



JIM HAYNES

*Contemplative and bookish men,
must of necessitie be more quarrelsome than
others, because they contend not about matters
of fact, nor can determine their controversies by
any certaine witnesses, nor judges. But as long
as they go towards peace, that is Truth,
it is no matter which way.*

—John Donne

Preface to *Biathanatos*

Are We Approaching the Threshold of Nationalized Health Care?

By Robert B. Crompton

Health care in America is regarded as a fundamental right. When providing it becomes more expensive and less profitable for the private sector, can nationalized health care be far behind?

The future of health care in America is a topic that never seems to go away. Many of the issues that actuaries and policy-makers were engaged with 20 years ago are still with us today, in some cases more so. Not only are we universally engaged as health care consumers, but many of us receive our livelihood from health care financing intermediaries (insurance companies, Blue Cross/Blue Shield organizations, etc.).

Since the health care crisis of the 1980s, prices have continued to rise. Health care now constitutes more than 14 percent of gross domestic product. Headlines provide anecdotal evidence of health care rationing (“Treating the Elderly Badly,” *U.S. News & World Report*, Aug. 11, 2003), and additional cost pressures when new and expensive medical procedures become part of normal treatment (“Hospitals Pressured by Soaring Demand for Obesity Surgery,” *New York Times*, Aug. 29, 2003). Even cost containment measures such as managed care haven’t stemmed the tide.

On a personal level, I’ve noted that my health insurer now routinely denies almost every claim with statements such as “pre-approval not obtained” when in fact it was, or “procedure not covered” when in fact it is. Once the company even told me that office visits weren’t covered.

Does this mean that nationalized health care is inevitable? Perhaps not, but it certainly gets more possible all the time.

Toward Nationalized Health Care

Health care isn’t like most other economic goods in our country. Prices aren’t set by the normal market mechanisms that work for houses, cars, and washing machines. Prices are set through

quasi-regulation—health insurers’ usual and customary fee schedules. Costs for most consumers are set through the health insurance premium. In addition, our federal government dictates premiums and reimbursements for federal medical care programs, adding a further layer of regulation.

Like any economic good with controlled prices, the market adjusts through perversity—that is, through basic market forces working within the constraints of the controlled prices.

One such adjustment is the way productivity increases affect prices. In a competitive market, productivity increases will generally result in lower prices as producers seek to optimize market share by decreasing prices some fraction of the cost savings. When prices have already been set, productivity increases result in profit maximizing activities among health care providers.

For instance, one area where there has been productivity improvement is outpatient surgery. Clinics and doctors will specialize in certain procedures and develop an almost assembly line approach, performing dozens of procedures in a day. Fifteen minutes of surgery will pay for as much as an hour of surgery at less efficient clinics.

Adjustment to fixed prices also occurs on the patient side. Once the insurance premium is set, the consumer has only a limited incentive to consume health care moderately (deductibles, co-pays, and out-of-area limitations). This is true even if the consumer pays 100 percent of his premiums; once the all-you-can-eat price is paid, consumers have no incentive to limit their health care consumption.

For most consumers, getting maximum value for their health care premium means overusing it. And even if they’re not over-

using, they'll consume more health care than they would if they paid all costs out of their own pockets. One study ("Why Health Care Costs Too Much," Liebowitz, *Cato Policy Analysis No. 211*, June 23, 1994) estimates that health care expenditures would be reduced by one-third to one-half if health care consumers paid 100 percent out of pocket rather than through third-party payers.

There are also losers in the process of adjusting to pricing by fiat. Because certain stipulated fees are below market—namely Medicare and Medicaid—the number of doctors who are willing to treat Medicare or Medicaid patients has dropped. This drop in available medical care is a classic economic response to managed prices.

Another casualty of regulated prices is the hospital segment of health care. Hospitals have not only suffered from the legislated levels of Medicare and Medicaid reimbursement, they've also suffered from the implementation of managed care techniques. These techniques have moved some surgical procedures out of hospitals, while reducing hospital stays for procedures that have remained. The resulting oversupply of hospital rooms has resulted in a rash of hospital insolvencies.

