

## **Understanding Healthcare Policy – Facts and Fictions**

Healthcare policy has become a major issue for the upcoming 2020 election. There is also much confusion about the delivery of healthcare services and the real costs involved with it. For our November 1 Topical Seminar, we will be discussing both healthcare policy and healthcare costs. To prepare for the session, please read the following information as a guide to the discussion. If you have other information that you would like to share in the seminar, please feel free to bring this information with you and share with the group.

### **New York Times**

Sept 12, 2019

### **Opinion**

#### **Four Key Things You Should Know About Health Care**

Yes, it's a complicated issue. But clarifying these fallacies will help voters understand it.

By [Ezekiel J. Emanuel](#) and Victor R. Fuchs

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Health care, so far perhaps the biggest issue in the Democratic primary, is also the most complicated issue facing government and the public. Unfortunately the debate is filled with persistent misconceptions, from the role insurance company profits play in health care costs to who is actually paying for workers' health coverage.

Clarifying four fundamental health care fallacies could make it easier for voters to square some of the Democratic proposals — and their critiques — with reality:

#### **Fallacy No. 1: Employers pay for employees' health insurance.**

Employers write checks that cover most health insurance premiums for employees and their dependents. But as the Princeton health economist Uwe Reinhardt once [explained](#), employer-sponsored insurance is like a pickpocket taking money out of your wallet at a bar and buying you a drink. You appreciate the cocktail until you realize you paid for it yourself.

With health coverage, employers write the check to the insurer, but employees bear the cost of the premium — the entire premium, not just the portion listed as their contribution on their pay stub. The premium money that goes to the insurance company is cash that employers would otherwise deposit in employees' accounts like the rest of their salary.

The fallacy is in thinking an employer's contribution comes out of profits. In fact, higher health insurance premiums mean lower wages for workers. Since 1999, health insurance premiums have [increased](#) 147 percent and employer profits have increased 148 percent. But in that time, average wages have hardly moved, increasing just 7 percent. Clearly workers' wages, not corporate profits, have been paying for higher health insurance premiums.

Health care costs are one — though not the only — reason wages have stagnated over the last few decades. With health insurance costs rising faster than growth in the economy, more labor costs go to benefits like health insurance and less to takehome pay.

Yet the belief that employees don't pay for their own health insurance is widespread. One reason is that individuals cannot be sure what causes their wages to change or remain stagnant for decades. Another reason is that employers want Americans to believe that they pay for their workers' health insurance. Still another reason is that there are those who profit from the employment-based system: drug companies, device manufacturers, specialty physicians and high-income individuals. They all want you to believe companies are being magnanimous in giving you insurance.

Who else benefits from the belief in this fallacy? Opponents of national health insurance.

### **Fallacy No. 2: Medicare for All is unaffordable.**

The key to evaluating the cost of Medicare for All is to distinguish between increasing spending on health care and shifting expenditures from private insurance to the federal government.

True, Medicare for All would increase *federal* health care spending. But that is not the same as increasing *total* health care spending, which was [over \\$3.5 trillion last year](#). Instead, Medicare for All would move money from one column (private health insurance spending) to another (federal health spending); it does not automatically increase *total* costs.

[A recent study](#) by the Mercatus Center at George Mason University — a freemarket center generally hostile to government programs — estimates that for the 10 years between 2022 and 2031 the total national health costs for Senator Bernie Sanders's Medicare for All plan would actually be \$50.1 trillion. That would be \$2 trillion *less* than if we let the system operate as it currently does. However, [Mercatus researchers doubt](#) that the Sanders's plan would ultimately save trillions because they believe Congress would have to increase Medicare rates paid to hospitals and physicians to get the legislation enacted. They may be right — or wrong. But that is a different argument — a prediction about the politics of enacting laws — than that Medicare for All would inherently increase total health care spending.

We have our doubts about Medicare for All. But unaffordability is *not* a reason to oppose it. Whether it's our current arrangement or a future Medicare for All, the per capita cost of our health care system already far exceeds that [of any other industrialized country](#) — including those with single-payer systems. When you hear a health care price tag in the trillions, know that the existing system has already brought us there.

### **Fallacy No. 3: Insurance companies' profits drive health care costs.**

In the second Democratic presidential debate, Senator Bernie Sanders declared that the health care industry [makes \\$100 billion in profits](#). He [once railed against the insurance company Anthem](#) for denying a claim while noting that it reported "fourth-quarter profits for 2017 had increased by 234 percent to \$1.2 billion."

Many Americans believe that profits have no place in health care. They see forprofit health insurance, like buying and selling kidneys and livers for transplantation, as what the Nobel Prize winner Alvin Roth termed a "[repugnant industry](#)" — something that should not be exchanged in the market.

That is an important moral stand, but it makes no difference to the claim that eliminating for-profit insurers will reduce high health care costs. The fact is, we could eliminate those profits and it would hardly matter to the cost of health care. You would not notice it in your premiums.

