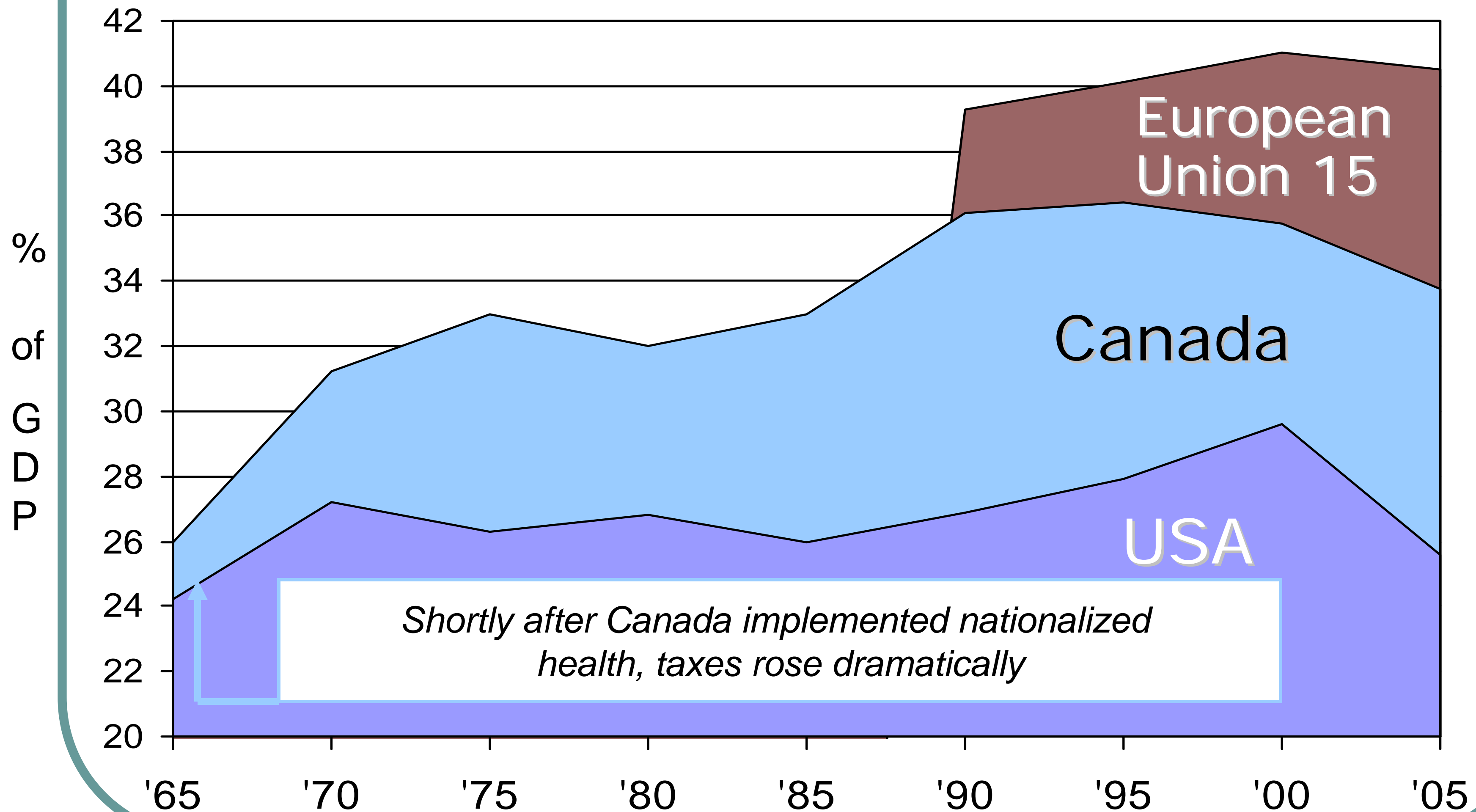
- Canadians live 2 ½ years longer than Americans; and Europeans live a little more than a year longer than us.
- How long we live is not so much an indicator of the quality of healthcare we receive at the time that we experience a major health event as much as it is determined by how we live our lives up to that point.
- Americans just eat a little more and move a little less than many people in other countries. More than 60% of Americans are overweight, and almost 40% are obese.

Source: Obesity: World Health Organization, 2006. NOTE: Obesity is commonly defined as a Body Mass Index (BMI) of greater than or equal to 30.

4. International comparisons – infant mortality

- It’s not so much about what happens on the day of the birth as it is about what that Mom has been doing for the prior 9 months and how she treats the child in the first year. Has she been eating properly? Did she smoke or drink during pregnancy? Did she actually get on the bus and go to her prenatal appointments?
- The worst infant mortality occurs amongst the poorest Moms. One should also keep in mind that in Canada and Europe governments tax the wealthy and middle class more, and give more money to its poorest citizens.

4. International comparisons - taxes



Source: OECD Revenue Statistics, 2006 / NOTE: This graph tracks America and Canada back to 1965. As an additional comparison, this also shows the "European Union 15" data – although just back to 1990.

