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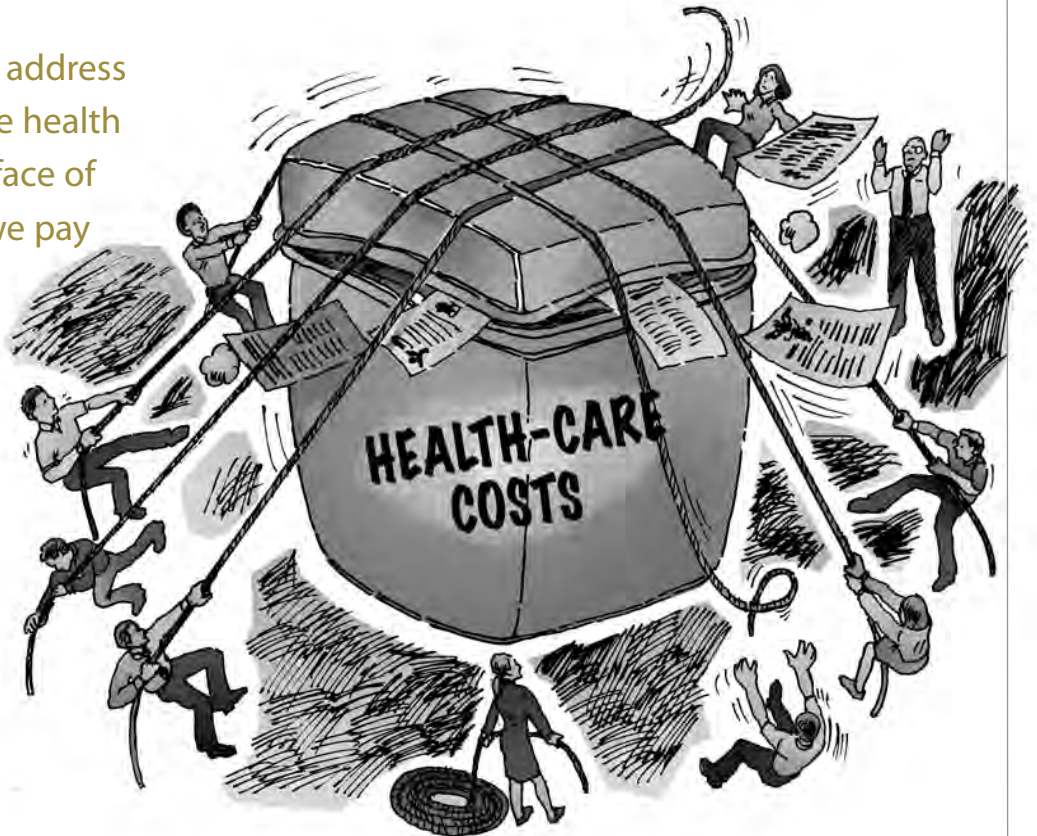
ISSUE IN BRIEF

>> Coping with the Cost Of Health Care

How Do We Pay for What We Need?



The questions we must address are: How can we get the health care we require, in the face of rising costs? How can we pay for what we need?



>> More than Dollars and Cents

NEARLY THREE OUT OF FOUR AMERICANS today worry that their income will not keep up with rising prices, according to a recent Kaiser Family Foundation survey. Specifically, 73 percent worry about having to pay more for health care or health insurance. And 65 percent are concerned that they may not be able to afford the health care they need. These worries outstrip anxieties about losing a job, terrorist attacks, crime, and losing savings in the stock market.

A remarkable 47 million Americans go without health insurance at all. The cost of this fact—to individuals and to society as a whole—is staggering. Medical bills are one of the chief causes of personal bankruptcy—and three-quarters of such bankruptcies are declared by people who do have health insurance. When individuals cannot pay their medical bills, the costs are passed on to the public at the rate of almost \$35 billion per year.

According to the government's Agency for Healthcare Research and Quality, more than 6 in 10 Americans have health insurance through their employers. However, the cost of such coverage is rising, both for employers who subsidize it and for employees who purchase it. According to the Kaiser Family Foundation, the average cost per family for employer-sponsored health insurance has about doubled in the last decade, with premiums that individuals pay going from an average of \$122 per month in 1996 to \$226 per month in 2005. Employers pay even more than this on behalf of each covered employee: \$680 per month in 2005.

