

ENTITLEMENTS FROM ENTANGLEMENTS

THE TRANSFER OF PUBLIC PATIENTS INTO THE PRIVATE HEALTH CARE SYSTEM

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Government entanglement in health care threatens to strangle the system. Its micro-management both of the delivery of and payment for health care does immense damage to private health care. Yet, Congress focuses on fixing the private health care system.

On May 8, 2009, a gathering of people in Milwaukee talked about free market health care. As each discussion leader completed a talk, the audience asked piercing, well-informed questions. Clearly, this audience wanted to avoid making government the arbiter of personal health care in the United States.

Then a man stood to express an opinion. We call him Bob. Bob genuinely believed it to be in the spirit of that day's discussion. His appearance was impeccable, and he wore expensive clothes. Obviously, he had enjoyed financial success (or at least, wanted everyone to believe so).

"I am 70 years old now," Bob began. "My wife and I are on Medicare Advantage, and we don't pay anything for it. Well, except for a few low co-pays. Why can't our children have a plan like this?"

Bob made no mention of the fact that his great-grandchildren were stuck with paying the cost of his entitlement to Medicare.

BLOATED HEALTH SPENDING

After 1965, health care cost spiraled out of control, rising at a double-digit rate more often than other services and commodities. What happened that spawned this runaway health care spending?

Prior to 1960, private insurance paid the catastrophic health care cost for 78 percent of all Americans. Insured people paid cash for their own non-catastrophic medical costs. If an insured person actually qualified for an insurance reimbursement it meant they had experienced a very bad year – faced a serious illness or accident.

People were free to choose their own doctors and pharmacies. No one told them to choose a provider in a network because there were no networks.

Poor people who had no health insurance received care at government facilities – the county hospital and city health clinics. Doctors expected to donate some of their services to people who lacked finances to pay for their care. Charitable clinics and facilities filled the gaps. People were not dying on the streets for lack of health care.

The 1950s and 1960s are often called the "Golden



The United States Congress has been the micro-manager of the U.S. health care system since 1965. Has this been the most cost-effective way to manage your health care?

Age of Medicine." U.S. health care was the envy of the world. The United States' health care system was affordable, efficient, and effective.

FROM GOLDEN AGE TO SPENDING MOUNTAINS OF GOLD

Medical researchers and entrepreneurs in the United States made major breakthroughs during the 1940s, 1950s, and 1960s, most of which were done without major federal or state government money. Each breakthrough added to the need for more care, and oftentimes, more expensive care.

Governments across the world faced many of the same difficulties, but they created health care programs that put parliaments, prime ministers, and presidents in charge. Presidents Franklin Delano Roosevelt and Harry Truman tried to persuade Americans to go along, but the people refused.

Then came 1965: Congress created Medicare and Medicaid alongside Community Health Centers.

Medicare began paying the health care cost of everyone aged 65 and older, regardless of income or need. For the first time in U.S. history, the richest senior citizens became entitled to government-paid health care right alongside the nation's poorest people. Everyone 65 and older could now access private doctors and hospitals.

Medicare would have certainly failed if the government had forced middle- and upper-income enrollees to use government facilities and providers. With Medicare



TV advertisements encourage Medicare enrollees to buy all kinds of health care services and devices. One tells the eager patient that Medicare will buy them a motorized scooter, for nothing. The payroll taxes of working people pay for all this.

(as well as Medicaid) Congress opted for taxpayers to pay most of the cost of all health care recipients to use private physicians, hospitals, and other health care providers.

Through Medicaid (for people younger than 65) government began paying the cost of private health care for the nation's poor people. Instead of going to the county hospital or a city clinic, Medicaid paid private providers to care for poor people. This gave poor people access to the same doctors as middle-class and wealthy people and made health care a fairness issue.

Soon, state and local governments began selling or closing many public medical facilities, preferring that everyone have access to the same private market clinics and hospitals. This eliminated the stigma formerly attached to using government health care ("being on the dole"). Community Health Centers offered quality primary care at low or no cost.

From being stigmatized by government help, people aged 65 and older began to feel entitled to government help – just like Bob (above). From a desire to be self-reliant people who preferred to make it on their own, people became comfortable with government chipping in to help pay their way. Rich and poor people had been given the same health care entitlement.

THE SAME CARE FOR ALL CREATED A COVERAGE PARADOX

Before Medicaid, poor people had little or no money for even the first dollar cost of health care. They had no need to buy insurance to protect their assets because they had very little to protect. For many, even catastrophic insurance lay outside their ability to pay the premium.

In contrast, middle- and upper-income people could easily afford routine health care costs. Their primary need was to protect their health, estate, and future income if they suffered a large, catastrophic illness or injury.

