

Reform: Be Careful What You Ask For

Financial Leadership and Health Reform: Be Careful What You Ask For

Jeffrey C. Bauer

Momentum for health reform is building to its highest level in years. Should health care's finance leaders be optimistic ... or cautious?

The chorus of voices for health reform builds to a fever pitch every decade, as predictably as hot weather in August. The American people are once again deeply concerned about the cost, quality, and access problems of medical care. Just about everyone is presumably ready to do something meaningful, at long last. A new scrum of political leaders even gives the populace hope that fresh ideas will finally lead to a solution.

In our zeal to do something, we tend to disregard lessons of history that might stop us from repeating previous debacles. We take hope in a belief that the situation is different this time. In several ways, it is. The number of Americans without health insurance is rising to unprecedented levels. The number of workers covered by employer-provided health plans is the lowest it has been in 50 years and falling fast. The vestige of the last rush to reform, consumer-directed care, has brought insured patients' out-of-pocket payment obligations to all-time highs.

The Same End ... but Different Means—The net effect of deteriorating coverage in mid-2007 is that virtually every interest group is now pursuing the same general goal—universal access—so that all Americans will be covered by a health plan. However, the various constituencies are pursuing different ways to get there. Proponents of private markets want mandatory health insurance as the path to universal access. People who favor a government solution are renewing the push for a single-payer system. Most commentators overlook significant differences in these divergent means to the end. They assume that reform really will happen after the 2008 presidential election because all parties seem to agree for the first time that everyone should have health insurance.

CFOs and other hospital and health system executives should pay special attention to one significant difference between the current push for reform and previous attempts. This time, healthcare organizations are supporting universal access. They are forming coalitions and sponsoring activities to promote the goal of insurance coverage for all. Indeed, the industry's opposition to previous reform efforts (e.g., the "Harry and Louise" ad campaign of the Health Insurance Association of America) has taken an about-face in the past year.

The reversal is not surprising because economic realities have changed significantly since the 1990s, when Bill and Hillary Clinton led the last fight for reform. Approximately two-thirds of all money spent on health care has come from government and employers for several decades. Every previous battle started when these two payers decided that something had to be done to stop “skyrocketing” costs for health care. Providers could count on getting what they needed after the dust had settled because government and industry would always find extra money to pay the rising costs—albeit begrudgingly.

Since 2000, the financial tide has turned against providers because the two big payers have lost their capacities to increase expenditures on health care. The federal government has gone from balanced budgets to serious deficits while the number of Medicare and Medicaid beneficiaries has continued to rise. The prospects for more deficit spending for health care are fading fast due to political sclerosis, trade deficits, and foreign ownership of federal debt. Employers are constrained by domestic and global competition, energy costs, and tight labor markets. They cannot raise prices to raise more money for health care.

Passing the Buck_The inevitable result is “consumerism.” Having reached the limits of what they can spend on health care, governments and employers must ask beneficiaries to pay a greater share of their covered benefits. A strong economic case can (and should) be made for involving people in payment for their care, but the relatively sudden resort to consumer-directed health plans resulted from economic necessity—not careful planning.

Providers watched from the sidelines as payers shifted significant financial responsibility to patients who were not prepared to pay their share. Providers are only beginning to understand the ominous impact of deductibles rising from a few hundred dollars to a few thousand dollars. Some commercial health plans have prepared impressive resources to teach their beneficiaries how to spend less on health care by staying healthy and shopping for value, but consumer behavior will not improve nearly as fast as their payment obligations will rise.

What’s This Got to Do with Universal Coverage?_Hospitals and medical groups have begun to experience significant financial stress as out-of-pocket responsibility is shifted to patients. The outlook is not good. Governments and employers will express sympathy for providers’ precarious position, but they will not offer more money to make up the difference. Candidates for national office, especially president, will see the corresponding problem as a political opportunity. Michael Moore’s latest movie, “SiCKO,” will rouse public discontent, and the media will feature even more stories about people who cannot afford the care they reportedly need.

The likely outcome is obvious: widespread agreement that everyone should have health

insurance because everyone is talking about it. For the first time, no significant interest groups will be opposed to the current version of health reform. Stakeholders who have disagreed on reform in the past will come together around the general concept of universal access, and joint campaigns will be launched to lobby legislatures in its favor. The conventional wisdom will say that the question is not whether everyone will have a health plan by 2010, but how universal access will be provided.

CFOs will be among those healthcare executives asked to give a speech to a service club, write a letter to the editor, call a legislator, and send a check to a political action committee organized for the good of the cause. After all, what could be more important than ensuring access to medical care for all Americans and ending the problem of uninsured care at the same time? The simplicity of it all will be overpowering.

What's Wrong with This Picture?—The simplicity of it all will also be harmful to providers. Universal coverage is not going to help providers if everyone is given or forced to buy a high-deductible plan. (The odds of first-dollar coverage under universal access are equal to a snowball's chances in August.) Hospitals and medical groups might actually be worse off if today's uninsured patients become tomorrow's insured patients who are expected to pay several thousand dollars they do not have—especially because universal access will almost certainly be used as a reason to reduce Medicaid.

Providers may be painting themselves into a corner. Before joining the crowd that supports universal access as the solution, they should determine whether consumer-directed (i.e., high-deductible) insurance for all is better than no insurance for some under current circumstances. This paradox has a precedent. Medicare and Medicaid were created to ensure access to the Americans who did not have employer-based health insurance back in 1965, immediately creating some of our health system's most vexing and enduring problems.

Are we about to repeat history because we did not learn a lesson from the 1960s' version of universal access? The emerging consensus on reform suggests we are headed in that direction. We need to pause and reconsider our next steps before we lay foundations for the next healthcare crisis. One of providers' two critical challenges—the other being the imperative to become efficient (i.e., to eliminate waste)—is reforming insurance before giving it to everyone. Providers' current financial problems stem at least as much from the flawed incentives of insurance as from many patients' lack of insurance.

CFOs who want a fair and equitable health system for all (my goal!) could do more for the good of the cause by working first with payers to redesign the third-party payment processes that direct the flow of dollars through the system. Creating health insurance with rational, socially conscious economic incentives is arguably the best way to start the

necessary task of ensuring better health care for all. Asking for more insurance of the type we have today may simply be trading a headache for an upset stomach.

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