



Health Care: Cost & Access

This discussion guide includes three points of view about how to address the issue of cost and access to health care. The points of view are drawn both from what the experts say and from what the public thinks about the issue, based on surveys and focus groups conducted by the national research organization Public Agenda. This guide is based on a Public Agenda discussion guide, which we have adapted for the local community.

The broad choices presented here are designed to be discussion starters, not a political program. They aren't the only way of dealing with the problem, nor are the viewpoints mutually exclusive. But each choice offers a distinctive diagnosis of the issue, and each leads to distinct actions.

Please remember that the discussion is not a test of facts, but rather an informal dialogue about your perspectives on the issue.

The problem with the American health care system is simple and persistent: Some people just can't afford to get sick. Medicine offers new and better treatments every day and more than a few are developed in the U.S – there's a reason why people from overseas fly here for advanced treatments. But some 45 million Americans don't have health insurance and two thirds of the uninsured come from low-income families. Those who do have insurance are paying more and more.

In Kansas City, Missouri, 13% of residents lack basic health insurance. Excluding children and the elderly, 15% of Kansas

and Missouri residents are without health insurance.

Health care experts say there are three key elements a good system should have: quality, access and reasonable cost. But it's difficult to get all three at the same time. If you offer coverage to everyone, total costs will go up. If you act aggressively to control costs, you might have to cut quality. Offer the best high-tech care, and you may not have the money to extend coverage to more people.

You don't have to be sick or uninsured to have a personal stake in this debate. If you get insurance from your employer, ris-

ing premiums are probably taking a bite out of your take-home pay. If you're young and healthy, maybe you can "go bare" and gamble on going without insurance. But for many people with families to care for or illnesses of their own, fear of losing insurance can keep them in jobs they don't like – or threaten their financial security if they become unemployed.

The American way

In many European countries and Canada, there are government-run health care systems that cover everybody – in fact, many of those nations guarantee health care as a basic right, much as Americans have the right to attend a public school. In the U.S., while people sometimes talk about health insurance as a right, it really isn't.

In 2004, legislation was introduced in Missouri for a single payer health care system; the legislation was defeated. Fourteen state governments will consider single-payer plans in 2005; Kansas and Missouri will not be among them.

For most Americans, health coverage is a benefit they get from their employer, like paid vacation. And like paid vacation, the employer is not required to offer insurance. Some government programs offer health insurance to the elderly (Medicare), the poor (Medicaid) and children (the Children's Health Insurance Program).

In 2003, 18% of children in Kansas and 24% of children in Missouri were enrolled in Medicaid. In fact, 39% of the births in Missouri in 2003 were covered by Medi-

caid.

When people talk about "the health care system," they're talking about a hodgepodge of programs that cover some people and not others, and benefits that vary from situation to situation.

Changing the system is politically difficult. Forty states, including Kansas and Missouri, expect a Medicaid budget deficit in 2006. Twenty states, including Kansas and Missouri, are considering reducing payment rates and increasing co-payments for Medicaid benefits. A recent federal budget proposal indicates that Medicaid spending is expected to increase by seven percent in 2006; however, the administration's budget for 2006 calls for \$45 billion in reductions to Medicaid over ten years.

Such cuts at the federal level would shift more of the costs to the states, which could mean one billion dollars less for health care in Missouri and \$320 million less for health care in Kansas.

Missouri has enacted legislation which reduced or froze eligibility levels and reduced or discontinued many pharmaceutical assistance programs. The legislation effectively removed about 90,000 people from Medicaid eligibility. According to a February 2005 article in the *Kansas City Star*, a single person making more than \$290 per month or a family of three with income in excess of \$450 per month is now ineligible for Medicaid benefits in Missouri. In response to the federal Medicaid cuts, Kansas has legislation pending which will increase the number of people receiving prescription drug benefits

while limiting the number of prescriptions available to each beneficiary.

The attempts of elected leaders to make the current system more effective run the risk of alienating special interests ranging from businesses, unions and the elderly to doctors, drug companies and insurers.

