

# READY *or* NOT

**N**ATIONAL HEALTH CARE REFORM IS ON THE WAY. IT'S INEVITABLE. The irresistible force of desperation will overwhelm the heretofore immovable object of political inertia. And while it's too early to predict how it will be funded, what form it will take, and who among the stakeholders will be outraged and who delighted, it's abundantly clear that economic and political forces are rapidly approaching critical mass.

What's different this time?

Unions and auto manufacturers, Wal-Mart and the Service Employees International Union, the AMA and consumer groups, Democrats and (a few) Republicans are all calling for major changes in the way we fund, purchase, evaluate, and deliver health care. They have their own reasons, but the basic problem is universal—cost.

One of the key elements of cost is the growing recognition that without universal coverage, there is no solution to the cost conundrum. Forty-six million Americans are currently uninsured, yet they require, and receive, health care from providers who are legally required to render care to all regardless of their ability to pay. The result? Their care is paid for by cost-shifting to those of us with insurance, to employers, and to taxpayers. The latest figures indicate the average family premium includes a “cost-shifting surcharge” of more than a thousand dollars (Families USA). This surcharge, or hidden tax, would disappear if providers weren't forced to “tax” their insured patients to pay for care rendered to those without insurance.

Large employers find themselves competing with international companies based in countries with health care costs that are not funded by employers and are also dramatically lower than those here in the United States. Most of these big firms may wish they could do what many small employers do: Drop health insurance altogether, especially in states such as Texas and Florida.

Local and state governments and politicians see their Medicaid budgets and employee and retiree health benefits expenses increasing much faster than other line items. Simultaneously, taxpayers are rebelling against higher property taxes, and income tax increases are politically radioactive.

And those in the middle class (i.e., the voters who decide elections) are increasingly concerned, fearful of losing coverage if they lose their jobs, watching small wage gains overmatched by rapidly rising health insurance premiums, troubled by news of the FDA's stumbles and angry over health insurers' seemingly arbitrary and unfair treatment

of members, and overwhelmed by the bewildering mess of claim forms, coverage limits, network restrictions, and approval requirements. According to a UPI/Zogby poll conducted in February 2007 and reported by UPI, “Nine out of 10 Americans want health care reform... an equal percentage of respondents, 45 percent, said they supported major reform and minor reform.”

While the emotional forces are strong, the economics behind those emotions are, if anything, even more important.

The United States spends twice as much on health care as the average industrialized country (*Health Affairs*, 4/2005). Compared with the next most profligate nation, we spend 50 percent more. Contrary to public perception, this is not because of high malpractice costs and shorter waiting lines. In fact, only 3 percent of costs are for services that involve waiting lists in other countries. Malpractice costs, including extra services attributed to defensive medicine, add an additional 5 percent (at most). Even after factoring in these frictional costs, U.S. per capita health care costs are still five times higher than Korea or the Czech Republic, three times higher than Spain, and twice those in countries such as Germany, Denmark, Austria, France, or Sweden.

Considering those countries are home to Airbus (Austria, Germany, and France), Hyundai and Samsung (Korea), and VW/Audi/BMW/Daimler Benz (Germany), the competitive burden placed on U.S. companies by higher health care costs is obvious.

The auto industry provides a stark example of the impact of health care costs on U.S. manufacturers. In 2002, U.S. consumers bought 1.7 million cars that were manufactured in Japan (where health care costs are half of ours). Toyota (which is about to overtake GM as the world's largest automobile manufacturer) spent \$201 on health care costs per car in 2004; in comparison, GM's outlays were \$1,538, Ford's \$1,400, and Chrysler's \$1,100. The \$1,300 differential restricts GM's ability to cut prices, invest in training and equipment, fund R&D, or build up a cash hoard. (The “hidden tax” to

cover cost-shifting discussed above amounts to \$480 million annually for GM alone.)

