ObamaCare: Improving Reform's Bill of Health

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Abstract

Introduction

Healthcare reform in the United States is by far not a new headline. Despite numerous presidents trying to make their mark on the healthcare system by initiating reform efforts, none has ever been successful. Cutler (2002) points out that the United States is the only G7 nation that does not have a universal healthcare and insurance system, although the government does provide Medicare and Medicaid (p. 883). Most recently, President Barack Obama, as part of his campaign for office, promised major reform efforts, and has been successful so far in getting reform bills passed in the House of Representatives in November 2009 and the Senate in December of that same year (Kaiser Family Foundation, 2010b, p.1).

Americans, at the time, were strongly supportive of then-Senator Obama and his promises for reform. Yet, as 2009 passed, Americans started to withdraw support from the plan. As the year grew older, Americans grew more impatient with the slow speed of reform through government. Figure 1 indicates that the number of people paying attention to health care reform efforts grew slightly, but all of that disappeared by January 2010. In the meantime, the United States was still in the midst of a severe depression. Many Americans increasingly felt that 2009 was not the time for healthcare reform to be occurring, as Figure 2 shows. The number of people who believe that it is the right time for reform dropped from 62% to 54% from October 2008 to January 2010, while the number of people that said the country cannot afford to take on healthcare reform at the moment increased slightly. Figure 3 shows in April 2009, 67% of surveyed Americans favored a public health insurance option, while by September, only 57% did.

Yet, President Obama and Congress continue to try and push the reform bills through despite protests and loss of public support. One of the more notable protests occurred in State College, PA, when Senator Arlen Specter (D) attempted to hold a town hall meeting discussing healthcare reform (Associated Press, 2009). Protests, anger, and hatred were alive at the meeting, and many attendees at the meeting didn't feel their needs were being met by the Senator's efforts.

If our congressmen keep pushing through health insurance despite having deep initial support for the program, something within the bills must be irritating Americans. The citizens of this country must be angry about some part of the reform effort. We aim to discover, and explain, those faults in the plan that is creating the loss of support for the bills.

In our paper, we begin by outlining the history of healthcare reform in the United States during the 20th and 21st centuries. Beginning with efforts by Presidential candidate Theodore Roosevelt, we'll look at the legislation and agencies involved in making healthcare what it is today. Second, we'll outline President Barack Obama's plans for a revised healthcare system, and compare it to legislation currently in the Senate and House of Representatives. Finally, we offer suggestions of how to improve current legislation and reform ideas in order to improve support for an overhaul of the healthcare system.

A Brief Review of the Literature

The Kaiser Family Foundation maintains health statistics for the United States. They maintain a timeline of the history of healthcare reform. In addition, a monthly report (2009, 2010) is published with the results of surveys regarding public opinion of healthcare reform

efforts. The organization (2010) has also compiled a comparison of reform legislation passing through the House and Senate.

The New England Journal of Medicine (2009) also publishes a timeline of healthcare reform activities in the 20th century. Each event on the interactive timeline has additional information available in an attached link.

The White House compiled a document outlining President Barack Obama's healthcare reform ideas. Sections of the outline distinguish between advantages for those with health insurance, those without, and everyone.

Ken Terry (2007) examines the modern healthcare system and argues that the rising prices are a result of physicians, hospitals, insurance companies, and other healthcare venues trying to maximize profit. He contends that a complete overhaul of the system is the only way to rectify the situation, and offers a plan for physicians and physician groups to help facilitate the process.

Roger Feldman (2000) examines President William Clinton's healthcare efforts and, through the views of fourteen experts in economics, history, medicine, and law, explains why healthcare reform efforts generally fail. In sections regarding health insurance, healthcare services, and drugs, Feldman analyzes the downfalls of healthcare reform and suggests market reforms to fix these problems.

David Cutler published an article (1994) early in President William Clinton's term outlining that president's healthcare reform plan. He noted some of the economic and cost implications of universal coverage, and noted that universal access might be a better idea because it is easier to guarantee and cheaper to fund. He later analyzes (2002) healthcare reform efforts in many G7 countries and the economic difficulties of healthcare reform. He compares the programs of the different countries and discusses methods to best have any healthcare reform effort be successful.

