

Angus McRae Insurance Brokerage Services, Inc.

4725 Peachtree Corners Circle, Suite 155
Norcross, GA 30092
770-300-0001 – voice / 770-300-0827 – facsimile
amcrae@angusmcrac.com



National Health Care?

Hold on Tight – Here Come the Elections!

By Angus A. McRae, Jr., CEBS

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- Politician bemoans two-tier health system in U.S. – wealthy vs poor, insured vs uninsured, haves vs have-nots.
- Politician promises government solution of “universal health care” – coverage for all.
- Citizen elects Politician.
- Politician installs a “standard” benefit plan (read high deductible, catastrophic coverage).
- Politician raises taxes to pay for “universal health care.”
- Citizen realizes that there are holes in the “standard” coverage.
- “Wealthy” Citizen purchases private insurance to supplement the government’s “standard” plan.
- “Poor” Citizen cannot afford private insurance; has high out-of-pocket medical expenses.
- Politician bemoans two-tier health system in U.S. – wealthy vs poor, insured vs uninsured, haves vs have-nots.

And, so it goes...

Differing types of “National Health Care”

The term “national health care” should not be used interchangeably with “universal health care.” Universal health care simply means that coverage is available to all – a worthy goal indeed. “National health care” is coverage that has been nationalized by the government.

There are a number of national health care models. These include:

Socialized Health Care. Under this model, the government owns the health care facilities and the providers – the doctors and nurses – are government employees. The National Health Care System (NHS) in the United Kingdom is an example of socialized medicine.

Single-Payer Health Care. In a single-payer system, the government collects taxes and uses those funds to pay for benefits. But, unlike a socialized health care system, the delivery of care may be provided by *privately employed* doctors and hospitals, but paid for with public funds (taxes). Canada, Denmark and Sweden have single-payer systems.

Mandated Private Insurance. Here the government mandates that its citizens maintain health care coverage. The Clintons’ universal health care plan was an enforced employer mandate to provide basic medical coverage to all employees through closely regulated HMOs. In 2006, Massachusetts created a plan that, in part, establishes an “insurance exchange” where small businesses, their employees and individuals can purchase insurance. The plan also imposes a mandate on individuals to purchase coverage and penalizes employers who do not offer and subsidize coverage.²

The Dark Side of National Health Care

Walter Reed Army Medical Center – Socialized Health Care

The recently exposed trouble at Walter Reed Army Medical Center is a good example of the problems one can expect in a socialized medical system. The Walter Reed facilities are owned by the Federal government. And, its

¹ Single Payer 101, By Kao-Ping Chua, February 10, 2006.

² The Heritage Foundation, The Massachusetts Health Plan: Lessons for the States, by Nina Owcharenko and Robert E. Moffit, Ph.D., July 18, 2006.

employees, until recently, were employed by the government and represented by the American Federation of Government Employees union.^{3 4} This made Walter Reed, in essence, a socialized medical system, much like what you see in the UK.

In January 2006, the Army approved the decision to have a private company, IAP Worldwide Services, run the facility. IAP took over management responsibility on February 4, 2007. Between January 2006 and February 2007, around 80 union facility workers (out of 180) terminated employment and the hospital found it hard to replace them.⁵

IAP had been on the job for about *two weeks*, when on February 18, 2007, the Washington Post published a story it has been researching for *over four months* which exposed problems of rodent infestation, moldy walls and government bureaucracy.⁶

Should we be surprised that when the number of facility workers drops by almost 50% that cleanliness and maintenance will suffer? Some are painting Walter Reed as an indictment of privatization, when it really should be viewed as a failure of socialized medicine. Properly maintaining Walter Reed was and is the responsibility of our Federal government – whether the work is done by union or non-union employees is irrelevant.

Take your office building as an example. Whether the building's owners employ an in-house maintenance staff or contract those tasks to an outside firm, it is still the owner's responsibility to maintain a clean and safe work environment for you.