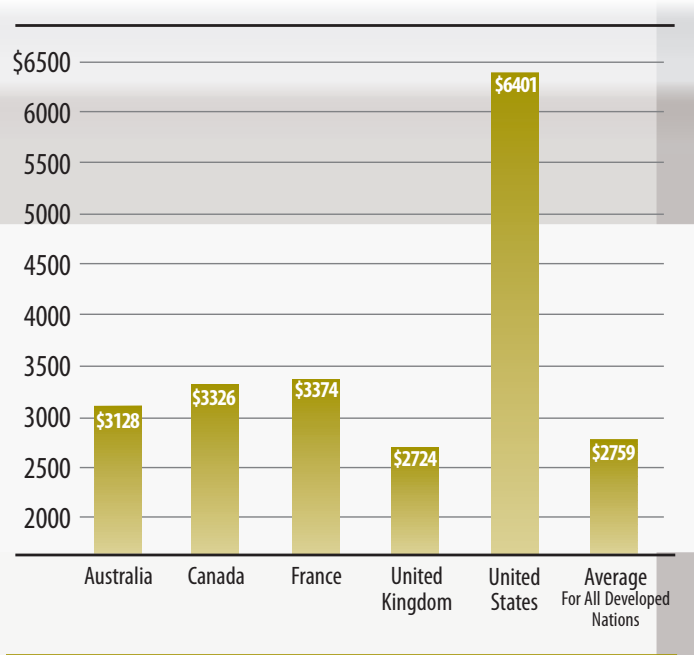
The rising cost of health care is a major contributor to government budget pressures and the federal debt as well. The amount the government will have to pay for Medicare benefits, for instance, rose \$1.2 *trillion* in 2007 alone, according to an analysis by *USA Today*.



Meanwhile, the quality of care is not as good as it could be. The U.S. health-care system lags far behind other developed nations by many measures. The United States ranks 29th in the world in terms of life expectancy, behind nearly all of Europe. In this and similar rankings, the United States has been slipping for some time. Furthermore, according to the *Dartmouth Atlas of Health Care*, a comprehensive look at health-care use across the country, the United States does not do a good job of getting health care to those who need it, nor in making sure that different people in different parts of the country get comparable care.

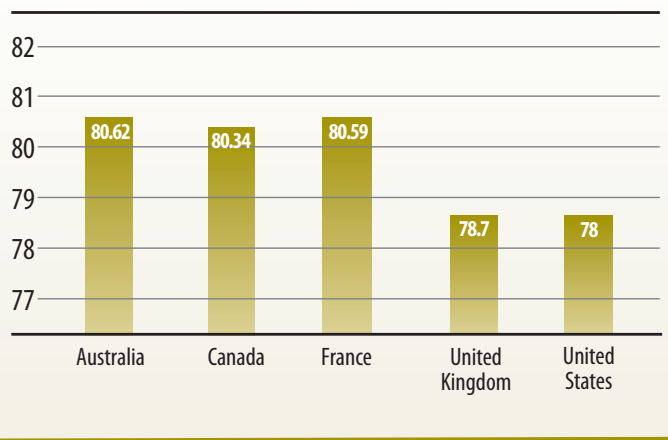
The health-care problem in America, while driven in many ways by cost, is not solely a dollars-and-cents issue. Deeply held values come into play and many of these are threatened by trends in the current system. For instance, rising prices increasingly create a “have” vs. “have-not” health-care system in which the poor have very limited access to care, an inequity that many Americans find intolerable. Rising costs are seen by many as driven by greed on the part of pharmaceutical or medical equipment manufacturers, and that motivation, they say, deserves no place in