Christopher Conover (2004) argues that many citizens do not have healthcare coverage due to a lack of regulation in the system. He contends that this lack of regulation results in many of the faults that exist, and although he is a proponent of better, tighter regulation, he concedes that it would cost taxpayers too much money to have the level of regulation required to remove all flaws.

Price and Norris (2009) discuss the difficulties American healthcare is facing in terms of Medicare fraud. They urge physicians to act in the right manner and to report fraud as an ethical duty and in order to help maintain the quality system the United States utilizes.

History of Healthcare Reform in America

The healthcare reform efforts of the 20th and 21st centuries began in 1912 with Presidential candidate Theodore Roosevelt. Three years later, the American Association of Labor Legislation, a labor union political action group, publishes their version of a draft bill for universal health insurance (Kaiser Family Foundation, n.d.). Champions of women's and prenatal health care won a victory when Congress passed the Sheppard-Towner Act in 1921. This bill provided government coverage for women's health and prenatal care. Unfortunately, the bill was not renewed when it expired in 1929 (New England Journal of Medicine, 2009). Health care reform remains relatively silent until the Great Depression. In 1934, as part of his New Deal plan, President Franklin D. Roosevelt begins to push for national healthcare. Although his plans didn't work out, in 1939, the first Blue Shield plans became available for

physician care. Blue Shield plans provide prepaid coverage for physician visits, such that the patient pays a fee for membership, and then the plan provider would pay for most, if not all, of a physician visit (Kaiser Family Foundation, n.d.). In 1945, President Truman, as part of his 10-year plan, called for national healthcare and a doubling in the number of physicians and nurses (New England Journal of Medicine, 2009). The National Health Assembly, a committee of physicians, pharmacists, lawyers, economists, and other health care experts, was formed in 1948 and, from the start, encouraged universal health coverage (Kaiser Family Foundation, n.d.).

The first large-scale attempt at government health coverage went into effect in 1965 in the form of Medicare and Medicaid (Kaiser Family Foundation, n.d.). According to the Centers for Medicare and Medicaid Services (2005), the agency overseeing both programs, Medicare is government coverage for patients over 65, or those under 65 with special disabilities. It includes hospital coverage, physician coverage, and, added recently, prescription drug coverage. Medicaid, on the contrary, is for those that can't pay all their medical bills, and eligibility has tight restrictions, including limited income, age, and assets (CMS, 2010). Hawaii mandated employer-paid health insurance for employees in 1974, the first state to do so. In 1986, Congress passed the Consolidated Omnibus Reconciliation Act (COBRA), which mandated a continuation of coverage requirements to be sure that patients retained access to health benefits (Conover, 2004, p. 13).

President Clinton introduced his version of healthcare reform, the Health Security Act, to Congress in 1993. The bill never made it through the signing process to become law. The most recent developments, prior to President Obama's efforts, occurred in 2006, when Massachusetts signed into law healthcare coverage for neatly all of its residents. This was the first state to do so, and was followed by Vermont roughly a year later (Kaiser Family Foundation, n.d.).

Current Healthcare Reform Efforts

President Obama's ideas for healthcare reform focus on four main population areas: those already with health insurance, those that are Medicare beneficiaries, those without health insurance, and the general public. Bills that passed in the House of Representatives and the Senate have similar provisions.

Those citizens that already have health insurance will no longer be discriminated for pre-existing conditions (The White House (n.d.). Cutler (1994) points out that many insurers currently discriminate based on conditions that patients have prior to the beginning of coverage, and some have lifetime reimbursement limits (p. 18). Both the House and Senate bills have similar provisions (Kaiser Family Foundation, 2010b, p. 11-12). Obama's plan also places discrimination limits on the areas of gender and age. Insurance companies are not allowed to "drop" coverage if a patient becomes sick. If the patient enrolled in the plan while healthy, the insurance provider is not allowed to remove coverage because of the onset of a new health condition. The president's plan also hopes to cap out-of-pocket expenses in the form of co-pays and to remove fees for preventive care (The White House, n.d.). This means that vaccines, well-visit physician check-ups, and other health visits to prevent disease will be cheaper, if not free to allow all easier access to quality care.