National Health Care Waiting Lists

In 2005 in the case of *Chaoulli v. Quebec (Attorney General)*, Canadian Supreme Court Chief Justice Beverly McLachlin wrote, "Access to a waiting list is not access to health care" thus, in essence, recognizing that the Canadian government's health care monopoly is harmful to its citizens.⁷ The landmark ruling in the case strikes down a Quebec law banning private medical insurance.

Would you like to be covered by a single-payer system that has found it necessary to publish a document entitled, "Final Report of The Federal Advisor on Wait Times?" Canada has set wait time "benchmarks" for curative radiotherapy for cancer of within 4 weeks of being ready to treat, for coronary artery bypass graft surgery of between 2 and 26 weeks, and for knee replacement surgery of within 26 weeks.⁸

In the United Kingdom's National Health System (NHS) if a patient has to wait for over six months for a surgery they are offered a choice of moving to another hospital or provider for their treatment.⁹ NHS has even developed a handy on-line tool where you can see how long you have to wait before being treated! For example, in Southampton, England (postal code SO30 4DA), a person willing to travel 25 miles will typically wait between 19 and 71 days for in-patient breast surgery - <http://www.nhs.uk/England/AboutTheNhs/WaitingTimes/Search.aspx>.

If you are diagnosed with breast cancer in the UK, it is the government's goal for you to be seen by a specialist within *62 days* of your general practitioner's referral to that specialist. Just *visiting* the specialist, not necessarily beginning treatment, within 62 days of referral is considered a success in England!¹⁰ The fact that the UK's Department of Health has a web site dedicated to tracking waiting times for medical treatment - <http://www.performance.doh.gov.uk/> - is illustrative of the problem.

Immediate gratification – especially when it comes to health care – is the rule of the day here in the U.S. It would be a rude shock to most Americans to be thrust into a national health care system such as you find in Canada or the UK.

³ The Army Times, Committee Subpoenas Former Walter Reed Chief, Kelly Kennedy, March 3, 2007.

⁴ American Federation of Government Employees Press Release, Congress Subjects Privatization Review at Walter Reed Army Medical Center to Additional Scrutiny, Jason Fornicola, May 3, 2006.

⁵ The Boston Globe, Privatizing of Walter Reed Scrutinized, By Steve Vogel, Washington Post, March 11, 2007.

⁶ Washington Post, Soldiers Face Neglect, Frustration At Army's Top Medical Facility, Dana Priest and Anne Hull, February 18, 2007.

⁷ Taking Canada's Medical Monopolies to Court, John Carpay, February 2007.

⁸ Final Report of The Federal Advisor on Wait Times, Minister of Health Canada, June 2006.

⁹ National Health System website, <http://www.nhs.uk/England/aboutTheNHS/waitingTimes/whatTheyTellYou.cmsx>.

¹⁰ Department of Health, <http://www.performance.doh.gov.uk/cancerwaits/2006/q3/part5.html>.

Private Insurance to Supplement National Plans

The joke has always been, “If you think health insurance is expensive now, just wait until it is free.”

Just as you have seen “Medicare supplement or medigap” policies sold in the U.S. to fill in the gaps of Medicare coverage, private insurers in countries like Canada and the UK are marketing private medical insurance designed to reduce waits for medical treatment and for care not covered by the national plan. “But wait,” you say. “I thought that when we moved to a national health care system I would not have to deal with the evil insurance industry.” No, not only will you pay your taxes to fund the government plan, but, if you value quality, timely care you will also buy a private plan. And, who amongst us will do this, but the wealthy.

So a national health plan which was designed to eliminate inequity of care between differing classes of citizens reverts to a two-tier system – the government standard of benefits for those who cannot or will not pay extra, and a higher level of benefits for those who can and are willing to pay more.

Health Care Coverage in the U.S.

The term “health care” should not be confused with “health insurance.” Health care is the treatment you receive when you are sick or injured; health insurance is just one method of paying for that care. A person can receive health care, but have no health insurance.

One could argue that in the U.S. we are already close to having “universal health care.” Not everyone has health insurance, but health care is available in one form or another to most everyone (including illegal aliens). People without insurance can get care in privately-run charitable clinics, in emergency rooms, and other venues – all of this being paid for by you and me through higher insurance premiums, charitable donations and taxes.