Average Spending Per Person on Health Care in 2005



Source: Organisation for Economic Co-operation and Development

Life Expectancy at Birth, 2007



Source: 2008 CIA World Fact Book

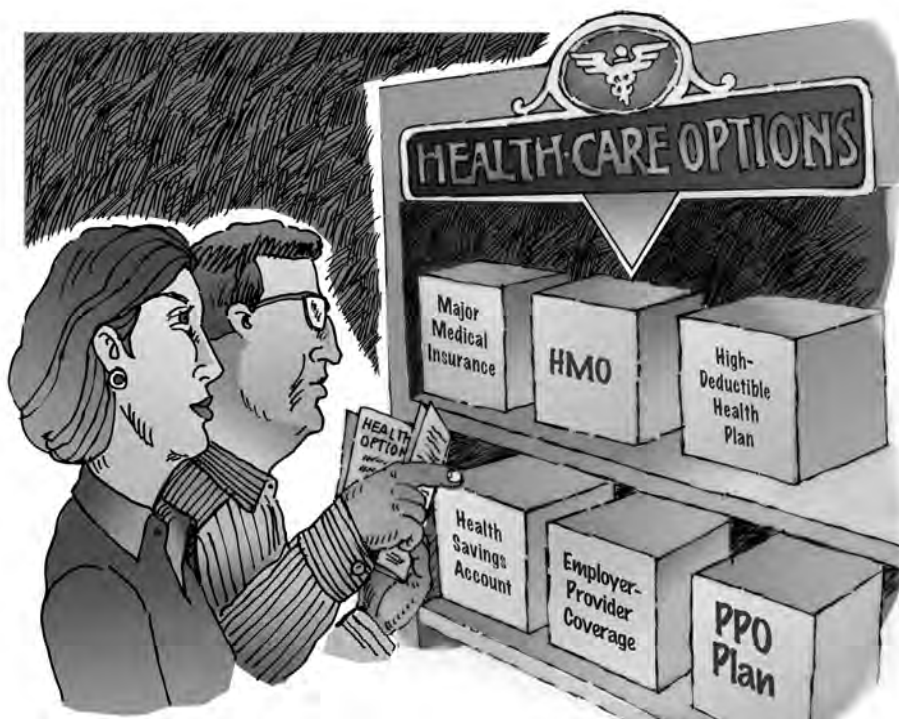
something that touches the well-being of all citizens. And many Americans live in fear that a serious illness will leave them in financial ruin.

There are a number of proposals and plans for what to do about health-care costs in America. Some are new, while others have been around for some time. Many of them respond to some, but not all, of the concerns Americans have when it comes to paying for health-care coverage—and they all come with drawbacks that the public is rarely asked to consider. It is these trade-offs that need to be faced squarely.

This issue brief is meant to spark deliberation on the issue of health care in America. It asks citizens to consider how different approaches to this issue stack up against the values they hold important and to weigh the trade-offs they might be willing to accept. The approaches arise from the key concerns about personal security, fairness, and justice that Americans say they have when it comes to health care:

- They are worried about being wiped out financially by medical expenses;
- They feel taken advantage of by out-of-control costs for health care; and
- They say it's wrong for some to get care while others don't just because they can't afford it.

The costs of illness make people feel vulnerable, with no control over their future. They worry they may be wiped out by medical expenses.



>> Reduce the Threat Of Financial Ruin

SUSAN SQUIRE OF WARREN, MICHIGAN, is a trained bookkeeper. “I know finances and how to deal with them and pay your bills,” she says in a recent article in *USA Today*. When she was laid off from her job back in 2000, she was able to figure out a way to continue paying for ongoing medical expenses even though she has diabetes.

Then in 2005, she was rushed to the hospital. She tells *USA Today*, “The doctor said, ‘Well, Susan, you’re having a heart attack.’ . . . That’s when it hit me, ‘Oh my God, I can’t be going through this. I don’t have insurance.’” The tab for her heart attack was nearly \$92,000 and eventually sent her into bankruptcy. “I never had a problem with [paying medical bills],” she says, “until I got hit with \$92,000 in one lump sum.”

Susan Squire is not alone. Sixty-five percent of Americans are “very” or “somewhat” worried that they will not be able to afford medical expenses,

according to a recent survey by the Kaiser Family Foundation. Almost everyone can tell a story of someone they know who was ruined financially by medical bills.