5. The case for consumerism

- Many health policy analysts believe making consumers aware of the actual cost of health services will improve the relationship between the consumer (i.e., patient) and the physician.
- Once consumers control payment for most services, they will become more inclined to shop for services and inquire about the cost and quality of that care, which in turn should lead to improved quality and increased patient satisfaction.

5. The case for consumerism

- Many do not believe it is appropriate to rely on market mechanisms for financing and delivering healthcare. But economic forces work in healthcare just as they do in other markets. To wit…
- **Price controls lead to shortages**. Medicaid programs set fees for doctor visits below market prices and often below the cost of the visit. As a result, there is a shortage of doctors willing to treat Medicaid patients.

Source: "Ten Principles of Health Care Policy", 2007, Heartland Institute

5. The case for consumerism

- **Competition reduces prices.** While health care costs overall have risen dramatically in recent years, prices for Lasik and cosmetic surgery have fallen.
- When Wal-Mart recently reduced the price of several hundred generic meds to $4 for a month's supply, other pharmacies quickly followed suit.

Source: "Ten Principles of Health Care Policy", 2007, Heartland Institute

5. The case for consumerism

- **Consumers respond to financial incentives**. Many studies have found that consumption of healthcare changes when prices change.
- Health plans with increased cost-sharing reduce discretionary spending and unnecessary visits to emergency rooms.

Source: "Ten Principles of Health Care Policy", 2007, Heartland Institute

5. The case for consumerism

- **<u>NEW TREND - Convenient care clinics</u>**. Wal-Mart now has 76 RediClinics in 12 states, with plans to expand this to 400 clinics by 2009 and 2,000 within 5 years. CVS, Walgreens, Target, and others are setting up clinics in their stores, with the added convenience of having the pharmacy on the premises.
- Prices vary for services from flu shots ($15-$30), to care for allergies, poison ivy and pink eye ($50-$60), and tests for cholesterol, diabetes and pregnancy (less than $50).

Source: "Customer Health Care", WSJ Commentary, May 14, 2007, Page A17 / http://www.convenientcareassociation.org/

5. The case for consumerism

- A Harris Interactive poll conducted in March for The Wall Street Journal said that 22% of those visiting the clinics were uninsured. Wal-Mart says that half of its clinic visitors are uninsured.
- Retail clinics are also attractive to 4.5 million people with Health Savings Accounts who have health insurance with higher deductibles and want an affordable option for some of their routine care.

Source: "Customer Health Care", WSJ Commentary, May 14, 2007, Page A17 / http://www.convenientcareassociation.org/

5. The case for consumerism

- **Consumer Driven Health Plans (CDHPs)** got a "jump start" in June of 2002 when the Internal Revenue Service confirmed the favorable tax treatment of employer-provided coverage and medical care expense reimbursements under health reimbursement arrangements (HRAs).
- **Health Savings Accounts (HSAs)** were created shortly thereafter following the passage of the Medicare Modernization Act in December of 2003.

5. The case for consumerism

- As of January 1, 2007 HSAs now cover about 9 million beneficiaries in 4.5 million accounts. Health reimbursement arrangements (HRAs) currently cover 6.2 million beneficiaries.
- In 2006 the Treasury Department projected more than 21 million HSAs (covering as many as 40-45 million people) by 2010 if the HSA rules were to be revised, which in fact occurred in December.
- The average HSA established now will have a $22,000 balance ten years from now. Unspent balances in HSAs will help employees better plan for and afford health care in retirement.

** Sources: America's Health Insurance Plans, April, 2007; "Fact Sheet: Dramatic Growth of HSAs" - http://www.treas.gov/offices/public-affairs/hsa/*

5. The case for consumerism

- At the end of the day, tax-favored account-based plans should swing the pendulum away from third party payment and pre-paid healthcare and move us back toward more of a direct payment model, which the baby boomers grew up with when the family doctor used to make house calls and Dad handed the doctor a check or paid him with cash.
- Once account-based plans achieve critical mass (2010-2011?), their prevalence should help curb overutilization, a significant healthcare cost driver.

6. Market-oriented healthcare reform ideas

- America's Health Insurance Plans (AHIP) has put forth the idea of universal health accounts (UHAs).
- Like HSAs, the new UHAs would allow pre-tax deposits to be made by employers and employees. Employees would own the UHA funds, so there would be portability in the event of one's loss of employment.
- Individuals with UHAs would be allowed to purchase insurance coverage in the group and non-group markets.

Source: http://www.ahipresearch.org/PDFs/UHAbackgrounder.pdf

6. Market-oriented healthcare reform ideas

- UHAs could be paired with any health plan.
- UHAs would help uninsured people buy health insurance on a pre-tax basis.
- For persons with incomes less than 300% FPL, the federal government would make matching contributions of up to $1,000 for individuals and $2,000 for families.

Source: http://www.ahipresearch.org/PDFs/UHAbackgrounder.pdf

6. Market-oriented healthcare reform ideas

- **An unusual partnership** including Wal-Mart, labor unions, AT&T, and several policy groups in February of 2007 announced four principles to create "a new American health care system by 2012." The "Better Health Care Together" campaign calls for universal coverage and promotes the idea that "businesses, government, and individuals all should contribute."