There is a lot of ambivalence and many contradictions in public attitudes on health care. The answers in opinion surveys conflict and sometimes seem to change depending on how the question is phrased, which to pollsters is an indication that people haven't thought through an issue. In surveys, the public thinks health care is important, but not as important as terrorism, the economy or education.

Most people considered cost and access to health care as the most urgent health problems in 2003, compared to 1999 when AIDS and cancer topped the list. A poll taken in Kansas by the Kansas Chamber of Commerce in 2004 revealed that "driving down the cost of health insurance" was the number one economic concern of Kansans.

A majority of Americans say the health care system needs fundamental changes. Yet most Americans say they're satisfied with the quality of health care they receive and their own insurance coverage. Most Americans say the federal government should guarantee health insurance for all Americans, and even support a government-run universal health care system, but support falls if it means a limited choice of doctors or waiting lists for treatment. While majorities say they support the idea of prescription drug benefits

for seniors, Americans are divided on the actual changes recently made to Medicare.

Who has it, who doesn't

About 15 percent of the population lacks health insurance. The people who are more likely to be uninsured are young people, minorities, low-income people and the unemployed.

Nearly 30 percent of those 18-24 are without health insurance, often because of its cost. Nearly a third of Hispanics lack insurance and both black and Asian persons are more likely to go without than whites. People lose their health insurance when they lose their jobs, and many low-wage or part-time jobs don't offer any benefits at all.

Certain groups are more likely to have insurance than others, including the elderly and people who work for large-and mid-sized organizations. The elderly are covered through Medicare, and 98 percent of companies with more than 200 employees offer health insurance. Only two-thirds of businesses with fewer than 200 offer insurance. In 2004, one study found that 60% of uninsured Americans were employed full-time.

No job, no insurance

Because so many people get health coverage as part of their job (some 61 percent of the population), there's a predictable pattern among the uninsured: when the economy is booming as it was in the late 1990s, more people have coverage. When there's a recession, the number of uninsured goes up.

Of course, anybody can go to their neighborhood insurance agent and buy a health policy – but since you don't get the group discounts businesses get, you'll be paying the highest rates. Only 5 percent of the population has these individual policies.

Due to keen insurance industry competitiveness and a relatively low level of state mandates regarding insurance coverage, Kansas City has been ranked as "the most affordable city in the country for health insurance outside of the group market," according to an article in the *KC Star* in December, 2004. A family of four can obtain health insurance as low as \$171.86 per month. However, chronically ill persons or people with serious ailments are likely to be shut out of individual plans.

The price of health

For those who do have insurance, it isn't cheap. Health care spending increased 7.8 percent in 2003, according to federal government estimates. The cost of health care to employers climbed 12.4% - about five times the rate of inflation – between 2002 and 2003.

If nothing changes, the government estimates the U.S. will be spending \$3.4 trillion a year, or more than 18 percent of the gross domestic product, on health care by 2013. Health care experts say the biggest factors driving increased costs are the cost of prescription drugs and the overall aging of the population.

Life expectancy has grown dramatically, with both men and women gaining an average of eight years since 1950. But as peo-

ple get older, they often get sicker and that drives up their health costs. Health care for the elderly is drawing more attention and dollars. In 2005, both Kansas and Missouri are considering legislation addressing nursing home care, home- and community-based care, family care-giving programs, assisted-living facilities and tax deductions or credits for long-term care insurance.

The number of prescriptions dispensed increased by 65 percent between 1993 and 2001, while the average price of a prescription jumped 85 percent. Critics point out that prescriptions cost less overseas. The pharmaceutical companies contend that high prices are the cost of innovation as they research new drugs – drug firms spent \$30.3 billion on research in 2001. Both Kansas and Missouri are looking for ways to join with other states for bulk purchasing of prescriptions to increase their negotiating power with the pharmaceutical companies.