A couple of provisions exist in President Obama's plan intended to affect America's seniors on Medicare. Many worry that as the reserves for Social Security dwindle, so will the reserves for Medicare. The president's plan intends to prevent this. President Obama hopes to have enough funding to maintain the Medicare service for the nation's elderly. The plan also

calls for an elimination of the "donut-hole" coverage gap (The White House, n.d.). Medical beneficiaries currently pay a certain amount to enroll for coverage. Medicare will pay a percentage of prescription purchases up to around $5000, depending on the plan. After this is used up, the next couple thousand dollars of prescription spending are entirely out-of-pocket for beneficiaries, a downfall and hardship for limited or low-income seniors. After this is past, Medicare covers all purchases for the rest of the year. Most seniors, however, get caught in this gap, some earlier than others. The House Bill calls for a decrease and eventual elimination of the coverage gap by 2019, while the Senate bill only decreases the "donut hole" (Kaiser Family Foundation, 2010b, p. 21).

The major goal of President Obama's healthcare reform effort is to help those without insurance. First, he hopes to create a new insurance marketplace. This provision would provide a "one-stop shopping" place for health insurance, where patients can look at a variety of plans and make comparisons between them (The White House, n.d.). Both the House and Senate plans provide this provision (Kaiser Family Foundation, 2010b, p. 7). Second, President Obama intends to provide tax credits for individuals that enroll in coverage for the first time. This acts as an incentive to improve coverage numbers. Third, President Obama will be instituting a public health insurance option. Patients can enroll in this option for healthcare coverage. Since this plan is government-run, it is meant to compete with private health insurance companies, having the direct effect of lowering prices on private insurance plans, benefitting all patients (The White House, n.d.). While the Senate plan has no provision for a public option, the House version does have a government-run public health insurance written into the bill (Kaiser Family Foundation, 2010b, p. 7).

Lastly, President Obama's plan provides provisions intended to benefit all citizens. First, the plan is not supposed to add to the already large federal deficit. If the reform bill does begin to add to the federal deficit, additional cuts to the plan will go into effect to keep the cost under control. There are also many cost-cutting and fraud prevention measures (The White House, n.d.). At the present time, Medicare and Medicaid face an estimated 3-10% loss of all healthcare spending due to fraud, or about $226 billion, according to Price and Norris (2009, p. 287). Finally, the president's plan requires that certain employers, especially those with over 50 employees. This would help lessen the burden on the government to provide or help provide insurance for these employees (The White House, n.d.).

Methods in Improving Public Support for Healthcare Reform

After analysis of the current healthcare system and reform proposals set forth by the House of Representatives, Senate, and White House, we have found three areas in which adjustment of the proposals should have a positive effect on the popularity of the healthcare reform. These areas include: cost, coverage, and regulation. First, the overall cost to the government of a healthcare program must be reduced. Second, improvements and changes in the elements of the plan need to occur in order to not make beneficiaries and the nation worse off. Lastly, the federal government needs to play a larger role in shaping and overseeing the healthcare system.

Decrease the Cost of Healthcare Reform

The proposed healthcare reform is estimated to cost around $900 billion over a ten-year period. If the healthcare bill is passed, the budget deficit will inflate to $239 billion over the same year period. In order to avoid this increased deficit, the government is going to have to find ways either reduce its cost or raise the funds to pay for it. One method is to squeeze money out of Medicare and Medicaid, and reallocate the money set aside for those to pay for a new plan. Second, the government can increase taxes in some areas to help fund the reform. A tax on the wealthy and taxes on employee health insurance benefits could be used to raise almost $1 trillion for the reform effort. Another tax area that could be affected is itemized deductions. By decreasing the itemized deductions that citizens take, the government can reign in even more money. Finally, the government could penalize employers who do not offer health insurance, equivalent to having them help pay for government insurance for their employees (Andrews, 2009).

Improve and Alter Plan Elements

Four elements of the current healthcare reform bill have come forward as being least popular. First, there is a mandate for every individual to have health insurance. If this is not met, then these individuals face a penalty. This penalty is paid in addition to the nominal tax increase used to pay for the public option. This element needs to be removed, as patients do not want to pay a penalty in addition to paying for everyone else's insurance if they choose not to have insurance.

