Forbes

Health Wonk Review Review: One of the Strongest Yet

By: Avik Roy
March 31, 2011

Jason Shafrin of Healthcare Economist hosts an unusually strong and interesting edition of Health Wonk Review.

A Man, A Plan, Panama

One of the common themes of debating health-care policy is the endless set of complaints that "Republicans don't have a plan." I have been among those who have criticized Republicans for not, as a group, focusing on much as health care as they should have. But it's either ignorant or dishonest to say that Republicans have no plan. Paul Ryan put forth a plan years ago—admittedly one that most other Republicans are scared to endorse, for fear that they'll be demagogued for doing so. (They should do so anyway.) John Goodman, in this excellent post, points out that John McCain proposed universal coverage in the 2008 campaign, only to be demagogued by Senator Obama because McCain's plan—designed by Douglas Holtz-Eakin—would have increased taxes somewhat. Here's Goodman:

> *The Obama campaign spent tens of millions of dollars on TV commercials attacking the John McCain health plan! It spent more money than has ever been spent for or against any policy proposal in the history of American politics.*
>
> *The McCain plan, for all those suffering from collective amnesia, proposed to replace all existing health care tax and spending subsidies with a universal health grant, structured like a refundable tax credit. The Patients' Choice Act version of the idea is sponsored by Tom Coburn (R-OK) and Paul Ryan (R-WI). It promises $2,300 (individual) or $5,700 (family) to everyone who isn't enrolled in a government health plan.*
>
> *So what was candidate Obama's problem with that? Did he object that the plan wasn't generous enough? Too few regulations? No, none of that. The Obama TV ads focused like a laser on raw self-interest. McCain's health plan, the ads said, will cause your withholding taxes to go up (without mentioning the offsetting credit that would cause them to go down).Think about that. The Obama campaign spent all that money attacking the most comprehensive and progressive proposal for universal care proposed by any*

serious presidential candidate in modern times on the grounds that somebody's tax bill might — just might — go up!

I'll skip over the question of how you can spend that much money on TV ads and not come to the attention of The New York Times or any of the opinion writers mentioned above, to address a point that can easily get lost with all the demagoguery swirling around. Under the McCain/Coburn/Ryan approach, the first $5,700 a family spends on health insurance is courtesy of Uncle Sam. To have the kind of coverage a typical large corporation has, employees and employers would have to kick in about $6,300 more (with unsubsidized money). Not everyone may choose, or be able, to do that. Some might add $3,300 of their own money and buy a $9,000 plan. Some might settle for whatever catastrophic coverage $5,700 will buy. But everybody — and I mean everybody who doesn't turn down a free lunch — would have protection against large medical bills.

Let's contrast that approach with what happens under the new health reform legislation. Recently, Health and Human Services Secretary Kathleen Sebelius gave 30,000 McDonald's workers a temporary waiver from the new regulations so they can keep their limited-benefit, "mini-med" plans — which would otherwise be wiped out by ObamaCare regulations.

If McDonald's lowered these employees' wages by $5,700 and bought them $5,700 worth of health insurance, the only subsidy available today is the one embedded in the tax law — the ability to pay premiums with dollars that escape the payroll tax. (These employees earn too little to pay income taxes.) That's worth about $872 — less than one-sixth of what the Republicans were offering.

Remember that the next time you hear someone complain about the lack of a Republican plan.

Three Unheralded Things That Drive Health Costs Upward

Rich Fogoros of the Covert Rationing Blog discusses how Medicare's decision to stop reimbursing hospitals the followup-care of patients with "never events"—those error-driven results that should never happen, such as leaving objects inside surgical patients—has evolved to encompass "sometimes events," whereby Medicare is now declining reimbursement for things like bloodstream staph infections. Hospital-borne infections are an indicator of hospital quality and performance; however, it might be unrealistic to eliminate them completely. Fogoros sees this as a form of covert rationing. In an ideal world, we'd eliminate hospital monopolies, and thereby drive market incentives for hospitals to perform at a high level. But the hospital lobby made sure that Obamacare would suppress, rather than improve, competition.

Hank Stern of InsureBlog writes of the difficulties insurers face in trying to keep costs down. In the case he discusses, the Immune Deficiency Foundation is fighting with Highmark Blue Cross about Highmark's new policy for covering patients with primary immunodeficiency diseases: affecting 350 of Highmark's 4 million members. "What struck me deeply," writes Hank, "is that, from my perspective, both sides are 'right.'" Actually, I disagree: to me, in this case, it's Highmark that is acting responsibly, and the IDF that isn't.