With Medicare, Congress created a paradox: a one-size-fits-all, benefit-rich health plan that lumped everyone together regardless of financial need. Congress had effectively eliminated the need for catastrophic health insurance for people aged 65 and older. They replaced it with a non-catastrophic government-subsidized plan, aided by an affordable insurance supplement that was, in fact, really needed only by the nation's poorest people.

Private health care facilities and physicians readily – even eagerly – accepted government-subsidized patients. Too few saw the long-term consequences that are "coming home to roost" today.

When Congress passed Medicare in 1965, it claimed that Medicare spending would be \$9 billion by 1990. Instead, it was \$67 billion. For 2009, total projected Medicare spending is set at \$495 billion.

A May 13, 2009 federal government news release projects that Medicare will begin losing money in 2017. Expect Congress to solve this crisis as it usually does by increasing the Medicare tax. This will force Medicare enrollees' grandchildren to pay even more for grandma and grandpa's health care.

The primary reason why health care costs so much is because government micro-management has produced wrong economic incentives at the consumer, provider, and payer level.

POLITICS ENTERED THE EQUATION

By 1974, government had finally entangled itself in both private and public health care.

Government oversight of its twin health care plans, Medicare and Medicaid, had created a new and powerful political interest group. The high stakes politics that has resulted affected everyone.

During the early 1970s, working people younger than 65 noticed that seniors and poor people had more health benefits than they did. They also saw the new Medicare payroll tax withheld from their checks, and the increase in income taxes needed to pay for Medicaid. They saw their poor neighbors and senior friends in the same clinic waiting rooms, only these others were paying little or nothing for care.

Working people became envious. Congress heard their complaints.

In 1973, Congress passed the Health Maintenance Organization (HMO) Act. The HMO offered benefit-rich health plans to people with private health coverage, just like people on Medicare and Medicaid. To make sure HMOs thrived, government spent tax dollars to subsidize HMO premiums, and mandated that larger employers must offer an HMO plan as an option.

Those 1970s health care reformers felt that the HMO

could save money and increase the quality of health care. They felt that inexpensive preventive care would be the key to saving money in the future by keeping people healthier – providing health care not sick care.

Congress' goal was to do for working people aged 64 and younger what it had done for those aged 65 and older who were now on Medicare – entitle them to a wide range of health care services. Congress trumpeted that the HMO would improve health, reduce long-term treatment cost, and save billions of dollars every year. So how has that worked out?

DOUBLE DIGIT INFLATION FOR A GENERATION

Late in 2008, the United States' Centers for Medicare and Medicaid Services predicted that total U.S. health care spending would equal \$2.56 trillion in 2009. This is 6,000 percent more than Americans spent for health care in 1965.

Even though government manages and pays for many other common public services, none other has seen a 6,000 percent growth in spending from 1965 to 2009.

- Consider government-managed public education. Federal and state government spending on public education grew by 2,950 percent since 1965.
- Consider defense spending, a function we entrust to the federal government. It has only increased by 1,177 percent since 1965.

INTEGRATED HEALTH SYSTEMS AT THE ROOT

Prior to 1966, the United States relied upon a dual system of health care. Private health systems cared for insured people and people who could afford to pay their own way. Government health systems provided health care for everyone else.

From that simple dual system of care prior to 1966, we now have a complex, integrated public/private system that is rife with waste. From private health pricing that was subject to a patient's ability to pay, we now have government price-fixing through the Medicare reimbursement system. From a limited role for government to play in the delivery of and payment for health care, modern government is obsessed with health care micromanagement and repeated failed attempts to reduce health spending in a vain attempt to pacify anxious voters.

Today's political health care systems divide people into interest groups, and point fingers at the villains whom they claim drive up health spending: drug companies, insurance companies, doctors, for-profit providers, free market advocates. Lately, government has begun blaming people for letting themselves become unhealthy.

We cannot successfully reform health care until we agree on this fundamental truth: The primary reason why health care costs so much is because government micromanagement has produced wrong economic incentives at

1965 Chev Impala SuperSport



Comparing the price of a 1965 Chevy to the increase in national health spending is not intended to compare value. It is simply to demonstrate the scale of change.

Health Care Spending - 1965 - \$6.9 Billion
Health Care Spending - 2009 - \$2.6 Trillion
6,000 percent increase

Chevy Impala Super Sport - 1965 - \$2.500
At a 6,000 percent increase
\$150,000

the consumer, provider, and payer level.

The intermingling of government and private health care has destroyed incentives to spend wisely, save money, and reduce cost as it replaced consumerism with entitlements. This is why we face a health care spending crisis.

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- Your Health Matters: What you need to know about US health care*
- FACTS: Not Fiction – What really ails US health care*
- Why health care costs so much: The Solution – Consumers*

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