

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

DEPARTMENT OF PREVENTIVE MEDICINE AND BIOMETRICS

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HEALTH SERVICES ADMINISTRATION

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Stephen C. Phillips

Christopher Keller

Vincent Moore

Tram T. Nguyen

Kathryn Tierney

Piper C. M. Williams

Propose and debate the pros and cons of three alternative methods for financing healthcare in the US. Which of your proposals do you consider the most likely to be adopted and why? What policy and/or regulatory changes would need to be effected to implement your proposed alternative? How would this proposal affect the financing of government healthcare programs for the military, veterans, federal employees, elderly and economically disadvantaged?

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There is no single system for financing healthcare in America today. Rather, healthcare is financed through a myriad of different and complex methods that leave consumers confused and often without adequate healthcare at all. Most people have some sort of health insurance through their employers. Others are insured through some sort of government-financed program such as military or veterans medical benefits or Medicare for those over 65. Many of the nation's poor get their healthcare financed through Medicaid programs. Finally, a very few pay for all their medical expenses out of pocket. As the current U.S. system is actually a system of systems, and there is no single entity that oversees it to address its flaws, this paper will explore alternative methods of financing healthcare in America and discuss the advantages and disadvantages of each. Finally, we will discuss a method that we believe is the most likely in the near future.

The first alternative for financing healthcare in America would be for the entire country to move to a system where no one was any longer assumed to be just a consumer of healthcare, but rather everyone would be a buyer of healthcare. This would involve a return to the days before third party insurance, both private and government sponsored, and everyone would simply pay for medical expenses the way they pay for food or other expendables and services. Many conservative minded folks see this as a return to the "good old days" when doctors made house calls and you paid the doctor for the services he/she provided at the time of service. The primary advantage of this sort of system is its simplicity- no complicated forms to fill out, no consideration of pre-authorization, etc; just a simple pay as you go system. Other advantages of this sort of system include the fact that employers could get out of the business of managing healthcare as a business expense. The savings that businesses would reap from not having to buy insurance coverage for their employees would result in higher wages. Many argue that the spiraling costs of healthcare

would be contained, as patients would now face their entire medical bills alone. The “moral hazard” associated with spending what is perceived to be other people’s money would be eliminated.

However, it is highly unlikely that we will ever go back to this kind of system. The disadvantages of this system would make it untenable to most Americans. The gaps between “haves” and “have nots” would grow as the very rich would be able to afford “luxury medicine” while the very poor would be left with minimal or no care at all. The middle class would not be able to afford many procedures now considered basic, such as MRI or some preventive services. Furthermore, patients might delay seeking healthcare when other bills were pressing on their budgets, resulting in declining health for the majority of the nation. Finally, there are too many people making too much money managing care and providing insurance to Americans to expect that they would give up their livelihood (along with a significant percentage of the GDP) to go back to this sort of system. Many of the forces that originally created the third party payer system in healthcare, such as competition for employees, are still at work today, thus making this sort of healthcare reform unlikely.

At the other extreme of consideration for healthcare reform is a single payer system of national health insurance (NHI), where the government acts as everyone’s health insurer (based on the philosophical notion that healthcare is either a right or simply in the best interest of the public good). The idea of NHI has been proposed and debated for many years and is still one of the hottest of hot potatoes for political candidates who make healthcare finance reform part of their agenda. The specific form of this alternative that we debated in our group was single payer national health insurance, similar to the Canadian system, as opposed to a nationalized health service such as the UK system. The primary

advantage to this system, like the individual pay as you go system, is that it is a very simple idea to understand. Essentially outlaw any other sort of health insurance and give that role to the government. Everyone gets his or her care for free (or for a small co-pay) and Uncle Sam takes care of the rest! Proponents of this kind of system believe that the government has proven to be a responsible insurer as it either directly or indirectly finances almost 60% of healthcare in America today. Transitioning the remaining portion does not seem to be too difficult a task. The increased efficiency of having one government office in charge of healthcare, along with a “small” tax increase could easily pay for everyone’s care. Finally, many believe that the problems associated with access to care and quality of care, particularly problems of unequal distribution of access to the poor and lower working classes would be eliminated by NHI. They also argue that businesses, freed from having to pay for health insurance for employees would have increased revenues. That, along with overall improvements in public health, would be a remarkable boost for the economy.