Hank, unintentionally, makes it sound like Highmark wants to drop the 350 patients, and not cover their medications. But all Highmark is seeking to do is to ensure that physicians use the most cost-effective form of intravenous immunoglobulin (IVIG) for their patients. There are eight different brands of IVIG, manufactured by five different companies. These are the situations where insurers earn their keep: negotiating lower prices from competing drug manufacturers, and passing those savings on in the form of lower premiums. But no: the IDF sees this as unacceptable interference in the doctor-patient relationship. So long as Highmark is acting on the best available medical evidence, it is of course appropriate for them to manage care in this fashion. (That's why they call it "managed care.") If you don't like it, find another insurer, and pay the higher premium that goes along with it.

Politicians love to demonize insurance companies. But in these two blog posts, we see how two less-demonized institutions—hospital monopolies and patient interest groups—do far more to drive costs upward.

Another driver of rising insurance premiums is the fact that your government forces you to see a doctor to do things that shouldn't require one: things like buying over-the-counter medications. In a brilliant post, Dr. Liberty points out the absurdity of this system, for it needlessly increases health expenditures while preventing our limited supply of doctors from treating the truly ill. Dr. L draws on Paul Starr's widely-cited history of how doctors managed to give themselves a monopoly on medical care, and helpfully cites some examples of situations where patients should be able to self-medicate:

> *This is not just a lofty claim. There are at least a few types of cases when NOT going to the doctor might be reasonable, and could save a lot of money, particularly for those people who are savvy about reading medical information online:*
>
> *1. People who have been taking the same medication for a period of time and don't expect any changes in the near future. An example: a young girl who takes an oral contraceptive.*
>
> *2. When a patient knows more about something than does his doctor. Genetic counseling can be a good example.*
>
> *3. Repeated attacks of the same illness. For example, someone with gout who has been treated with colchicine can learn to recognize and treat the flare-ups.*
>
> *4. Treatment of early stages of chronic illnesses like high blood pressure and high cholesterol, and even diabetes. This is certainly far away from current practice, but I see no reason why a savvy patient with elevated cholesterol can't modify his own diet, take a statin, and get blood tests regularly at a local lab.*
>
> *With regard to the last case, chronic diseases account for 47% of health care costs in the U.S., so self-care could help reduce health care costs. Certainly in all of these cases, self-care would free up doctors to take care of more sick patients. Given the shortage of*

physicians in the U.S., I'd rather have more people engaging in self-care than have the sick wait to see a doctor.

This is actually something that Congress and the FDA could work to delineate: specific situations where patients should be able to self-medicate, such as oral contraception; prescription medications for common chronic diseases (high blood pressure, high cholesterol, diabetes); and flaring illnesses (such as gout). Since we're not going to build 100 new medical schools anytime soon, and access to primary care is going to worsen substantially with Obamacare, let's at least liberate physicians to treat the people who really need it.

Are Consumers Competent?

Finally, there's been a bit of hoopla around a new study from the RAND Corporation assessing health care spending in consumer-driven health plans. Like every other well-run study, RAND found that patients with CDHPs had lower health expenditures. However, one interesting finding of the RAND study—which is contradicted by other studies—was that patients cut back on preventive tests such as cervical cancer screening, colorectal cancer screening, and mammography, despite the fact the high-deductible plans studied by RAND included first-dollar coverage of preventive care. "This suggests that enrollees in high-deductible plans either did not understand this part of their policy, or some other factor discouraged them from getting preventive care," the authors speculated.

Louise Norris rightly points out that consumer ignorance is not the only possible explanation for patients' behavior. It could also be that many consumers actually have a view as to the value of so-called preventive care, and are actively choosing to forego it:

I think that this is an area that deserves a lot more study, and definitely more than a passing sentence dismissing the drop in preventive care spending as a factor of the insureds not understanding their coverage or some "other factor" that "discouraged them from getting preventive care." Maybe researchers could begin tracking the long term health outcomes for those families, rather than assuming that their reduced spending on preventive care will likely translate into higher medical costs in the future.

Preventive care is a bit of a misnomer, as much of it involves screening and detection rather than truly preventing illness. And it is not without controversy. Experts have changed guidelines in recent years to recommend less-frequent screening in some cases, and some question whether or not we're doing too much screening in general. Vaccines are also a bit of a controversial topic, and have become more so in recent years as the number of vaccines recommended for children has increased dramatically.

It's certainly possible that CHDP beneficiaries are behaving in ways contrary to their self-interest. But it's also possible that they aren't. Wonks tend to assume that consumers are dumb, and therefore that consumers would be better off if health policy experts wielded more control over the health care system. It's an unsafe assumption.