Nokia enjoys a similar advantage over Motorola, Airbus over Boeing, MAN Diesel over John Deere, and British Airways over Delta.

In addition to creating higher costs for U.S. businesses, health care will soon come to dominate governmental budgets. The two big issues on the national scene fall on the revenue and expense sides. Simply stated, the United States will not be collecting anywhere near enough tax revenue to sustain predicted spending levels. The Bush tax cuts are scheduled to sunset in 2011; if they're renewed, the Treasury will be forgoing \$400 billion in annual income (CBO, 12/2005, "the long-term budget outlook"). While it's never easy to predict what politicians will do, when it comes to taxes, the odds are always on the side of lower.

There's also a demographic contributor here we need to consider. In 2012, the first of the baby boomers will become eligible for Medicare. And the influx will grow dramatically each year until 2025, swelling the Medicare-insured population to 69.7 million, or 44 beneficiaries for every 100 workers (Urban Institute, "Growth in Medicare and Out-of-Pocket Spending," Maxwell et al., 12/2000).

By 2011, the cumulative federal deficit attributable to Medicare, Medicaid, and Part D will be \$24 trillion. Fully one-third of

that expense is from Part D alone. If Medicare costs grow just 1 percent faster than the rest of the economy, by 2050 the program will be bigger than the rest of the entire U.S. budget. Barring substantial changes in tax policy and receipts, the cumulative deficit for federal health programs will be well above the \$24 trillion figure.

### What Are the Options?

The ideas and policy plans presently under discussion range from Medicare for all to individual high-deductible plans; from single payer to private insurer only; from tax-based funding to income-indexed premiums; from employer-based to individual mandates; from state-specific to national. To illustrate some of the problems that any meaningful reform proposal will have to address, we'll examine the proposals advanced by President Bush in the State of the Union address.

Bush's health reform plan is based on eliminating the blanket tax deduction for employer-funded health insurance, replacing it with a tax deduction of \$15,000 for a family and \$7,500 for an individual, available to anyone buying health insurance. According to supporters, the proposal would make so-called gold-plated health insurance plans less attractive, while expanding the tax break for policies to individuals (their deduction is currently limited). The other main component, dubbed "Affordable Choices," is meant to help provide states with more flexibility in designing plans to cover lower-income people. But this flexibility comes at a cost; in return for freeing states from onerous restrictions, Bush would also cap federal contributions at the current level.

Introducing the plan, Bush noted: "Right now, there's a limited market for the individual. It makes it hard to find a product that either suits your needs or you can afford. The more policies written to meet the individual—in other words, the larger the risk pool—the more likely it is that costs will come down for the individualized policy. That's just the way it works. Yet the tax code discourages the individual from being in the market."

In reality, the incentive provided by the deduction is tiny compared to the actual cost of insurance coverage. And people covered by their employers' plans already enjoy a tax benefit, as employer-paid premiums (and in most cases, employee-paid premiums) are paid with pre-tax dollars. Thus, the deduction would only provide a financial incentive for people seeking coverage via the individual market, a relatively small population.

### The Demand Problem

Financially, the numbers don't support the president's optimism. In 2004, according to a Kaiser Family Foundation report on the uninsured, there were approximately 88 million people in families earning between one and three times the federal poverty level (\$19,307 for a family of four). Of those 88 million, 20.2 million were uninsured, or almost half of all individuals without health insurance. When one considers that the best-off among these families would have to allocate fully 20 percent of their gross income to health insurance, the error in the president's calculus becomes apparent. Their wealthier brethren, those earning up to four times

PROFESSIONAL.

COMPETENT.

A COMPANY  
YOU CAN TRUST.