Proponents of this approach say what chiefly worries them is the prospect of financial ruin.

While employers provide health-care coverage for the majority of the American workforce—to more than 160 million people, according to the nonprofit Commonwealth Fund—not everyone has a job and not all of those who have jobs can get coverage. A study by the Robert Wood Johnson Foundation, found that fewer than half of parents in families earning below \$40,000 per year could get health insurance through their employers.

What people need, according to this approach, is assurance that events like Sally Squire’s \$92,000 heart attack and, less dramatic but no

less costly, health problems do not wipe them out financially.

The answer, according to Approach One, is to require that all citizens have a minimum amount of health insurance and to ensure that such insurance is available and affordable.

We can begin to move right away to broaden basic coverage and place downward pressure on costs, say advocates of this approach. For ideas we need only look to what is already happening in many states. Over the last handful of years, a number of states, some of them frustrated with the slow pace of reform on the national level, have implemented or proposed their own health insurance plans.

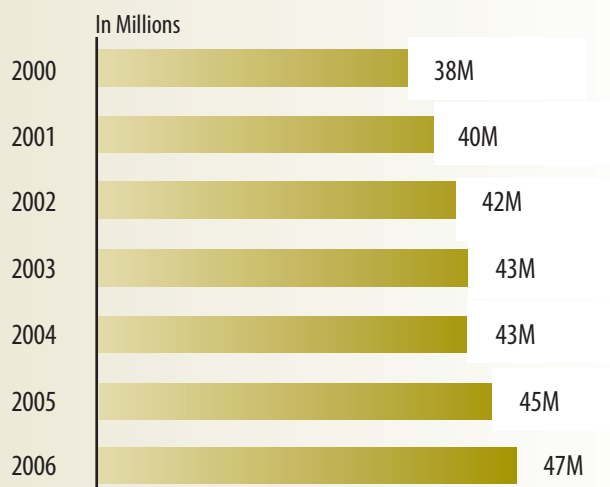
Massachusetts may be the best-known example of a state government that makes it significantly easier for its citizens to get basic health-care coverage. In 2006, it became the first state to require that all businesses offer health insurance or pay the state at least one-third of the cost of coverage. This payment goes toward helping those who do not currently have insurance through their employers get their own insurance. Indeed, this is the essence of the Massachusetts effort: to create a variety of means that will enable more people to find affordable health coverage.

Massachusetts is not alone. Maine and Vermont have also implemented new health-care plans, albeit more modest, and California along with Pennsylvania, Michigan, Minnesota, and New York—all of whom are considering health-care reforms—are being closely watched.

Most of these efforts have some key elements in common: a legal requirement that employers offer health insurance to all employees or else pay into a state fund; a requirement that individuals obtain health insurance; a government “connector” office that matches people who need health insurance with insurers who will accept them at various levels of payment and benefit; and subsidies for those who cannot afford to pay.

This approach would require that all citizens get at least one of these means of health insurance, much as states now require all motorists to carry automobile insurance that at least covers

Americans Without Health Insurance



Source: U.S. Census Bureau, March Current Population Survey

them for liability. Some automobile policyholders choose high deductible policies that only pay in the case of a severe accident. This approach would leave it in the hands of citizens to make sure they are prepared for the possibility of high medical bills, but does not dictate a one-size-fits-all policy, which for many is too costly and might give them more coverage than they feel they need.

This would not mean that everyone automatically gets comprehensive health insurance. In some cases, it might mean insurance that kicks in when medical bills rise above a predetermined amount.

An additional tool suggested by Approach One is the expanded use of health savings accounts. These are savings accounts into which individuals can put pre-tax dollars up to a certain amount. They are not taxed on the money if it is used for medical expenses, indirectly reducing the cost of care. This gives many people a way to set aside money for the routine expenses not covered by their insurance; it is a self-directed way of preparing for medical expenses that go beyond petty but fall short of ruinous.

This approach not only helps individuals and families by making health insurance more available to those who cannot now afford it, but



it delivers an added benefit to society: reducing the number of Americans who are uninsured keeps costs down for everyone. When uninsured people get very sick, the cost of their care is indirectly spread around to others throughout the health-care system. Premiums go up, and hospital operating costs go up to cover those who cannot pay. Over a year, these uninsured costs mount to \$35 billion.