Source: http://www.walmartfacts.com/articles/4800.aspx

6. Market-oriented healthcare reform ideas

- Nearly 40 firms launched the Coalition to Advance Healthcare Reform on May 7, 2007 - www.coalition4healthcare.org/
- Members of CAHR believe there are five core elements essential to any meaningful reform.
  - Market-based healthcare system
  - Universal coverage with individual responsibility
  - Financial assistance for low-income individuals
  - Healthier behavior and incentives
  - Equal tax treatment

Source: www.coalition4healthcare.org/

6. Market-oriented healthcare reform ideas

Premium subsidy programs – recent initiatives

- **Illinois All Kids** offers a rebate of up to $75 per person per month to cover private insurance.
- Wisconsin's BadgerCare program includes a premium subsidy program to cover private insurance.
- Kentucky and West Virginia offer premium subsidies for qualified Medicaid beneficiaries who have access to employer-sponsored health insurance.

Source: National Association of Health Underwriters

6. Market-oriented healthcare reform ideas

Premium subsidy programs aimed at individuals

- Utah's UPP program - http://health.utah.gov/upp/faqs.htm
- State of Washington's Basic Health program – http://www.basichealth.hca.wa.gov/
- Oregon's Family Health Insurance Assistance Program (FHIAP) - http://www.oregon.gov/OPHP/FHIAP/member.shtml

Source: National Association of Health Underwriters

6. Market-oriented healthcare reform ideas

Premium subsidy programs aimed at employers

- Oklahoma's O-EPIC Employer-Sponsored Insurance program - http://www.oepic.ok.gov/index.aspx
- Kansas - http://www.ksrevenue.org/taxcredits-employer.htm
- Kentucky ICARE program - http://doi.ppr.ky.gov/kentucky/docs.asp?Divid=28

Source: National Association of Health Underwriters

6. Market-oriented healthcare reform ideas

- The **Healthy Indiana Plan**, legislated earlier this year, will create a new HSA-type program for uninsured adults earning up to 200% of poverty. It combines a funded account for first dollar health expenses, high-deductible private insurance coverage, and a separate fund for preventive services.
- Beneficiaries get a payment toward funding a POWER account to pay medical bills under $1,100. The state will pay premiums for commercial insurance to cover bills above $1,100.

Source: http://www.in.gov/isdh/

6. Market-oriented healthcare reform ideas

- Deposits to the POWER account will be inversely proportional to income. The lower a person's income, the more the state will deposit. Whatever the deposit, beneficiaries will be required to put some of their own money into the account to top it off. They would spend money from the account for routine bills and when it is exhausted, insurance kicks in.
- **Funding**: An increase in the state cigarette tax to bring in $206 million a year, which is being used as leverage to draw down additional federal matching Medicaid funds of up to $800 million.

Source: http://www.in.gov/isdh/

7. Concerns about Illinois Covered

- Smaller employers that do not currently provide health insurance may decide to lay off employees or use non-employee independent contractors to get under the mandate threshold of 10 employees.
- Its “pay or play” provision appears to be very similar to the Maryland “Wal-Mart” law that was recently struck down in federal court on ERISA grounds.

7. Concerns about Illinois Covered

- Guaranteed issue and community rating are failed market reform concepts that over the last 15 years have done much more to destroy insurance markets than help.
- Too much reliance on administrative rule-making. There is a relative lack of details in the proposed statute. Rules could end up being good, bad, or ugly.

7. Concerns about Illinois Covered

- The Office of Patient Protection is needless additional bureaucracy. Illinois currently has adequate statutory legal protections for members to appeal claim denials
- I would prefer seeing more funding earmarked for the Division of Insurance, which in recent years has been “gutted” in the annual budget process.

8. Moving toward a "21st Century" system with universal access

- America can lead the way in creating a health care system that fits our 21st century economy by putting in place new policies that respond to consumer demands for more affordable, portable health insurance. The means to achieving this include:
  - **Tax equity**: The first step would be giving favorable tax treatment of health insurance to everyone regardless of how they buy coverage, whether on their own or employment-based.
  - **Refundable tax credits**: Offer refundable tax credits for those in lower-income categories who need additional help in purchasing policies.

8. Moving toward a “21st Century” system with universal access

- **Encourage purchase of private insurance**: Public program eligibles should be permitted to apply the value of the subsidies for which they are eligible toward the purchase of private health insurance, whether on their own or employment-based.

- **Alternatives to job-based coverage**: Create new opportunities for citizens to purchase group health insurance through organizations that may be more stable forces in their lives than their jobs, such as churches, labor unions, and professional and trade associations.

9. Key questions to ask

- What are the appropriate roles for governments, individuals, and businesses?
- Do the policy proposals address the underlying causes of unnecessary health care spending, or just try to impose caps and mandates?
- Do the reforms empower consumers to make better choices, or leave them with less control over their health care and fewer choices?

9. Key questions to ask

- What role should personal responsibility play? What happens if we discourage it?
- What are the other possible unintended consequences of what is being proposed?
- What will things look like not next year or 5 years from now, but rather 10, 20, and 30 years from now?

Thank you

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or www.heartland.org.