STEWART SEARCH  
ACTUARIAL RECRUITMENT

PLACING ACTUARIES WORLDWIDE  
LIFE, HEALTH, PROPERTY & CASUALTY,  
PENSION, ANNUITIES

[www.stewartsearch.com](http://www.stewartsearch.com) 888-JOB-OPEN

Plan Sponsor	Mandated Universal Coverage	Medicare's Role	Centralized Insurance Purchasing	Insurance Provided by	Funding Source	Benefit Design	Underwriting/Risk Selection Parameters	Impact on uninsured	Cost Control Mechanisms	Status
<b>Bush</b>	No	Status quo	No	Status quo	Individuals, employers, and tax incentives	Status quo	Status quo	Tax breaks will encourage consumers to purchase coverage	consumerism	Proposed in State of the Union; no further action
<b>Clinton</b>	No	Status quo	Yes, no details provided	Medicare and private insurers	No change	Mandates inclusion of preventive care benefits	Guaranteed issue; community rating	Not noted	Reduced administrative expense, streamlined administration, fewer uninsured reduces cost-shifting, heavy emphasis on prevention and chronic disease management, establish federal "Best Practices Institute" to promote improved medical care, Med Mal reform, Medicare direct negotiation on drugs, reformed FDA generic approval process	Proposed in platform; no further action
<b>Edwards</b>	Yes	Status quo	Yes through regional "health care markets"	Employers, expanded role for Medicaid and SCHIP to cover low income, unemployed, and children	Eliminate renewal of Bush tax credits	FEHBP	Guaranteed issue; community rating	Uninsured eliminated through mandated coverage	Centralized purchasing of insurance reduces administrative expense; mandating insurers spend 85% of revenue on medical care; FDA reforms	Proposed in platform, no further action
<b>Kucinich</b>	Yes	Medicare greatly expanded	N/A	N/A	Taxes	Comprehensive, including dental, vision preventive care	N/A	Uninsured eliminated through mandated coverage	Not noted	House bill H.R. 676, co-sponsored with John Conyers
<b>McCain</b>	No	No information	No	Status quo and expanded SCHIP program	Status quo	Greater use of consumerism/HSA's	Not addressed	Not addressed	Med Mal reform	Proposed in platform
<b>Obama</b>	Not in the plan, but his speeches indicate commitment to universal coverage within 4 years	Status quo	Yes, regional purchasing coalitions and national plan for individuals	Private insurers. National public plan accessible by individuals without employer plans	Employer contribution required, individuals, subsidies for low income, reinsurance via governmental entity (no details available)	FEHBP	Guaranteed issue; community rating	Uninsured eliminated through mandated coverage	Technology and preventive care will reduce expenses by \$2,500 per family; some form of catastrophic coverage will reduce cost of insurance, although likely to require governmental funds	Proposed in platform; no further action
<b>Richardson</b>	Yes	Elimination of Medicare Advantage, individuals 55+ could buy into Medicare	Not noted	FEHBP, private insurers	Employers, individuals, income-indexed tax credit for low income	FEHBP	Community rating	Eliminated through mandated coverage	Not noted	Proposed in platform
<b>Wyden</b>	Yes, verified through IRS	Status quo	Yes, regional purchasing coalitions	Private insurers	Employers, individuals, and governmental subsidies for low income (>4x poverty level)	FEHBP	Guaranteed issue; community rating	Uninsured eliminated through mandated coverage	Financial incentive for insurers to maintain/improve member health status	Strong emphasis on preventive care; elimination of uninsured removes incentive for cost-shifting by providers

Copyright 2007, Joseph Paduda, used by permission

the poverty level, or \$57,000, would still have to pay one-seventh of their gross income to their insurance company.

Karen Davis of the Commonwealth Fund emphatically makes this point, stating: “Ninety-five percent of the uninsured wouldn’t get a significant amount of money from this deduction because they earn so little” (*Newsday*, 1/22/07). Health care economist Jason Shafrin’s analysis of the impact of the proposal on individuals at various tax levels supports Ms. Davis’ statement, as does his conclusion. According to Shafrin, “the plan is very inequitable. Since this is a tax deduction, if you’re poor and don’t owe any taxes, you won’t receive any financial help with the deduction. Since tax rates are progressive, the deduction is most valuable to individuals in the high tax bracket, the rich” ([www.HealthcareEconomist.com](http://www.HealthcareEconomist.com), 1/24/07).

