# Two Issues In The U.S. Health Care System

*by Brian A. Jones*

Two issues dominate most discussions of health care among actuaries, among nonactuaries and in interactions between the two groups. They are: first, U.S. health care costs as a percentage of GDP are far higher then those in other countries; and second, large numbers of people in the United States lack coverage.

## Issue One—Health Care Costs

A major factor in the high cost of U.S. health care—and a source of wonder to foreigners—is the high level of earnings amongst doctors, not just leading doctors, but virtually all except a few who choose to serve the poor in low-paid or even volunteer positions. In my opinion, the country has, in effect, put practically all its doctors on a pedestal in a way that other countries do not and has given them a top-echelon lifestyle: McMansion, top-grade automobiles, country club memberships, etc. Doctors' fees reflect that assumption.

A symptom, and one of the causes of this, is the fact that entrance to medical school requires an undergraduate degree. Other countries do not have this requirement, and it is far from obvious that their doctors are inferior. Recent personal experience, in fact, suggests just the opposite to me. It is unquestionably true that medical school professors prefer to teach classes full of graduates in philosophy or science, but it is probably equally true that professors in those and other disciplines would like to teach a class full of graduates too.[1]

Consumers might prefer a less expensive route to qualification if that was reflected in reduced education costs and eventually in reduced doctors' fees. It seems unlikely that much can be done about this, at least in the short run. Nevertheless, we could consider offering an option to aspiring doctors with a high school education which would not involve a period of study as long as the present system of four-year college followed by medical school. One way to start would be with people who are willing to make a commitment such as service in the military for a period, in exchange for tuition-free medical education.

Another significant factor in U.S. medical cost is administration—marketing, underwriting, coordination of benefits, etc.—which is largely eliminated under a universal plan. These areas involve actuaries who will have to face the fact that some of them may not be required if the system is reformed.

Finally, the allegation that universal coverage will be expensive is based on inconsistent analyses: first, that additional medical services will be required which are not being provided now; and, that doctors' and other fees are now padded to reflect unpaid care which is being provided. These fees will not be reduced when that care is covered by the new plan, replaying the Medicare windfall.

## Issue Two—Coverage

It is important to note that the people who are most affected by loss of coverage are not the lowest income strata of society. The poorest people usually qualify for Medicaid, and even if for some reason they do not, they will not be refused care in a hospital emergency room: an expensive option for many reasons including the fact that treatment is often postponed unduly. The classic example of this is pregnant women coming in at the last minute after little or no prenatal care. The people who are hardest hit financially are not such poor people. They are those who have assets, but find themselves uninsured for reasons ranging from loss of coverage after loss of employment or expiration of COBRA, to such mundane problems as a missed or mislaid premium notice. The result is serious horror stories which arouse sympathy for those affected and also trigger concern: "Could I be next?"

Built into the system now is an implicit assumption that the sensible way to finance health care is through per capita premiums, paid by individuals or by employers. Clearly the poorest part of the population cannot afford premiums of hundreds of dollars per month; hence the lack of coverage.

Elaborate subsidies and/or rebates must be devised if coverage is to be expanded while maintaining a per capita

approach to funding. Presumably, the resulting cost will be met from general revenue. There is simply no other source, though earmarked taxes such as tobacco or other health-related items may make the subsidy more palatable.

If the per capita approach is really the best way to fund health care, one wonders why it is not carried over into other parallel areas, a prime example being fire protection. Instead of financing fire departments from taxes, should we not use a per capita premium approach here too—perhaps with rebates, subsidies et al? It would not be practical to let the homes of uninsured people burn down—unless they were very isolated—because that would put the neighbors' houses at risk too; but we could pursue uninsured people for the cost of putting out fires in their houses after the fact, piling an additional cost on them just as they are faced with the cost of repairing or rebuilding.

The precedent is in place. That is what we do with the medically uninsured or underinsured. We treat them in the emergency room—much more expensive, especially when treatment is delayed—and then pursue them for the cost of treatment, often driving them to bankruptcy. To add insult to injury, we charge them the full cost, without the discounts that Blue Cross and other plans are able to negotiate. Since the poorest people are virtually without assets, the burden of this approach falls largely on the lower middle class.

Perhaps we should also encourage a profusion of competing fire departments. Competition among health plans touted as one of the advantages of our current approach to health care. Why not in fire protection too?

By contrast, countries with universal coverage rely primarily on a tax-based approach to the entire cost of benefits and provide a uniform level of benefits.

If the United States is to provide universal coverage, the questions which must be addressed are:

1. Can we afford deluxe coverage for all?
2. If not, and deluxe coverage is to be provided outside the universal plan, will those with private coverage have to pay full costs in addition to being taxed to pay for the universal plan?
3. If such double payment is to be avoided, how do we integrate private and universal plans?

It is suggested that the answer to question 1 is that clearly we cannot afford universal deluxe coverage if that implies private rooms, caviar for lunch, and individual bedside telephones and perhaps TV sets. Where the deluxe line comes is obviously a political issue to which actuaries bring no special expertise. Nevertheless, it seems unlikely that public opinion would tolerate the notion that certain cutting-edge technologies would be available only to an elite with private coverage, but it probably would tolerate the difference in waiting periods for non-emergency treatment which often occur in other countries (though probably not as often as the more hysterical opponents of universal care allege).

Question 2 is also basically political. It seems likely that if large numbers of people face double costs—for their own coverage via premiums paid by them, or by their employer but reflected in their pay package, and for everyone else through taxes—support for the health care reform will fall. This could result in inadequate coverage in the universal plan or in outright rejection.

Question 3 is where actuarial expertise will be essential. Integration could come via separate payment for excess benefits not covered by the universal plan or via subsidy payments based on projected (or possibly actual) cost savings to the universal plan when the private plan pays. Either way, establishing a fair approach will be complex, especially so if minimum standards are not set for private plans.

A recent article in the *New Yorker* magazine[2] traced the evolution of various national health care regimens noting that national systems reflect history in the various countries

and casting doubt on the one-size-fits-all proposals of many would-be reformers. Unquestionably, the public is demanding universal coverage. The issue is how that can be provided; and if it is provided, does the United States need a complete upending of the system or can it make a smooth transition?

Actuaries, I suggest, can make a major contribution to such a transition. It should not be beyond our capabilities to devise a procedure which will result in a tax-financed basic plan allowing private deluxe supplementation.

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[1] *Law schools now require an undergraduate degree before entry, capping the maneuver by rebranding their undergraduate degree as a J.D. rather than the more transparent LL.B. used by other common-law countries. (Ironically, the next step up remains the LL.M.) Fortunately for the rest of society, the effect on lawyers' earnings outside the elite, has been less dramatic though by no means negligible. It should be a source of satisfaction to actuaries that the profession has not attempted this maneuver, which may be a tribute to some of the titans of the profession who did not have degrees at all.*

[2] The New Yorker. *January 26, 2009. "Getting There from Here"*