Second, the government is slated to define a "basic" package. Individual private insurance companies will be required to follow this set of benefits to have a basic plan. This mandate also needs to be removed. Insurance companies should be allowed to set plans based on what they can comfortably and affordably provide.

Third is the late effective date of the plan. President Obama's plan, along with those of the Senate and the House, don't go into effect until 2013 or 2014. These dates need to be moved up to late 2010 or 2011, depending of the time of passage. Americans would like to begin to save money and see the benefits now, rather than three or four years down the road, when President Obama could possibly be out of office.

Finally, the plan is supposed to limit increases in Medicare payments to health care providers. This provision also needs to be eliminated. Healthcare providers, including pharmacists and physicians, face decreased payments, yet require these payments to stay in business and provide quality care.

Increase Government Regulation of Federal Agencies and Insurance Companies

The Food and Drug Administration is the only major federal agency who monitors and controls aspects of healthcare. The government needs to set up additional agencies to help regulate healthcare. One method involves setting up ethics boards. These boards would ensure that hospitals, physicians, pharmacists, and other healthcare providers are providing the highest quality care available. A second method creates a national technology assessment board. This group would oversee the status of health technology and would work to not only to be sure that

such technology is utilized, but that every city has this technology such that it is within reach of nearly every resident of the country.

Discussion and Conclusion

Many different methods, both practical and not, exist to help cover the cost of a reformed healthcare system. One of the proposed ideas is to squeeze savings out of Medicare and Medicaid, which has a very high chance of being included in the final bill. The value of this idea is $465 billion. The biggest cost to the citizens with this proposal is Medicare Advantage beneficiaries may see a decline in quality of care (Andrews, 2009).

Taxing the wealthy is the next idea to help with funding, which is still unclear if it will be included in the bill. This would create $544 billion over a ten-year period. This will affect individuals who make over $280,000 or a family with income over $350,000, which will give these groups a tax surcharge of 1.0-5.4% on top of income. Another idea is to tax employee health insurance benefits. This would yield $2.5 trillion, and the cost to the citizens would be paying tax on the value of employee benefits. Limiting the itemized deductions of the wealthy would bring in around $267 billion. The chance of this being included on the bill is very low and most likely not going to be included. The cost to the people is the top income brackets will not be able to fully itemize deductions. Imposing or raising "sin" taxes will also generate $113 billion over the ten-year period. This will create a tax of three cents per twelve-ounce can of sugar-sweetened beverage and a tax of fourteen cents per bottle of beer or glass of wine (Andrews, 2009).

Another option that has been discussed is penalizing employers who don't offer health insurance. This will accumulate around $163 billion over ten years. This is mostly directed towards small businesses and can result in harsh penalties for the business if they do not offer health insurance to employees (Andrews, 2009).

The final idea is to lower the insurance subsidy threshold. This is still in the development stages and is uncertain what it will cost and how much money it can create. It could have the most impact on people who make between $32,000 and $43,000, who may lose subsidies to help pay for health insurance (Andrews, 2009).

Changing the scope and coverage of the plan will help increase support. First, removing the individual mandate for health insurance will help improve support among those citizens that do not want health insurance. Patients typically don't mind having health insurance because it is generally cheaper to have instead of paying entirely out-of-pocket for healthcare expenses. They would prefer, though, not to be charged for having health insurance if they feel they don't require it. Patients are already going to be paying slightly higher taxes as a result of a public option, and don't want to pay extra for not choosing to have health insurance.

Insurance companies and patients do not want a mandated basic plan. Patients like to be able to compare and "shop around" for the insurance plan that fits them best. Patients benefit from comparing plans to find a low-cost plan that covers what the patient feels needs to be covered. Insurance companies like to offer plans that best fit their budget, beneficiaries, and comply with the latest in therapies for diseases. Instead, the government should consider providing guidelines for plans. Suggestions for plans should be made available so that private insurance companies have a rough outline to follow. Customization of plans should come from the insurance companies, not from the government.