Shafrin goes on to note that the deduction applies to any health plan regardless of actual premiums paid. Thus, if an individual buys a “plan” for \$1 that covers all health care expenses above \$1 trillion, he qualifies for the deduction.

The Bush proposal would free up some funds for individuals who can’t get health insurance through their employer to purchase health insurance coverage, but the funds wouldn’t amount to a meaningful “subsidy.” For most of the uninsured, health insurance is just not affordable, no matter how big the tax de-

Taxable Income	Deduction Value	Marg. Tax Rate	Deduction Value
\$ 5,000	\$5,000	10%	\$ 500
\$ 10,000	\$7,500	15%	\$1,125
\$ 35,000	\$7,500	25%	\$1,875
\$10,000,000	\$7,500	35%	\$2,625

duction. Thus, while some demand would be created, it would most likely be insufficient to cause much excitement among insurance carriers.

### The Supply Problem

Not only does the president’s plan provide little incentive or financial assistance for the vast majority of the uninsured; it also depends on a broken market to supply the solution. The individual health insurance market has four major problems that must be addressed before it can be part of the solution.

First, individual insurance plans cost more than employer-sponsored plans. In large part, this is due to their administrative expense, which is significantly higher than the expense of policies issued to large groups or employers. These costs can add 10 to 15 points to a policy’s premiums. Individual health insurance is regulated by the states, whose requirements, mandates, policy limits, and underwriting guidelines vary wildly.

This regulatory thicket requires insurers to design plans, prepare documents, configure information systems, train sales and customer service staffs, negotiate provider contracts, and establish managed-care programs in each state where they want to operate. This adds significant cost and overhead, cost that must

be allocated across each insured. The Affordable Choices initiative does address this issue in part, as it would allow states to put together buying groups or create pools for individuals or small groups. But these are options, not requirements.

Second, affordability. As discussed above, insurance is expensive. A typical family policy premium is about \$11,500. The typical family (median-income) is just under \$45,000. Even without paying any taxes, this family, we’ll call it the Flintstones, would have to spend more than a quarter of its total income on health insurance. That’s this year; if annual health plan cost increases remain in the 7 percent range (a historically low percentage), the Flintstones will be spending a third of their income on health insurance in five years, and that’s before paying deductibles and copays, which averaged \$788 in 2004 (“Health Care 101,” California Health Care Foundation.org). (Fred doesn’t get insurance through the Bedrock Gravel Co., as the cost of coverage got so high that Mr. Slate just couldn’t afford it.)

Third, underinsurance. If the plan required health insurers to eliminate medical underwriting and implement community rating, it might well help those families that do decide to take advantage of the deduction. Unfortunately, individual health insurance almost always requires medical underwriting. If the Flintstones do buy their insurance from Granite Mutual, they’ll find that coverage is limited; Fred’s obesity and Wilma’s past treatment for breast cancer are warning flags for Granite underwriters, and the policy issued to the Flintstones excludes cardiovascular disease for Fred and all forms of cancer for Wilma. Now, if Mr. and Ms. F do need treatment for either condition, they’ll find they are still “uninsured.”

Finally, and most critically, the nature of the insurance industry today doesn’t support the president’s stated goals. If the individual health insurance market is going to be part of the solution, it will require major reform. And that reform must recognize that for-profit private insurers have a financial obligation to their owners, an obligation to seek out the low-risk individuals and minimize claim payments. Insurance companies work very hard to not cover anyone with a current or past health care condition that may at some point in the future lead to claims. They’re not purposely being “bad”; if they cover everyone their competitors won’t, they’ll soon find themselves bankrupt.

