Keeping America Healthy (without breaking the bank)

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Reform and Repeal is DOA in DC. No matter what the outcome, nobody will be happy except a few policy wonks on the "winning" side and costs will continue to spiral out of control. Sadly, the bitter debates will only yield yet another non-solution and the headlines will continue to scream about the shortcomings and inequities of whatever comes out. The flailing about would be comical if it wasn't such a tragic manifestation of the damage done when politicians try to solve problems through a toxic combination of political ideology and political expediency while completely ignoring the reality of the situation.

The reality of the American health care system is that it is widely recognized as one of the least effective and most expensive systems in the world. The Commonwealth Fund's 2014 report on international competitiveness, Mirror, Mirror on the Wall, ranked the United States dead last in effectiveness despite being by far the world's most expensive. In 2016, Bloomberg ranked us 50th out of 55 countries.

Most importantly, none of the changes and reforms being discussed in Washington by either side will have any significant effect on either the cost or the quality of care because they focus on health care insurance not on health care. However, insurance is the problem not the solution.

The plethora of choices in health care insurance is responsible for a spider web of complexity that both causes unproductive administration and facilitates massive waste and overutilization; not surprising since the system pays for delivering care rather than keeping people healthy. As we will see, the total unproductive cost is over One Trillion Dollars. Moreover there are clear pathways to eliminating these costs that have been demonstrated both in this country and in many other countries around the world. What is lacking is the political courage to recognize and acknowledge the real problems and the political will to begin what will be an arduous transition to a more effective and efficient system.

The providers – the professionals and organizations that actually provide the goods and services that keep people healthy (i.e. physicians, hospitals, pharmaceutical companies, etc.) - are the best in the world. However, their ability to deliver affordable, high quality care efficiently and effectively is crippled by excessive unproductive costs. The driving force of these extraordinarily high costs is the complexity of the nation's byzantine billing, insurance and reimbursement (BIR) systems both private and governmental. For example, before redesigning their website earlier this year, einsurance, an on-line vendor of health insurance plans, advertised on the opening page that a purchaser could "choose from over 13,000 plans from over 600 suppliers". Similarly in 2016, the Medicare Advantage program included about 3,500 plan options. What useful purpose could such a mind-boggling number of choices serve? The notion defies common sense.

These complex choices create enormous and unproductive administrative costs not only within the insurance companies themselves but also for every single health care provider, business, educational institution, enterprise and individual in the country. The US National Library of Medicine (NLM) estimated the resulting BIR costs to have been $471 Billion in 2012. After adjusting for increases in premium prices, that projects to about $600 Billion in 2017. The NLM further estimates that 80% of these costs, ~ $500 Billion could be eliminated by bypassing the insurance companies.

Moreover, as we'll see, this complexity also facilitates the delivery of a comparable amount of unnecessary and unproductive care commonly referred to as overutilization. In other words, waste and overutilization account for over one third of the $3.2 Trillion the United States spends on health care and we're not addressing either problem. One might ask "can this possibly be true?" and, if it is, "how could we ever have created such a monstrosity?" and finally; "what do we do about it?" Let's try and provide some answers.

We'll start with the portion of the population that is covered by insurance including all private and governmental. First, consider that there is absolutely no connection between an individual's choice of insurance coverage and the type of medical care he or she will eventually **need**. Health insurance policies don't guarantee that you will get the care you need when you need it. They only tell you how much of the bill the insurance company will pay. The real decisions that affect the care you will receive come when you actually need the care and have to deal with the limitations of the coverage that require cash outlays - e.g. copays, coinsurance and deductibles.

So the many thousands of coverage choices that the insurance companies are so constantly celebrating as the route to better, more efficient health care are empty; they have little effect except to attempt to ration care based on ability to pay at the time of need. In fact, however, these choices are somewhat academic because 50% of the cost of all care delivered to insured patients (roughly $1,760 Billion) is in a hospital setting and once you are in the hospital you will receive all necessary care by Federal mandate. If insurance doesn't fully cover the cost, the hospital will bill the patient, attempt to collect and, in many cases, turn it over to a collection agency. If all attempts to collect fail, the hospital will write it off as a bad debt or charity care. **But in all cases the care will have been delivered.** The real impact of the limitations on coverage on hospital care is to deny care and kick off the collection cycle with all its attendant costs and emotional and financial stress.

The requirements for cash outlays do impact the two other major categories of care delivered outside the hospital setting: Professional services (35% of cost) and prescription drugs (15%). These outlays encourage patients to skip routine care (e.g. preventive care, annual check-ups and diagnosis of early symptoms) and outpatient treatment of chronic diseases (monitoring, adhering to prescribed medications and outpatient procedures) that are among the most cost/effective ways of preventing and controlling disease and its attendant health care costs.