The picture for health care intermediaries isn't as clear. There has been significant consolidation among health insurers over the past decade, proving at least that it's more profitable to be acquired than it is to be a small health insurer. Profitability for the large survivors appears possible but not easy. The table below shows the profits over the past four years for the three largest health insurers.

	2003	2002	2001	2000
Aetna	933	(2,523)	(280)	127
CIGNA	668	(398)	989	987
United Health Group	1,825	1,352	913	736

Lack of satisfactory profitability among both for-profit hospitals and health insurers is one of the warning signs of potential nationalization.

In *The Effective Executive*, Peter Drucker points out that nationalization occurs when critical industries are unable to attract sufficient private capital. AT&T's Theodore Vail foresaw the need for sufficient financial capital to allow the U.S. phone system to remain private. Vail managed AT&T so it was steadily and consistently profitable, and its stock provided a steady stream of dividends to small investors, who made AT&T a mainstay in noninstitutional stock portfolios.

The capital from individual investors, as much as any other



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factor, allowed the phone system in the United States to develop as a private (albeit regulated) industry. Drucker then compares this with the European phone experience in the 20th century, where governments had to step in because the European phone companies were unable to generate sufficient capital as private businesses.

Although earnings for health care intermediaries have been cyclical rather than steady, the current Wall Street outlook seems to assign reasonable expectations of sufficient earnings to these companies. It's not clear, however, how long such reasonable expectations will remain. If health care costs continue to rise at a rate far in excess of general inflation, it seems unlikely that insurers will continue to be able to pass these costs along through double-digit premium increases.

In addition, some insurers may be using profit tactics that are inconsistent with the public's understanding of the social contract. These tactics are related to paying claims. Both Aetna and CIGNA have recently settled lawsuits with judgments in the hundreds of millions of dollars because of claims they short-changed doctors on fee payments. Both of these were class-action cases that have been filed against several of the largest health insurers. Resolution is still pending against the other insurers.

As with many class action cases, the rights and wrongs are difficult to discern. The settlement language is shrouded in legalese. Furthermore, the rules of evidence may or may not shed light on the material facts of the case.

However you look at it, these cases are bad news for private health insurers. If the cases were meritorious, then historical profits were generated through inappropriate claim payments, bringing up the question of whether these insurers could have generated profits without such inappropriate actions.

On the other hand, if the cases aren't meritorious, it's still bad news for insurers. These cases seem to signal that public expectations are evolving to where the public believes it's more important for insurers to pay all claims regardless of merit rather than just the claims for which insurance was designed.

The Push of Social Forces

Health insurance contracts are generally designed to limit the adverse effects of stipulated prices and costs. These design features usually limit the types or amounts of health care the insurer will pay for, such as the length of hospital stays, dictating when and how often certain procedures are allowed, and limiting the use of health care providers other than the "gatekeeper" (aka the primary care physician).

Changes in the social contract, however, are making these limitations less effective, shifting more costs to the insurance companies. Many Americans view health care as a right rather than a privilege. That is, health care is one of the items our government should guarantee to all citizens (and even non-citizens, in some cases) along with life, liberty, and the pursuit of happiness.

Many judges and juries are also sympathetic to this viewpoint. Good health is an important component of the pursuit of happiness (or so the logic seems to go), therefore health care is an implied right of all citizens. It's not only inappropriate but downright un-American for a big insurance company to limit access to health care.

These pressures not only make it difficult for insurers to earn

a reasonable profit, but they add to the expansion of health care relative to the rest of the economy.

So far, politicians have been enablers in this expansion of rights and have cleverly avoided any responsibility for paying for it. This political connivance will no doubt persist as long as politicians can continue to avoid responsibility for their actions, since "giving" constituents something for nothing makes good political sense. This is one more straw added to the camel's back.

Much has been written about the tidal wave effect of aging baby boomers on our health care system. Much has also been written on the baby boomers' penchant for modifying the social contract whenever they believe modification is in their favor. Although I don't recall anything written on how baby boomers might change the social contract to help ease them through their golden years in the style to which they're accustomed, it seems highly likely they'll push for further expansions of health care rights, adding one more burden to the health care system.

These pressures will continue to expand health care relative to the rest of the economy and put economic stress on certain members of our health care system. This stress cannot increase indefinitely. There has to be some eventual resolution.