Geography and affordability are crucial and related components of the issue of accessible health care. In Kansas City, health care is big business. In 2003, there were more than 4,000 health care and health care assistance operations in the Kansas City metro area. These facilities comprised more than 60% of such establishments in Kansas and 32% of those in Missouri.

Health care establishments in the Kansas City metro area employed over 96,000 people in 2003 and had annual payrolls exceeding \$2.5 billion. There are 35 hospitals in the Kansas City metro area while 45 counties in Missouri have no hospital at

all. In 2002, Johnson County, Kansas, had 858 full-time equivalency (FTE) medical doctors; Wyandotte County, Kansas, had 391. Considering population, the ratio of residents to FTE doctor in Johnson County was 549 to 1; in Wyandotte, the ratio was 401 to 1.

Some other analysts point to other factors driving up costs, such as malpractice litigation (and overcautious treatment by doctors to avoid it) and the paperwork needed to deal with all the private and public insurers. The *Business Journal of Kansas City*, in a May 2004 article, wrote that medical mal-

practice premiums have risen 92% in three years, while awards to injured patients have increased only 15%.

Insurance benefits and insurance costs engage the attention and finances of employers and employees, health care practitioners and patients. Businesses have to make a profit, after all, and money that goes to health insurance for employees isn't there for pay raises, other benefits or hiring more workers. So health care costs directly affect take-home pay as many employers require workers to pay part of their health insurance costs.

Option 1: Use competition to make the system more efficient.

The main problem with the health care system is that costs keep going up. All the other problems in the health care system stem from this and won't be solved until we give everyone real choices and the ability to take responsibility for what they spend on care. That means reducing regulation and using free market competition to allow insurers to offer a wider range of plans. We should also embrace managed care, which watches expenses carefully and has already slowed down the increase in health care costs. By moving further in the direction of managed care, and adopting medical savings accounts, which encourage individuals to save and shop around for health care, we'll be able to bring down costs and cover more people.

Values: free market system, competition, personal responsibility

What should be done?

- Encourage more employers to provide coverage through HMOs and other forms of managed care to ensure competition.
- Encourage small businesses to join together in insurance pools to negotiate for better rates.
- Allow private insurers to create basic policies that would cover the most common problems and make coverage affordable for small businesses and individuals.
- Give patients more ways to pay for care, such as tax-free medical savings accounts that can be used for premiums, co-payments and deductibles.
- Encourage the use of lower-cost generic drugs and allow people to buy approved drugs from Canada and Europe. Charge patients more if they insist on brand-name drugs.

- Limit expensive end-of-life care, which consumes far more resources than is necessary for procedures that are often futile.
- Streamline the administrative aspects of health care by standardizing insurance forms, billing and administrative procedures.
- Provide comprehensive information to consumers on the cost of medical procedures, percentage of costs spent on administration, and success rates at different hospitals. Inform consumers, too, on the quality of individual doctors, perhaps by instituting a rating system.

Arguments for this approach:

- If the health care system becomes more efficient, we can provide more services for more people, without spending more money.
- The constant rise in health care costs hurts everybody – it makes those with insurance pay more and it makes insurance too expensive for low-income people.
- A lot of health care costs are incurred at the end of life, when the procedures won't make any real difference in the patient's length or quality of the life. We should deny expensive and unnecessary treatment in these cases.
- The only way for patients to be informed consumers is to have reliable information about costs and quality, even if providing that information makes some hospitals and doctors uncomfortable.
- HMOs and other forms of managed care

control costs by relying on competition, rather than heavy-handed government programs.

Arguments against this approach:

- This approach will do little to expand health care to the millions of Americans who don't have insurance.
- This will mean patients will have to face a lot more red tape and may even be turned down for treatment an insurance company decides is too expensive.
- Under managed care, decisions about treatment are often made based on what's the cheapest treatment, not necessarily the best one.
- Hospitals compete to provide the *best* care, not the cheapest care, and they won't want to pass up having the latest equipment even if it's not really needed.
- Who is to determine when a patient can't be helped? Shouldn't we do everything we can to keep people alive?
- This will require people to make critical, complicated choices when they're sick and at their most vulnerable.
- Special interest groups will fight providing information about costs and quality, and the data are unlikely to be reliable.