If we apply many of these ideas on a national scale, it will significantly expand the number of people who have a health-care safety net. This will protect them and reduce costs for all of us.

What Should Be Done?

Proponents of this approach say we need to make health insurance that covers major medical expenses available to everyone.

- **Require all Americans to have some form of health-care coverage.** Individuals will not necessarily be forced to carry the same amount of insurance they now do, but they will need to carry, at least, a policy that covers major medical expenses.
- **Require employers to provide health insurance coverage to their employees,** or to pay into a fund that subsidizes individual coverage.
- **Create new insurance plans with higher “deductibles,”** so some people could opt for lower premium payments, which would cover them only when their medical expenses exceed a certain amount.
- **Help people, who are ineligible for current plans, buy health insurance.** Expand the eligibility for current government programs, such as Medicare, and create a fund that subsidizes the cost of buying health insurance for low-income citizens.

Trade-Offs

- This approach depends in part on increasing subsidies for people who don't have health insurance. This money may have to come from increased taxes.
- While this approach strives to make sure everyone has some form of insurance, it will not necessarily help those whose ongoing medical bills are more expensive than their insurance will cover. These people will still be subject to escalating medical expenses.

>> Opposing Voices

- Experience shows that, left to their own devices, some people will inevitably underinsure themselves, face financial ruin, and become a burden to the community.
- This is an insupportable expense for businesses, especially small businesses, which comprise the chief engine of America's economic growth.
- This approach does nothing to address the real problem: excessive prices charged by insurance companies and health-care providers. There are no incentives to control health-care costs in this approach. They will just continue to skyrocket.
- Health insurance plans that have high deductibles will discourage people from getting early diagnosis and treatment, because such expenses come out-of-pocket. Numerous studies show that prevention and early treatment are among the best ways to ensure both health and lower costs.
- This will cost more than proponents say it will. It is far too expensive to provide subsidies for people to buy health insurance.

When faced with the prices of drugs, insurance, and medical services, people say they are being ripped off. Prices are out of control.



>> Restrain Out-of-Control Costs

WHILE PROVIDING BASIC HEALTH-CARE coverage is a laudable goal, say proponents of this second approach, it fails to address the real problem confronting so many Americans: out-of-control costs, which are being passed on to the public.

Even having health insurance is often not enough protection against high prices. According to a Harvard study, health-care bills are the cause of more than half of personal bankruptcies—and of those who go bankrupt because of medical bills, three in four actually have medical insurance. Yet they still face “unaffordable co-payments, deductibles and bills for uncovered items like physical therapy, psychiatric care and prescription drugs,” according to Dr. David Himmelstein, the study’s author.

Jerry, a contributor to the Web site *It’s Our Health Care*, maintained by the *San Jose Mercury*

News, is a case in point. “My wife has health insurance, but it doesn’t cover the prescription drugs she needs,” he writes. “After her heart attack, she is supposed to take several medicines that cost about \$600 every month. Our family just can’t afford it, so she goes without the medicine that might prevent her from having another heart attack.”

This approach holds that costs are out of control throughout the medical system and the citizen is the one who ends up holding the bag. “Estimates on hospital overcharges run up to \$10 billion a year, with an average [overcharge] of \$1,300 per hospital stay,” according to an article at *Bankrate.com*. “Other experts say overcharges make up approximately 5% of hospital bills.”

Fraudulent and improper billing are not the only culprits. In this view, prices are simply too high. Reviewing one of her own medical bills,

medical billing advocate Nora Johnson points to a charge: “How about \$129 for a ‘mucous recovery system?’ That’s a box of Kleenex.”

“This is not a system . . . any patient would choose,” writes Ezra Klein in *The American Prospect*. “We pay way too much, and get nothing for it. We pay because most actors in the system seek profits rather than wellness, because doctors buy their homes based on the number of tests they prescribe, and pharmaceutical companies don’t give us discounts because they’ve bought Congress, and insurers get us to pay for them to figure out how to deny care.”