It may be advantageous to the government to delay implementation of healthcare reform in order to best implement the new programs. However, it is more advantageous for reform to take effect much sooner. Patients don't want to wait until after President Obama possibly leaves office. Rather, with a closer effective date, such as late 2010 or 2011, depending on passage of the bill, allows patients to begin to save money and take advantage of the new insurance availability and fraud reform sooner.

Imposing a limitation on the increase of Medicare payments to healthcare providers is not fair to those providers. Currently, Medicare reimbursement rates for services have been decreasing, as pharmacists and physicians lately have only been receiving a couple dollars for each visit and prescription when normal costs are much higher than that for the same visit or prescription. Physicians and pharmacists require increases in Medicare payments in order to be able to stay in business and continue to provide quality service. Cutting their Medicare reimbursement is only going to cause pharmacists and physicians to cut services and staff, thus preventing them from providing the highest quality care possible.

Health care regulation is currently non-existent. There are no governing bodies whatsoever in the industry. The only government agency available to regulate anything under the scope of major health care is the Food and Drug Administration (FDA). The FDA is responsible for protecting the public's health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines, and other biological products, medical devices, the nation's food supply, cosmetics, dietary supplements, and products that give off radiation. It also regulates tobacco products, advances the public health by helping to speed the innovation of healthcare products, and helps the public get accurate, science-based information we need to use medicines and foods to improve our health. Over-the-counter and prescription drugs, including generic drugs, are regulated by the FDA's Center for Drug Evaluation and Research (CDER). This work covers more than just medicines, as fluoride toothpaste, antiperspirants, dandruff shampoos, and sunscreens also fall under the scope of the FDA's research and approval (Food and Drug Administration, n.d.).

There is a long process to be able to market new drugs here in the United States, and the FDA oversees the entire process. Drug companies who are seeking FDA approval must test it in various ways. First come laboratory and animal tests, followed by tests in humans to see if the drug is safe and effective when used to treat or diagnose a disease. All human tests are run as clinical trials, usually taken on by a research hospital or special health organization that would greatly benefit from the drug's use (Food and Drug Administration, n.d.)

After testing the drug, the company then sends the FDA an application called a New Drug Application (NDA). Drugs being made out of biological materials are approved using a Biologics License Application (BLA), as opposed to an NDA. Whether an NDA or a BLA, the application includes the drug's test results, manufacturing information to demonstrate the company can properly manufacture the drug, and the company's proposed label for the drug. The label provides necessary information about the drug, including uses for which it has been shown to be effective, possible risks, and how to use it. If a review by FDA physicians and scientists shows the drug's benefits outweigh its known risks and the drug can be manufactured in a way that ensures a quality product, the drug is approved and can be marketed in the United States (Food and Drug Administration, n.d.)

As one can see, there is an extensive process for which drugs are tested, approved, and marketed here in the United States, and the FDA oversees the entire process from start to finish. This is truly the only aspect of healthcare that is regulated, however, and more needs to be done

if we want our current system to continue operating as it currently does. The government would need to play a large role in overseeing and implementing changes to the current system, just to get things moving the right direction. Once properly set-up, private companies may enter in and begin taking over government-run operations. This ensures that the government does not remain too involved in the overall system, yet also keep private companies in check by not allowing them to set up the entire operation as they would like.

One way to begin regulation of the current system involves the creation of ethics boards. When it comes to private insurance companies, horror stories are often heard of how a family ended up losing their son or daughter because the family's policy was dropped right when they needed coverage, and the hospital would not treat the patient because the family could not afford it out-of-pocket. An ethics board would be able to review individual cases, issue fines to insurance companies who fail to comply with their client's need for coverage, and provide consumers with a peace of mind and someone to trust. Keeping large insurance companies responsible and ethical is the key to succeeding with regulation of the healthcare system (Feldman, 2000).

With hospitals, the ethics board can ensure that each emergency facility around the country is running with the utmost efficiency and is able to run at capacity if the requirement is that high. It is often the case that hospitals, specifically emergency rooms, redirect ambulance traffic at certain times throughout the day. A major problem with this is when all of the hospitals in the immediate area are redirecting ambulances away from their emergency rooms, the one or two hospitals that do remain operational immediately become swamped and are not able to take on all of their ambulances and patients. This results in an obvious problem. With the ethics board, they would be able to ensure emergency rooms remain operational at peak hours during the day, and establish lines of communication between hospitals when emergency rooms do need to close or are already running at full capacity so big problems do not occur at other hospitals (Terry, 2007).