Option 2: Expand the current system to cover more people.

We don't need to rip up the existing health care system and start over. We already have the best high-tech medical centers in the world and insurance programs in place that cover 85 percent of Americans. We can just extend those proven programs, public and private, to cover more people. We can also give employers financial incentives to cover more of their employees. The federal government already has effective health programs for the elderly (Medicare), the poor (Medicaid), low-income children (CHIP) and its own employees. If we expand the eligibility for those plans, we'll be able to cover more uninsured people with the least disruption to those who already have insurance. Gradually expanding the current system is the most practical way to cover more people without breaking the budget.

Values: practicality, building on the current system

What should be done?

- Lower the Medicare eligibility age to 55.
- Extend the Children's Health Insurance Program cutoff age to 25.
- Increase Medicaid funding and raise the income cutoff to cover the working poor.
- Open up the federal employee health insurance program to allow individuals without insurance to buy coverage at favorable rates.
- Offer tax incentives for businesses to ex-

tend health coverage to part-time and low-wage workers.

Arguments for this approach:

- By expanding existing programs and employer-provided insurance we can cover most of the uninsured.
- This is the least disruptive way of attacking the problem – it won't require massive changes in how the health care system operates or how people get their insurance.
- People will still be able to pick their own doctors and health plans and get the same quality of care.
- By increasing its role as an insurer, the federal government may be able to achieve greater economies of scale and greater leverage to reduce costs.

Arguments against this approach:

- This will be an expensive expansion at a time when the federal government already has a budget deficit, and we still will end up with some people uninsured.
- The Medicare program is already at risk and will likely go broke as it deals with aging baby boomers. Adding more people to Medicare will just cause the program to collapse more quickly.
- This will do little to control health care costs, which are rising at an outrageous rate.

Option 3: Create national health insurance.

Decent health care ought to be a basic right, not something that depends on the job you hold. Our patchwork health care system of private insurance and government programs simply isn't working. It's time for the United States government to provide health insurance for all of its citizens.

The system would work much like Medicare, except that everyone would be entitled to coverage, regardless of age, income or job status. Like Medicare, you'd still pick your own doctor, but the government would get the bill. We've debated what to do about health care for years, but nothing else has solved the problem. This is the only way to solve the problem of the uninsured, once and for all.

Values: Universal access, equity, efficiency

What should be done?

- Create a Medicare-style "single payer" system, where the government provides health insurance for everyone.
- Allow patients to get a standard list of covered health services from any doctor or hospital in the program.
- Raise taxes or repeal existing tax cuts to fund the program, and require that every adult citizen pay something for his or her health insurance.
- Tie the new health insurance system into existing government programs to promote good nutrition, mental health

awareness and exercise.

Arguments for this approach:

- Health care should be a right, not a privilege for those lucky enough to have a good job, or to be over a certain age. This approach is the only way to guarantee that everyone gets medical care.
- Countries with national health care systems often have good health care at a lower cost because the government can make bulk purchases of drugs and control costs.
- This will actually reduce paperwork. Doctors and hospitals will only have to deal with one set of forms and one government agency, rather than dozens of private companies and government agencies, all with different rules.
- Any new taxes will be offset by the savings earned when employers and workers no longer have to pay insurance premiums.
- U.S. businesses will be better able to compete against businesses in other countries because their health-care burden would be eliminated.

Arguments against this approach:

- Under this plan, a government bureaucracy tells you what health care you can have.
- Insuring everyone will overburden the system. In Canada and other countries

it's common to wait months for elective treatments or surgery.

- This will require steep tax increases. All the health care costs now paid by private industry would be taken on by the taxpayers.
- The Canadian and European health care systems are expensive and those nations

struggle to cover their costs without breaking the budget.

- Health costs will still be a burden to businesses, which will trade a health insurance plan they control for a health care tax they can't.

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