In 2005, 68.6% of individuals had health coverage through a “private sector” plan (coverage through their employer or a privately purchased policy). 30.5% of the population had “government” coverage (a military, Medicare, or Medicaid/SCHIP plan). 15.9% had no *insurance* – the care they received was provided in clinics and hospitals and those medical providers, either directly or indirectly, passed the cost of care on to its paying customers.¹¹

Paid For By:	You and me – Through insurance premiums, taxes, and charity.					
Administered By:	Private Sector	Private/Government	Government			
	Employer Sponsored Plans	Individual Insurance	Uninsured	Military Healthcare	Medicare	Medicaid / SCHIP
2005	59.5%	9.1%	15.9%	3.8%	13.7%	13.0%
2004	59.8%	9.3%	15.6%	3.7%	13.6%	13.0%
1995 ¹²	61.1%	9.2%	15.4%	3.5%	13.1%	12.1%
1987 ¹³	62.1%	N/A	12.9%	4.4%	12.6%	8.4%

Between 1987 and 2005, the percentage of Americans covered by employer sponsored plans has dropped slightly from 62.1% to 59.5%. But, because population increases during that period the total number of people covered by employer plans has gone up by around 25 million. The bottom line is that there has not been a sea change away from private sector plans.

The Foundation in the U.S. Has Been Laid

If you were to nationalize the U.S. health care system an infrastructure would need to be in place. One would expect such a system to evolve – an evolution; not the revolution the Clintons tried in the early 1990’s.

To build such a system, you would need a plan of medical and prescription drug benefits, a low cost plan that encouraged people to save their own money and not use the government plan, and an efficient claims administration system.

¹¹ U.S. Census Bureau, Population Profile of the United States: Dynamic Version. The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

¹² U.S. Census Bureau, Current Population Reports, By Robert L. Bennefield, September 1996.

¹³ U.S. Census Bureau, Table HI-7. Health Insurance Coverage Status and Type of Coverage by Age: 1987 to 2005.

Plan of Medical Benefits. In 1965, Medicare was created to provide health care benefits to people age 65 and over. Medicaid was also created in order to provide health care benefits to low income Americans. House make-up: 295 (D) to 140 (R). Senate make-up: 68 (D) to 32 (R). Signed into law by President Lyndon B. Johnson (D).

Efficient Claims Administration System. Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) charged the Department of Health and Human Services with the responsibility of drafting “Administrative Simplification” rules. These rules include:

- Electronic Data Interchange (EDI) capabilities. Standardized data formats must be used to electronically transmit enrollment, claims, eligibility, premium payment and other health care data.
- National provider identifier. Starting May 2007, all doctors, hospitals and other medical providers using electronic communications must use a single unique ID number.
- Rule enforcement. Civil monetary penalties for violating the provisions of HIPAA became effective in March 2006; as well as procedures for investigations and hearings.

HIPAA was signed into law in August 1996. House make-up: 230 (R), 204 (D) and 1 (I). Senate make-up: 53 (R) to 47 (D). Signed into law by President William J. Clinton (D).

State Children's Health Insurance Program. As part of the Balanced Budget Act of 1997, Congress created title XXI, the State Children's Health Insurance Program (SCHIP), to address the problem of children without health insurance. SCHIP was designed as a Federal/State partnership, similar to Medicaid, with the goal of expanding health insurance to children whose families earn too much money to be eligible for Medicaid, but not enough money to purchase private insurance. SCHIP was signed into law in August 1997. House make-up: 228 (R), 206 (D) and 1 (I). Senate make-up: 55 (R) to 45 (D). Signed into law by President William J. Clinton (D).

Plan of Prescription Drug Benefits. In 2006, people covered by Medicare became eligible for prescription drug benefits through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. House make-up: 227 (R) to 207 (D). Senate make-up: 51 (R), 48 (D), and 1 (I). Signed into law by President George W. Bush (R).