For the eight largest for-profit health insurance companies, in 2016, their cumulative revenue amounted to nearly \$452.2 billion and profits were \$22.1 billion, for a profit margin of about 5 percent. By contrast, technology companies, banks and major drug companies generally make more than 20 percent profit.

True, \$22.1 billion is a lot of money — but it is 0.6 percent of health spending.

And last year alone health care costs increased over \$130 billion — six times insurance company profits. Health care spending would *not* be significantly cheaper if all insurance companies' profits were zero.

There are far more savings to be had in other efforts — by cutting unnecessary patient services, for example, or by making physicians and hospitals more efficient — to deliver the same care at a lower cost.

#### **Fallacy No. 4: Price transparency can bring down health care costs.**

"Hospitals will be required to publish prices that reflect what people pay for services," said President Trump when he signed [his executive order on health care price transparency](#). "Prices will come down by numbers that you wouldn't believe. The cost of health care will go way, way down."

There is no doubt that prices for medical procedures can [range widely](#) even within the same city or state. For instance, M.R.I.s of the spine can vary threefold in Massachusetts and mammograms fivefold in San Francisco.

Conservatives argue that informing patients of prices for tests and treatments will induce them to shop for lower-cost services, saving them, insurers and the country money. In theory, the beauty of price transparency is that neither the government nor insurers impose cost controls; the invisible hand of the market does it all.

Yet demonstrations of price transparency have been tried many times in many places, and in reality, it has not reduced the cost of care.

[One recent study](#) by Harvard Medical School researchers involved hundreds of thousands of employees and used a website telling them what they would pay out-of-pocket if they chose particular physicians and hospitals. The result: no savings. [A follow-up study](#) using another set of employers and another price transparency tool found the same result: no savings.

Since 2007, New Hampshire has had a state website, [N.H. Health Cost](#), that allows patients to select a medical procedure, insurer and ZIP code and then get a list of prices for the procedure from various providers. The most promising study of N.H. Health Cost suggests a few million dollars in savings per year. That works out to be about \$5 per New Hampshire resident.

The fact is, price transparency will not make health care costs "go way, way down." Health insurance insulates the patient from price. Over 80 percent of the cost of medical care is paid by private and public insurance. Patients have little incentive to seek out the cheapest provider. When pricing websites exist, few patients use them. Even in the most favorable studies, when offered a price transparency tool, only 12 percent of patients [took advantage](#) of it; usually it's less than 4 percent of patients.

Furthermore, price considerations are useful for choosing only about 40 percent of procedures — routine services like colonoscopies, M.R.I. scans and laboratory tests. Most of the expensive services — think heart catheterizations, cancer chemotherapy and organ transplants — are not the kind of thing you decide based on price.

Finally, in health care, Americans usually put relationships ahead of money. Once patients find a physician they trust and a hospital they like, they tend to stick with them even if there is a lower-cost alternative nearby.

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American health care is complex and any simplistic solution is likely to be based on a fallacy. But that doesn't mean there is nothing we can do. There are solutions — they just don't make for bumper sticker phrases like Medicare for All or Eliminate For-Profit Insurers or Price Transparency.

## Right, Privilege—or Tragedy of the Commons?

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The debate about whether health care is a right or a privilege is familiar and polarized. A quick online search in this topic area yields strong statements, deeply held convictions, and stern admonishments for those who hold opposite views.

As RWJF Clinical Scholars [Kate Vickery](#), MD, and [Kori Sauser](#), MD, (2012-14) point out in their recent blog posts, primary care physicians and emergency physicians can agree that the Emergency Medical Treatment and Active Labor Act (EMTALA)—by focusing exclusively on assuring access to emergency care—fails to ensure that health care is a right for all individuals in the United States across all health care settings.

As the three of us wrote in a *Journal of the American Medical Association* commentary earlier this year, the Patient Protection and Affordable Care Act (PPACA) will likely fall short of ensuring health-care-as-a-right-for-all as well.[\[1\]](#) That's largely because one-to-two dozen Americans (or more) will likely remain uninsured even with implementation of all of the coverage provisions of the PPACA. Congress did not have the appetite for even broader coverage initiatives that were considered in PPACA discussions but ultimately left out of the legislation.

If federal legislation falls short of ensuring health care as a right, does that mean that the American public is more comfortable with the idea of health care as a privilege? This is an answerable question. But to respond with data and carry on the debate is to perpetuate the idea that answering the right-vs-privilege question will somehow unshackle the argument from polemics and transport the U.S. to a more functional health care system. I'm not sure that it will.

In fact, I believe that the right-vs-privilege argument actually distracts politicians, health care professionals, and the public from a more fundamental, pressing concern.

From my perspective as a policy researcher and the chief medical executive for the state of Michigan in the Department of Community Health, whether health care is a right or a privilege does not alter the fundamental challenge of allocating scarce resources in the U.S. health care system. Either way, as a country the United States must deal with the fact that the health care workforce, facilities, and funds are available only in finite quantities. By failing to coordinate, systematize, or otherwise organize individuals' pursuit of their rational goals in the world of health care, the U.S. population is mis-using its common resources related to health.