In other words the complications of the BIR system motivate behavior that is in direct conflict with the national interest of keeping the population healthy. Fortunately, these limitations are also largely ineffective because most of the insured population is capable of paying these costs and does. The great majority of people get the care they need and the only impact the insurance system has is to determine who is billed for it. Moreover the care that is not delivered is among the most effective in ensuring a healthy population and denying it usually leads to the need for more expensive care in the future.

Table 1 below summarizes these conclusions based on a 5% estimate of the cost of care not delivered.

	Annual Spending	Cash Required At time of Need	Impact of Choice On	
			Care Delivered	Costs of Care
Hospital Care	$909B	Effectively Bypassed by federal mandate	Negligible	Negligible
Professional Services	$574B	Copays deductibles and coinsurance	Discourages preventive, routine and outpatient chronic care	~5% -$35B
Prescription Drugs	$277B	Copays deductibles and coinsurance	Discourages purchase of drugs for outpatient chronic care	~5% -$15B
Totals	$1,760			-$50

Table 1: Assessing the Impact of The Complexity Of Choice

Thus the total cost avoided by the limitations in insurance coverage is about $50 Billion but the costs of implementing these limitations is at least $500 Billion as documented by the National Medical Library. So we spend $500 Billion to save about $50 Billion by denying care that should be delivered. This does, in fact, defy common sense.

When one considers that the only constraint the Affordable Care Act (ObamaCare) places on health insurance companies is the Medical Cost Ratio that requires them to pass through a minimum of 80% of premium dollars to the providers of care, one can quickly come to the conclusion that health care insurance is a cost plus business. Connect that with the fact that the number of employees in the private health insurance industry has increased form 330,000 people in the year 2000 to 525,000 in 2015 you begin to understand why the continually increasing complexities of our insurance systems are at the heart of the Nation's continuing cost escalation.

Let's turn to the uninsured – the remaining 9% of the population. The details are different but the outcomes are similar. What happens in the real world is that most necessary treatment is accessible to the uninsured through our very complicated but inefficient and ineffective safety nets of emergency facilities and Federal statutory requirements. When the time comes that an uninsured person requires care, he or she will go either to a neighborhood clinic, an emergency room or to their personal physician (if they can afford one). In either case, if an individual is subsequently admitted to a hospital, he or she will receive all necessary care for their acute condition. In other words the uninsured have initial access to health care professionals and to all necessary acute care if they are admitted to a hospital. Similarly, emergency care is provided to all regardless of their ability to pay.

The great majority of care that is not actually delivered to the uninsured is when a person is not hospitalized. In that case an uninsured patient may decide not to seek care at an emergency facility for fear of creating a payment obligation. If they do go to an emergency facility they will receives emergency care but may not receive all medically necessary treatment and will be on their own until they once again reach an emergency situation. And even if these uninsured patients are hospitalized and receive all necessary care while an inpatient, they will also be on their own for continuing care once they are discharged. Moreover, in most cases, the absence of the continuity provided by a personal physician precludes the provision of preventive care that is relatively inexpensive and very effective. Once again, the system denies care that should be delivered if our national priority is to have a healthy population.

Let's try and estimate what the cost of providing all necessary care to the uninsured would be. The Kaiser Foundation has estimated that in 2015 there were about 28 Million non-elderly people

uninsured in the United States and that they generally incur about half the costs for medical care as an insured person. The average annual per person cost of care is about $10,000 so an additional $5,000 per uninsured person or about $140 Billion would provide the necessary care. Adding in the $50 Billion of cost to bring all necessary care within the reach of the insured we get a total additional cost to reach Universal Care for all Americans of $190 Billion. That's roughly 5% of our total spending on health care and roughly one third of the costs of complexity. And it's also a lot less than the $300 Billion in foregone tax revenues from subsidizing employer provided insurance for our most prosperous families. *Universal care is certainly well within the nation's grasp.*

The complexity of our BIR systems also complicates efforts to control unnecessary overutilization and fraud. The Dartmouth Atlas of Health Care has tracked Medicare costs for over 300 carefully defined regions for almost three decades. Their data shows that per capita Medicare costs vary by more than two to one among regions with no significant difference in outcomes even after correcting for differences in economic structures and patient characteristics. Similar patterns of overutilization are observed in most other patient populations. Estimates of the excess cost of waste and overutilization range from 10% to 30% of total health care spending or from about $300 Billion to $900 billion. Using the mid-range estimate of 20% yields $600 Billion in excess costs.