Between 1996 and 2004, the average cost per family for health insurance more than doubled, according to the U.S. Agency for Healthcare Research and Quality. And it’s not only individuals who are hard hit by these costs. Employers find it harder and harder to offer insurance to their employees. In 2005, health insurance premiums for covered workers went up more than twice as much as inflation. Meanwhile, just one year later, “in 2006, the nation’s six biggest private health insurers collectively earned almost \$11 billion in profits,” according to *Consumer Reports*. Such “continuously rising insurance costs,” writes commentator Mort Kondracke in *Roll Call* newspaper, “burden[s] U.S. businesses in global competition.”

According to proponents of this approach, both the price of medical care and coverage, and the tactics insurance companies use to deny coverage, are unconscionable. Medicine should not cost \$600 per month—it’s too much, they say. People should not be forced to “max out” their credit cards just to stay alive.

Meanwhile, health insurance companies are hit with fraud judgments totaling hundreds of millions of dollars. And, unscrupulous providers are adding to the prob-

lem. According to the National Health Care Anti-Fraud Association, fraudulent claims amounted to \$12.1 billion in 2001.

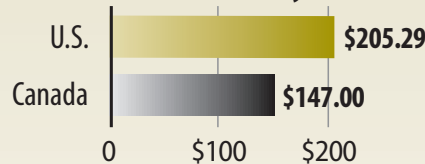
Ordinary Americans see something out of whack.

The answer, according to this approach, is to put a stop to these unfair prices, unfair practices, and outrageous compensation. While there are laws on the books already against fraud, they need to be enforced more strongly and new controls need to be put in place. “We have very high prices because people can get away with charging them,” says David Blumenthal, M.D., director of the Institute for Health Policy at Massachusetts General Hospital, in *Consumer Reports*. “In our decentralized, pluralistic system, no single purchaser has the market power or political authority to impose cost controls.” The result: pharmaceutical companies, health insurance companies, hospitals, and other health-care providers essentially

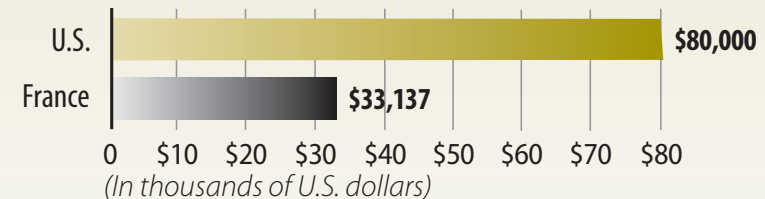
Medical Prices Are Far Lower Elsewhere

Estimated costs of procedures and medicines: U.S. vs. other nations

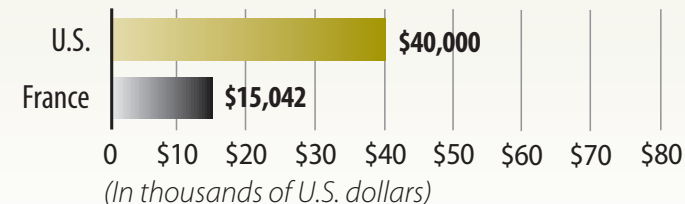
LIPITOR (a commonly used drug to reduce cholesterol)



HEART BYPASS SURGERY



HIP REPLACEMENT



Note: Canada is a common foreign source of medicines; France is a common destination for people seeking lower costs yet high-quality medical procedures.

Source: 2007 Consumer Assessment of Healthcare Providers and Systems Health Plan Survey

set their prices unchallenged.

The government needs to play a stronger role in regulating providers throughout the health-care supply chain, to keep prices as low as possible for ordinary people. It could start with regulating insurance premiums by requiring that they be approved by a government body before going into effect, much like utility rates must be approved. But it does not need to stop there. Because so much of the health-care industry is under some form of regulation, there are many opportunities for governing bodies to put downward pressure on costs.

Other markets in this country are regulated for the protection of individuals—energy, cable television, and banking, for example. Outside of the United States, many nations have more regulated health-care systems. For instance, in Germany, the government sets the prices for all medical services.