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The Look of Nationalized Health Care

Because our health care system is extensive and complex, it will likely exhibit behavior similar to other complex, dynamic systems—that is, understandable and well-behaved up to some critical threshold, chaotic and unpredictable once the threshold is reached. If we do reach the point of nationalization, it will be because the economic and social forces affecting our health care system push it beyond the threshold of chaos. This means that if and when nationalization occurs, it'll occur quickly in response to a sudden crisis. There will be little time for debate or to craft a well-thought-out response. Nationalized health care will be a knee-jerk reaction.

It's not certain where the threshold is. We currently pay about \$1 out of every \$7 earned for health care. Is the threshold at \$1 out of every \$6? \$1 out of every \$4? Wherever the threshold is, it's likely we'll reach it in the foreseeable future.

What will nationalized health care be like? Imagine the worst elements of the U.S. Postal Service, your state Department of Motor Vehicles, and your local tax office combined—inefficient and ineffective service, impossibly long waiting times, personnel more concerned with the most current government social engineering experiment than with your petty medical problems, physicians who hate being civil servants and consequently hate you.

If the experience of other countries teaches us anything about nationalized health care, it teaches us that we had better stay well. In Canada, some doctors have shut their offices for several days a month to protest lack of pay raises from the Canadian government. In Great Britain, the wait for heart surgery is so long that the risk of dying while in the queue is higher than the risk of dying while on the operating table. And patients are simply denied treatment if they are elderly or have a poor prognosis for recovery.

Health care rationing is repugnant to most Americans, but the experience of other countries shows that nationalized health care is unable to provide all of the health care people want. Under nationalized health care we'll have to decide how old a person can be and still receive health care. We'll have to decide how premature a baby can be and still receive neonatal care. We'll have to decide how unlikely recovery from serious injury or disease can be and still warrant health care. The only winners from these decisions will be attorneys.

Another issue with nationalized health care will be increased medical fraud. One of the serious problems that bedevil socialism in any form, including nationalized industry, is corruption. There's always some threshold level of corruption in any political system, but any time there's government largesse, there will be additional corruption relating to the spending of these funds. Say's Law (named after 18th-century French economist Jean Baptiste Say) states that production creates its own demand. Crompton's Law says that socialism creates its own corruption.

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With nationalized health care, the amount of government largesse will be staggering—hundreds of billions (perhaps trillions) of dollars. There are already a good many swindles associated with Medicare/Medicaid because of the large amount of government money involved.

Another symptom of controlled markets is the existence of black markets. Black markets emerge as an attempt to provide goods or services at a true market price when such goods or services are outlawed (as with certain drugs, or in former years, abortions) or when mandated prices are set below true market prices. It's difficult to say whether these subterranean market forces will produce a true black market in medical care or whether a two-tiered system will develop where those who can afford it can purchase health care not available through the nationalized system.

Can Nationalized Health Care Be Avoided?

As I foresee it, health care nationalization will be brought about by economic stresses induced by both a deepening of health care (more expensive procedures applied to those who have access to health care) and a widening of health care (forced coverage of the portion of the population not currently insured). This deepening and widening, brought about by willy-nilly utilization due to the third-party payer system, combined with evolving public policy regarding health care rights, will at some point overwhelm our current health care system.

If this view of the future is correct, can it be avoided? Because social trends are cyclical, one approach is to hope that views on public policy will change and that the pressures from only the third-party payer system won't be enough to tip the health care system into instability.

This approach seems naively optimistic. Social trends typically have a long cycle. We are not likely to see a reversion of health care rights any time in the next 50 years. Indeed, such a reversion is probably beyond the lifetime of anyone living today. In addition, it's not clear that simply removing the pressures of public policy will remove sufficient stress from our health care system.

Another approach is to prepare a firebreak to channel the social and economic stressors of the health care system into more acceptable channels. Now may be the time for the critical members of the health care system to consider what a revised health care system with significant federal regulation that is fair to consumers, providers, and existing intermediaries would look like.

ROBERT B. CROMPTON is a consulting actuary with Actuarial Resources Corp. in Alpharetta, Ga.