But efforts to control overutilization both by private and public insurance providers have been stymied by the complexity of enforcing the BRI system and by the misaligned incentives of fee-for-service reimbursement. There are many alternatives to fee-for-service (e.g. Kaiser Permanente, the Mayo Clinic, Intermountain Healthcare) that use various forms of integrated delivery systems and capitated care to reduce BIR costs and provide superior and efficient comprehensive health care to their enrollees. They are all focused on minimizing the total costs of keeping individuals healthy and out of the hospital as opposed to maximizing fee-for-service income.

Unfortunately, the national debate continues to focus on tinkering with our flawed notions of insurance as a way to limit the provision of care and, as a result, the move to integrated delivery systems with its potential for dramatically reducing waste and overutilization gets lost in the political noise. Thus, as noted in the initial paragraph, the total cost of these flawed principles (rationing based on ability to pay and fee-for service reimbursement) exceeds One Trillion Dollars every year – a truly staggering figure. Unfortunately, as also noted in the initial paragraph, international comparisons of health care costs confirm that our costs are way out of line with those of other countries and our overall performance is dismal.

All these excessive costs have been well documented and commented on for many years but the political will to face the problem, consolidate the insurance industry, reduce complexity and transition to integrated delivery systems has been lacking. This is not surprising given the clout of the vested interests of not only the insurance companies but also all the other institutions, think tanks and experts that have made a career of refining a flawed system not to mention the number of unproductive administrative jobs that will have to disappear. However, there is no way to reverse the spiraling costs of care without addressing these fundamental flaws.

All other developed countries treat health care as an essential service rather than a consumer product rationed on ability to pay and have moved to one form of universal care or another. Most of the "nearly" developed nations of the world have as well. ObamaCare was a poorly conceived attempt to move closer to universal access that exacerbated the cost problems by focusing on insurance and introducing additional forms and layers of complexity and bureaucracy. The contemplated attempts to "fix" it are likely to produce the same result.

It's ironic that the United States is already very close to providing universal access through the safety nets of emergency rooms, neighborhood clinics and legal requirements for hospitals to provide care. Consequently the actual cost of the additional care would be quite manageable and a relatively small fraction of the savings achieved through reducing complexity and overutilization. Equally ironic is the fact that the pressure to control costs is primarily on the providers who actually treat and heal patients while the insurance companies, who arguably add little value in this process, operate on a cost plus basis as noted above.

Finally the arguments that focus on the "dangers of having the government tell us what medical care we can have" are specious. We can achieve universal access with all the providers of care remaining in private hands; with medical professionals making the decisions on necessary care; and with competition based on the costs and quality of the care delivered. Medicare Part A is a simple universal care system unencumbered by the siren song of choice and treasured by our senior citizens. Moreover it is widely considered both effective and efficient and the care is delivered by the private sector. The role of government can and should be restricted to specifying the parameters of access and managing the total costs. The Centers for Medicare and Medicaid Services (CMS) could be streamlined and set up as a quasi-independent Federal Reserve like entity insulated from short-term political pressures. Eventually a transition to a private Foundation responsible for recommending the broad outlines of the system and, in particular, setting reimbursement prices could be considered.

Unfortunately the Republican majority in Congress does not accept the concept of universal care. However, if President Trump were to embrace it, and bring along his Republican colleagues he could probably count on substantial support from the Democratic side. Creating such a bipartisan coalition to plan and embrace what will necessarily be a lengthy and disruptive program of fundamental change is the real challenge facing President Trump as he moves to deliver on his campaign promises for health care reform.

Fred Gluck June 18, 2017

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His extensive background in health care includes serving as the presiding director of HCA as well as on the boards of Amgen, RAND Health Care, and the Cottage Hospital System of Santa Barbara. He also served on the board of the New York Presbyterian Hospital for over 30 years before achieving emeritus status in 2006. Fred is also the founding Chairman & CEO of CytomX Therapeutics (NASDAQ: CTMX) and Cynvenio BioSystems: a world leader in Liquid Biopsy™ for precision medicine and Co-Chairman of TrueVision Systems: a world leader in computer guidance for microsurgery.

Fred has also written and spoken on health care reform dating back to his service on an Advisory Panel for the Budgeting for National Priorities project at the Brookings Institution in 2005-2006. Fred started his professional career at Bell Telephone Laboratories in 1957 and was the program manager for the Spartan anti-ICBM missile system when he left to join McKinsey.