To proponents of this approach, the main goal is to put a lid on runaway costs throughout the health-care system, so prices paid by individuals for needed pharmaceuticals, insurance, hospital stays, and doctor visits are fair.

What Should Be Done?

Health-care costs are too high for too many people. This approach holds that they should be reduced directly through price controls and other means.

- **Limit or specify what can be charged for health insurance.** For instance, cap insurance rates at some percentage of household income,

or put a cap on allowable corporate profit.

- **Require insurers to accept all people regardless of health status** and limit the increased premiums insurers can charge for unhealthy people. People should not be penalized because they need the very medical care they are trying to be insured for.
- **Use the regulatory power of the government** to set prices on medical services and prescription drugs.
- **Allow individuals to purchase drugs—that meet safety criteria**—from overseas where they are not as expensive.
- **Place limits on the amounts that the courts can award for malpractice damages.** The cost of excess litigation is being passed onto consumers in the form of higher medical costs.
- **Place limits on executive compensation.** Health insurance executives literally earn millions, windfalls that could instead go to reduce costs for ordinary people who need medical care.

Trade-Offs

- Cost controls can hold down prices, but they may cause some health-care providers to limit the use of expensive, but life-saving, medical technologies.
- Caps on jury awards for damages could result in uncompensated losses, so people who are the victims of malpractice are not made fully whole.

>> Opposing Voices

- Government price controls would distort any market forces that are at play in health care, removing the element of competition—when competition is the best way to keep prices low.
- This approach will stifle innovation and advances in medical technology and pharmaceuticals. Lower profit margins will reduce money pharmaceutical companies make available for research on new products.
- Medical providers are not paid too much. They charge what it costs them to provide their needed services. They are squeezed in the middle by escalating costs on one hand and the push to reduce prices on the other. This approach would put doctors, nurses, and hospitals out of business.
- This approach removes a powerful check on slipshod medical care—the threat of lawsuits and court action.

High costs mean that some Americans have to choose between eating and taking their medicine. In the wealthiest nation on Earth, *everyone* ought to have health care.



>> Provide Coverage as a Right

THE UNITED STATES PAYS MORE than any other nation for health care, though with unequal results. Fortunate people at the top of the economic ladder receive excellent care, while those at the bottom get little or nothing. When it comes to health care, we're a nation of haves and have-nots.

According to a recent Gallup poll, 64 percent of Americans believe that all people ought to have health-care coverage guaranteed by the government, just as all people ought to have access to schools and fire and police protection. Proponents of this approach say that, as a society, we owe it to one another to make sure everyone is taken care of. "Education is a right, and we provide it to all, regardless of differences in need," says a *New York Times* editorial. "In the same way, nobody would be 'uninsurable' if we acknowledged health care for all as a public responsibility."

The answer, say proponents of Approach Three, is simple. It is time to stop talking about "increasing" coverage or "reducing" the number of

uninsured Americans and, instead, simply affirm that all citizens get to choose which doctors and specialists they wish to see, with a medical administration paying the bill.

This is not so-called "socialized medicine," nor is it like the British model of health care, where the government employs doctors and runs health facilities. It is a public payment system, like Medicare, where there is a "single payer," who pays formally established costs for every citizen's required medical care from an annual budget, sustained by the tax system.

According to the Organisation for Economic Co-operation and Development (a group made up of the 30 leading industrialized nations), nearly every developed nation can say that all of its citizens have health-care coverage. The United States joins only Turkey and Mexico in the bottom three in terms of share of citizenry that has health-care coverage. All other developed nations cover 97 percent or more of their populations.



It is not only the poor who need health insurance coverage and do not now have it. Increasingly, the middle class must make difficult medical decisions and go into debt in order to stay covered. Examinations of the characteristics of the 47 million uninsured people in the nation reveal that up to one-quarter have household incomes over \$50,000 per year. But with insurance for a family running as high as \$11,000 or more, it may not be surprising to find many still without insurance.

Over time, more and more countries have joined the ranks of nations that have health-care coverage for their entire population. France’s health-care system—which the World Health Organization has labeled “exemplary”—achieved 100 percent coverage as recently as 2000.