Moreover, the individual insurance companies are “insurance” companies, and insurance is the spreading of unforeseen risks among a large number of policyholders. By definition, a pre-existing condition is not an unforeseen risk.

And therein lies the problem with Bush health care. His plan seeks to use the insurance markets and tax policy to reduce the number of uninsureds, who will use tax credits to fund their new insurance plans. Except no one will sell them a plan at a price they can afford to pay if they have a pre-existing condition

### Solutions

Fortunately, there are several other reform proposals on the table. California, Massachusetts, Illinois, and other states have all pushed innovative health care reform measures to the top of the agenda.

My personal favorite is Sen. Ron Wyden's Health America Act that's before the Senate today; presidential candidate John Edwards has advanced an innovative plan of his own. Major health insurers have proposed their own initiative, as have the American Hospital Association and various physician groups. And, perhaps most tellingly, two archenemies, Wal-Mart and the Service Employees International Union, have jointly proposed that any health care reform package include universal coverage and involve all stakeholders in the design and funding of health care reform.

One of the best practical approaches is that put forth by the Coalition for Health Care Reform, a nonpartisan entity that includes providers, large and small employers, labor groups, insurers, and health plans among its members. It comprehensively addresses universal coverage, cost control, and financing, and is attracting growing support.

While a few may note that the president's political viewpoint precludes intervention in the free market, his enthusiastic endorsement of the Medicare Part D program indicates otherwise. Part D is a tightly regulated, community-rated, guaranteed-issue, totally voluntary health insurance program with upwards of 80 percent participation, serviced by too many insurers to count.

Bob Laszewski of Health Policy and Strategy Associates (no

relation to my firm) notes that "the Bush administration has already implemented an individual health insurance system that is voluntary, community-rated, and excludes no one, demonstrating that the individual market can work, and George Bush knows how to do it." Perhaps the president's initial proposal is just that, and he will follow that with a more comprehensive plan that addresses the limitations enumerated above.

Until then, while the tax deduction is nice, it applies to a relatively small number of people and will defray a relatively small portion of the premium expense. It relies on a market that's not exactly nonexistent but might as well be for those individuals and families at or even significantly above the median income levels.

JOSEPH PADUDA is principal of Health Strategy Associates, a consulting firm in Madison, Conn. He can be reached at 203-314-2632 or [jpaduda@healthstrategyassoc.com](mailto:jpaduda@healthstrategyassoc.com).

This article is solely the opinion of its author. It does not express the official policy of the American Academy of Actuaries; nor does it necessarily reflect the opinions of the Academy's individual officers, members, or staff.

## When the stakes are high, Confidence in your equipment is key.



Any insurance endeavor—such as taming loss liability or setting premium prices—is fraught with risk. Using Monte Carlo simulation, @RISK from Palisade shows virtually all possible outcomes, enabling decision-makers to minimize uncertainty. That's why, after Microsoft Office, @RISK is the commercial software most widely used by actuaries.\*

\*Survey results from "Actuaries excel: but what about their software?", presented by Louise Pryor, 2006 General Insurance Convention in Vienna, Austria, 26 September 2006

### "Really Helps"

"@RISK really helps sort out the influential factors."

— William Riker, Renaissance Re

### "An Outstanding Package"

"@RISK is an outstanding package. [It is] powerful, efficient, and fun to use. And [the] cost is reasonable."

— Richard E. Sherman, "Ask a Casualty Actuary," Business Insurance Magazine



North America:  
1 800 432 7475  
+1 607 277 8000  
[sales@palisade.com](mailto:sales@palisade.com)

Europe:  
+44 1895 425050  
[sales@palisade-europe.com](mailto:sales@palisade-europe.com)

Asia-Pacific:  
1 800 177 101  
+61 2 9929 9799  
[sales@palisade.com.au](mailto:sales@palisade.com.au)

Download a FREE TRIAL VERSION of @RISK and read FREE CASE STUDIES at <http://www.palisade.com?Contingencies>