Low Cost Base Plan of Benefits. Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, permits eligible individuals to establish Health Savings Accounts (HSAs). You can think of an HSA as a 401(k) plan for health care. If you have a “high deductible health plan” you pay lower premiums than a traditional insurance policy and can set aside money to pay for your out-of-pocket expenses. There are a number of tax benefits to such plans. House make-up: 227 (R) to 207 (D). Senate make-up: 51 (R), 48 (D), and 1 (I). Signed into law by President George W. Bush (R).

So, as you can see, in 1992 when the Clintons tried to enact their national health care system much of the foundation was not yet laid. Efforts of Democrats and Republicans alike seem to be moving us towards a nationalized system.

The \$64,000 Question – Will We Nationalize?

Two-thirds of respondents in a recent poll said that the government should guarantee that all Americans have health insurance.¹⁴ So, if you are a politician it is a safe bet that you can get votes by promising universal health care.

Politicians are not necessarily stupid, however. They can see the problems of deficit spending, rationing of care and other quality issues in the single-payer system in Canada and in the socialized system in the UK. And, they recognize that because of these problems the demand for private insurance in these countries is growing. *Therefore, I think anyone hoping to see such a nationalized program in the U.S. in the next ten years will be disappointed.*

Predictions

So, how can a politician get credit for promoting universal health care and still not have a nationalized plan in place? While trumpeting the “failures” of our current health care system – the millions of *uninsured*, the high cost

¹⁴ CBS News, Poll: The Politics of Health Care, March 1, 2007.

of private insurance, and the plight of the “working poor” - expect to see politicians making concerted efforts in the following areas:

- Expand eligibility in government plans, specifically SCHIP, by (i) making it easier to join the program and then stay on it, (ii) allowing childless adults to be eligible, and (iii) expanding the definition of “working poor.”¹⁵
- Mandating that individuals have health insurance, such as what Governor Schwarzenegger has recently recommended.¹⁶ An interesting note here, California mandates that every driver have auto insurance, but 25% fail to do so. 20.6% of Californians do not have health insurance.¹⁷ Will mandating health insurance produce results where similar actions with auto insurance have failed? Or, maybe, is there a segment of our population that will always value a new bass boat or six-pack over the protection of health insurance?
- Establishing “insurance exchange” or “connector” insurance purchasing entities. Think of these as stock markets for health insurance – theoretically facilitating transactions between government, employers, individuals and health insurers. An insurance exchange is a key component of Governor Romney’s newly enacted plan in Massachusetts.¹⁸

Conclusion

Our current health care system can certainly be improved. Cost, for instance, is a major concern. But, step back a moment, and think of someone you know who has had a significant medical condition. Did that person get prompt treatment at a relatively low out-of-pocket cost? As an insurance broker specializing in private health insurance, I am constantly seeing very sick or injured patients receiving timely, thoughtful care that would not necessarily be available in Canada or the UK.

The premiums to pay for this care are expensive. Imagine, however, having to pay higher taxes *and* these premiums to get the same level of care. That is the future with national health care.

Our natural, capitalistic free market dictates that private insurance will remain a significant method of payment for health care. Politicians, however, will continue an incremental march towards a nationalized system. And, though they may ultimately succeed in installing a government plan, the resulting “universal health care” will be neither *universal*, nor *health care* as we know it.

About the Author: Angus A. McRae, Jr. CEBS is an Atlanta, Georgia based insurance broker who has specialized in group benefits since 1989. He has an undergraduate degree in business from Florida State University (1984), a Masters of Business Administration from Emory University (1989), and the Certified Employee Benefit Specialist designation (1993).

¹⁵ A Blueprint for Universal Health Insurance Coverage in New York, Holahan, Hubert, Schoen, The Hospital Fund and the Commonwealth Fund, December 2006.

¹⁶ Governor’s Health Care Proposal, http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.

¹⁷ Insurance Mandates Aren’t the Answer to Uninsured, Health Care News, Greg Scandlen, March 1, 2007.

¹⁸ Mass. Gov. Romney’s Health Care Plan Says Everyone Pays, USA Today, Julie Appleby, July 4, 2005.