A national technology assessment board would be able to ensure that the same level of care available in Los Angeles, California is also available in Bluffton, Ohio. It is not likely that the same immediate level or care would be available in a city of over four million as opposed to a town of four thousand, but having the same levels of technology available within a certain distance would be very comforting to those with children or who often have medical problems who live further from cities. While a specialized clinic such as the Mayo Clinic is a different case, providing emergency room services with the same levels of technology all across the country provides for the well being of the entire nation.

President Barack Obama's healthcare reform plans, although not new to politics and America, are becoming popular because they are coming close to being realized. Yet, public support has dropped because of plan deficiencies in cost, coverage and regulation. However, changing aspects of the plan in terms of decreasing cost, altering plan coverage, and increasing government regulation can win public support back for a reformed healthcare system. With these changes, the United States will take one of the more sophisticated healthcare systems in the world and make it even better.

References

Andrews, M. (2009). What will healthcare reform cost you? [Electronic Version]. *CBS MoneyWatch*.

The Associated Press (2009, August 12). Protestors raise voices to 'big government' [Electronic Version]. *USA Today*.

Centers for Medicare and Medicaid Services (2005). *Overview Medicare Program – General Information*. Retrieved February 20, 2010, from http://www.cms.hhs.gov/MedicareGenInfo/

Centers for Medicare and Medicaid Services (2010). *Overview Medicaid Eligibility*. Retrieved February 20, 2010, from http://www.cms.hhs.gov/MedicaidEligibility/

Conover, C. (2004). *Health Care Regulation: A $169 Billion Hidden Tax*. Washington, DC: Cato Institute.

Cutler, D. (1994). A Guide to Healthcare Reform. *Journal of Economic Perspectives, 8*(3), 13-29.

Cutler, D. (2002). Equality, Efficiency, and Market Fundamentals: The Dynamics of International Medical-Care Reform. *Journal of Economic Literature, 45*, 881-906.

Feldman, R.D. (Ed.). (2000). *American Health Care Government, Market Processes, and the Public Interest*. New York: Transaction.

Kaiser Family Foundation (n.d.). *Timeline: History of Health Reform Efforts in the U.S.* Retrieved February 6, 2010, from http://healthreform.kff.org/flash/health-reform-new.html

Kaiser Family Foundation (2009, September). *Kaiser Health Tracking Poll: September 2009*. Retrieved February 6, 2010, from http://www.kff.org/kaiserpolls/upload/7989.pdf

Kaiser Family Foundation (2010a, January). *Kaiser Health Tracking Poll: January 2010*. Retrieved February 6, 2010, from http://www.kff.org/kaiserpolls/upload/8042-C.pdf

Kaiser Family Foundation (2010b, January). *Side-by-side Comparison of Major Health Care Reform Proposals*. Retrieved February 16, 2010, from http://www.kff.org/healthreform/sidebyside.cfm

New England Journal of Medicine (2009). *U.S. Health Care Reform Interactive Timeline*. Retrieved February 16, 2010, from http://healthcarereform.nejm.org/?page_id=1647

Price, M. & Norris, D.M. (2009). Health Care Fraud: Physicians as White Collar Criminals?. *Journal of the American Academy of Psychiatry and the Law, 37*(3), 286-9.

Terry, K. (2007). *Rx for Health Care Reform*. New York: Vanderbilt UP.

United States Food and Drug Administration (n.d.). *US Food and Drug Administration*. Retrieved February 20, 2010, from http://www.fda.gov/

The White House (n.d.). *The Obama Plan: Stability and Security for All Americans*. Retrieved February 7, 2010, from http://www.whitehouse.gov/issues/health-care/plan