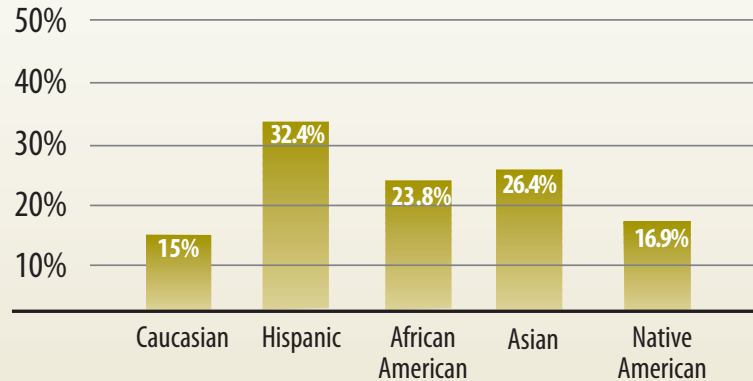
Providing health-care coverage for all Americans, say proponents of this approach, is not just the right thing to do—it is also the financially sound thing to do, as other developed nations have demonstrated.

All told, health-care spending accounts for 16 percent of the entire U.S. economy, or \$2 trillion dollars. We spend \$6,401 on health care each year for each person. This is far more than other developed nations, such as France, Britain, and Australia, spend. According to a recent study by the McKinsey Global Institute, “the U.S. now spends more on health care than it does on food.”

The number of uninsured Americans, meanwhile, continues to climb. Proponents of Approach Three say that a world leader like the United States ought not to be trailing far behind its peers. And there is “more than enough money in our health care system to serve everyone if it were spent wisely,” according to the Physicians for a National Health Program (PNHP).

In this view, centralizing the entire payment system for all medical expenses would allow new efficiencies that simply can’t be achieved under the current rules. The government could negotiate drug prices directly with pharmaceutical firms (much as the Veterans Administration now does). In a 2003 study, PNHP concluded that “adminis-

Percentage of Different Ethnic and Cultural Groups Who Say They Have No Usual Primary Care Provider



Source: Agency for Healthcare Research and Quality (2005)

trative waste consumes 31 percent of health spending,” compared to just 16.7 percent in Canada, where a government health-care payment system is in place.

Another driver for this approach is a sense of equity. “Ensuring that every individual has free access to health care should be an imperative of any fair and just society,” writes Tyler Zimmer in the *Vanderbilt Orbis*. “Health care . . . is not simply a commodity to be bought and sold according to the market, but rather it is a basic human need. As such, it should not be limited to only those who are able to pay for it.”

For many Americans, it is morally wrong—as well as potentially disastrous—that there are 47 million Americans who do not have health insurance. Indeed, “of all forms of inequality, injustice in health care is the most shocking and inhumane,” Dr. Martin Luther King Jr. said.

Advocates of this approach say it is critical that we remove the injustices in the current health-care system, which allow the have-nots to languish while the haves get world-renowned medical care—and that we insure *everyone*, which will reduce the overall costs of health care in our nation.

What Should Be Done?

Proponents of this approach say that health-care coverage is something every citizen is entitled to.

- **Provide health-care coverage to all as a public benefit.** One way to do this would be to expand Medicare so there is one insurance plan that covers all Americans.
- **Use the negotiating power of the government** to get reduced prices on prescription drugs and other medical materials.

Trade-Offs

- Proponents of this approach say that every health-care system on the planet must already grapple, not with *whether* to ration care, but *how*. Better, say proponents of this approach, to be rationed by need than by wealth.
- This approach will result in higher taxes to pay for health-care coverage although these costs may be offset by savings in other areas, such as reduced payroll taxes and eliminated health insurance premiums.

>> Opposing Voices

- This approach calls for the federal government to take over the health insurance industry for all Americans; this will send taxes through the roof.
- This approach provides no incentive for people to take responsibility for their own health. The government will need to create penalties for “bad” health-related behavior. This is too intrusive.
- This approach promises greater efficiency, but really delivers greater bureaucracy.
- Public confidence in the federal government is extremely low. Do we really want to place in government hands something as valuable and important as health care?

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