Disadvantages of this system for financing healthcare revolve around philosophical arguments about the government being in charge of something as personal and private in citizens’ lives as their healthcare. Many Americans simply believe that it is not the government’s job to be insuring citizens’ health. The most remarkable recent example of this thinking was in the early years of the Clinton Administration, when the proposed National Health Security plan was soundly defeated. Opponents argued that the government bureaucracy would be too cumbersome to handle the complexity of healthcare, and that rationing of care would result with Americans being denied access to basic services that they demanded. Finally, as before, there are too many people making too much money in the insurance business to just walk away from the current system of insurance. While NHI has many advantages, and similar systems are successfully financing

healthcare with good outcomes in many nations, the current political climate along with some uniquely American cultural beliefs such as distrust of government and wanting choice, make a move to NHI unlikely.

The members of our group concluded that the most likely alternative for financing healthcare would have to be an evolution of the current system of systems. When one considers American's cultural beliefs and capitalist roots, this seems to be the direction we are heading. Both of the articles provided for this section of study noted that the insurance industry is developing a new type of insurance that is gaining greater acceptance among Americans and their employers. The so-called Defined Contribution Plans (DCPs) incorporate something for both the insured employee and the employer who are paying the insurance premiums. Particularly appealing are the DCP's that establish medical savings accounts (MSA's) for their customers. We think that this will be the most likely alternative to our current employer-based health insurance method of financing in the coming years. The advantage of this sort of plan for the employer is that it takes the employer out of healthcare management and makes the insurance more of a pure financial benefit for employees. The DCP's are appealing to employees because they offer a lot of choice with regard to both how the money is saved and how the money is ultimately spent. The DCP's have initially debuted as being less expensive and thus a solution to rising healthcare spending by employers. Perhaps though, the biggest advantage is the fact that they are still an employer-based form of insurance, which is only a "little" change to the current system making it more palatable for all.

Many of the disadvantages of the current system also impact the DCP's. Employment-based insurance does one little good if he/she is unemployed. Also, many

Americans might not like having so much “choice” in how they spend their healthcare dollars, especially once they become aware of how much it really does cost for the procedures they have taken for granted up to this point in time. Finally, some have argued that many would not spend their healthcare dollars wisely, bypassing important preventive services and primary care in order to spend their limited resources on less important medical procedures.

Our group felt that the current Medicaid and Medicare systems could be reformed to include DCP-like arrangements. Although these programs would continue to be funded by the federal government, the health benefit would be distributed more like food stamps- a defined contribution of dollars, with the choice for how it is spent (within the parameters of the program) belonging to the patient. Legislative changes would have to be made to allow for funding of Veteran’s care in this manner. While the VHA system could remain essentially intact, its funding could be changed to allow for payment from veteran’s DCP accounts. Thus, most government-sponsored healthcare beneficiaries would be affected in a manner similar to the way private health insurance beneficiaries are affected. Other regulatory and policy changes that would be required for a switch to employer (or government) sponsored DCP’s with MSA’s would be legislation requiring employers to offer these kinds of insurance programs, with a gradual phasing out of more traditional indemnity types of insurance programs that pay fee-for service.

Finally our group discussed how a wholesale change in American healthcare financing to DCP’s with medical savings accounts would affect active duty military healthcare. We believe that the military system is such a small part of overall healthcare spending in America, that it could be excluded from this sort of program without major

disruption to the overall system. In lieu of the fact that national defense is highly dependent on the health of the military it should be maintained as a separate system for the sake of readiness and national security.

In conclusion, the current system of healthcare financing in America is more a mosaic of systems than a comprehensive unified system. While there are dozens of viable alternatives to this, we discussed three: individual pay-as-you-go financing, single payer government financing, and evolution of our current employer-based health insurance financing with an emphasis on defined contribution plans. The first is unlikely and unaffordable for most Americans. The second, single payer national health insurance, is plagued by political realities make its passage a remote possibility at least in the near future. Healthcare financing through employer-based insurance, with government-based insurance for the poor, the elderly, and federal beneficiaries, is currently evolving to a Defined Contribution Plan model. This method of financing is the most likely to be implemented in the near future because it builds on the current system and is most consistent with American cultural values.