In this context, misuse occurs by many people and organizations with many different interests, with respect to many resources—for example: prescribing brand-name medications when generic substitutes would be equivalently effective at lower costs; opting for subspecialty care when primary care management would be more efficient; accessing emergency care and hospitalization for ambulatory-care-sensitive conditions when timely access to primary care would be of greater value; health systems’ investment in new therapeutic modalities for limited groups of patients instead of enhancing availability of existing, evidence-based approaches for large groups of individuals in the population; spending on intensive end-of-life care when advanced directive conversations earlier in patients’ lives would have indicated some individuals’ preferences for comfort care only.

Consequently, individuals in the U.S. cannot uniformly maximize their health and therefore the aggregate population health is less than optimal. Instead, some individuals get to optimize their health while others are denied such opportunities; inefficiencies, inequities, and persistent disparities result. In other words, it seems that the U.S. health care system has many aspects of a **tragedy of the commons**.

Influential economist Adam Smith famously argued (hundreds of years ago) that individuals’ rational pursuit of their own individual goals would lead to maximization of the benefits of a free market for the entire population.<sup>[2]</sup> Biologist Garrett Hardin countered (in 1968) that, in cases where resources are scarce (his example: cattlemen taking advantage of their herds grazing on common property), unfettered individual actions—even while rational on an individual basis—will collectively degrade and diminish collective resources.<sup>[3]</sup> Hardin called this situation the

‘tragedy of the commons,’ and anticipated ‘ruin to all’ if appropriate regulation were not imposed to shepherd common resources and thereby control individuals’ behavior that would be harmful to others (and ultimately to themselves) through depletion of resources.

The general response to a tragedy of the commons is to regulate access to the common resources. Regulation can take many forms, not all of which involve larger government. For example, one response is to keep a common resource (e.g., forest preserve) as public property and allocate the right to access (based on strategies such as proportional use, uniform use, or even an auction system), but another is to privatize the property and place the incentive to protect the property and control access in owners’ hands. Another response is to hold property communally (i.e., as an organized group of private owners) and allocate rights to access through that community of owners.

In health care, many peer nations of the U.S. appear to employ the public property strategy to manage the tragedy of the health care commons. For example, in the United Kingdom, government ownership of most health care facilities and payment of health care providers allows the government to control access to those key resources for the population. Even in countries that have greater presence of private medical facilities (e.g., Germany), there is still a robust government-financed system designed to ensure timely and appropriate access to care through management of a set of core organizational and personnel resources.

It is not surprising that the U.S. has not pursued a similar strategy for marshaling and managing its health care resources to optimize population health. After all, the free market ideals of Adam Smith and other economists strongly influenced the enshrinement of capitalist principles at the core of American political and economic thought and practice. Individuals, and their rights to pursue their self-interested goals, are prized in the American mind.

Whether the core debate in U.S. health care can be shifted from the individual (right vs. privilege) to the community (tragedy of the commons vs. managing common resources) remains a key question. While the PPACA certainly includes provisions designed to shift the sense of coverage from a privilege to a right, it is

not clear that the U.S. health care system will achieve transformational change until the policy plane shifts from the individual to the collective.

Before there can be agreement about how to address a tragedy of the commons in health care, there must be a perception that there is a commons in health care—and that the commons is being depleted in its resources that key, politically active individuals and communities want and need to optimize their health.

## REFERENCES

- [1] Vickery KD, Sauser K, Davis MM. Policy responses to demand for health care access: from the individual to the population. *JAMA*. 2013;309:665-666.
- [2] Smith A. An inquiry into the nature & causes of the wealth of nations. First published in 1776; Bantam Classics, 2003.
- [3] Hardin G. Tragedy of the commons. *Science*. 1968;162:1243-1248.

*This commentary originally appeared on the RWJF Human Capital Blog. The views and opinions expressed here are those of the authors.*

## **Some other suggested readings if you wish to explore more:**

Is Health Care Right? by Atul Gawande in the New Yorker magazine  
<https://www.newyorker.com/magazine/2017/10/02>

Would Medicare for All Save Billions or Cost Billions by Katz, Quealy, SangerKatz in The New York Times  
<https://www.nytimes.com/interactive/2019/04/10/upshot/medicare-for-all-berniesanders-cost-estimates.html?searchResultPosition=1>

Canada's universal health-care system: achieving its Potential by Martin, Miller, Quesnel-Vallée, Caron, Vissandjée, and Marchildon in The Lancet  
<https://www.sciencedirect.com/science/article/pii/S0140673618301818>

Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition by Busse, Blümel, Knieps, and Bärnighausen in The Lancet [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(17\)31280-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31280-1/fulltext)

<https://www.theguardian.com/society/2018/jul/02/is-the-nhs-the-worlds-besthealthcare-system>