Appendix

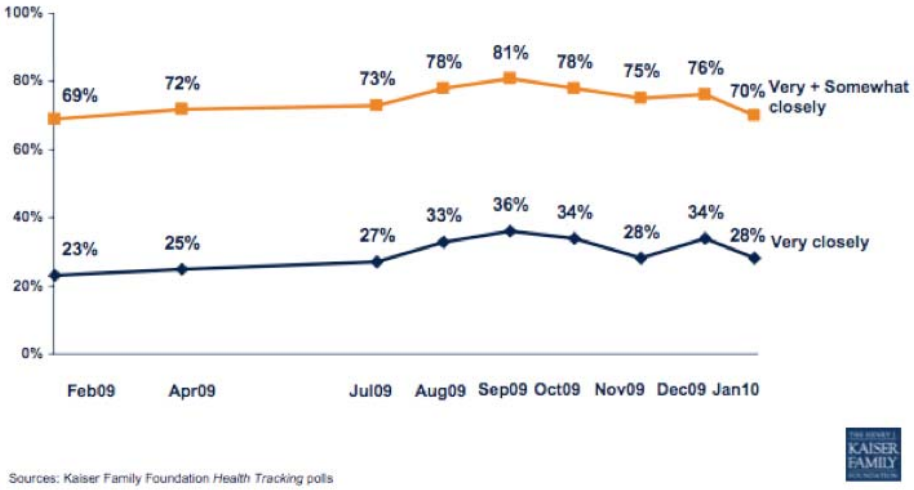

Figure 3 - Percentage of Americans Who Follow Healthcare Reform Efforts (Kaiser Family Foundation, 2010)

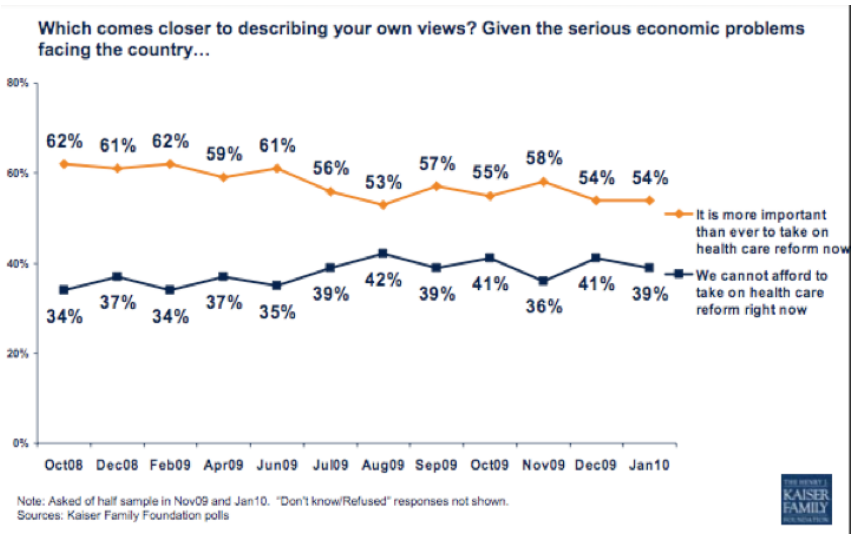

Figure 2 - Importance of Healthcare Reform at the Present Time (Kaiser Family Foundation, 2010)

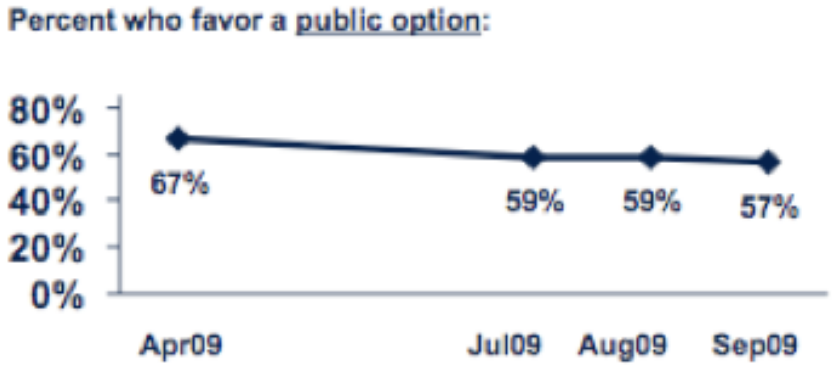

Figure 1 - Percentage of Americans Who Favor a Public Health Insurance Option (Kaiser Family Foundation, 2009)