CHIP

Consumers Health Investment Plan

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Introduction

The Louisiana State Medical Society wishes to present for consideration seven ideas we strongly urge for purposes of reduction of Health Care Costs in our nation.

It is a fact that during the past 25 years medical care cost has risen faster than inflation and most other services. This must be a pressing concern of physicians.

Fundamental to a solution of this issue, is to understand why.

A) Technological advances have produced a progressively superior product, hence a progressively more costly one. The legitimate concern here lies in those areas of over sophistication.[1]

B) The malpractice problem has produced defensive medicine. Hardly a creature of professional creation, yet widely charged as such by some.[2]

C) There is also the charge that physicians as "the brokers of services" are totally responsible by ordering medically unnecessary services. Admittedly there is an element of truth in this charge, but we do not share the view this is the pre-emptive cause on which all attempts at cost containment should be structured.

Tragically, this charge has been accepted in large measure by our profession, although it ignores the single most basic elementary fact of economics.

It is a fact based on this charge, almost all cost control to date bears on a restriction of supply or rationing. Consider: P.S.R.O., area planning, second opinions, hospital cost containment and fiscal utilization review all have one thing in common — the intent to restrict supply.

It is a fact that elementary economics dictates that price is a function of supply and demand. What have we done during the past 25 years to demand? You make any good or service seem cheap or free at the point of consumption and you can be sure that demand will rise. It is a fact that government subsidy and payment of cost at a point far removed from the point of consumption has created an illusion of a cheap product causing unbridled demand in this nation.

Physicians who have practiced medicine for the past 25 years have noted the change in public attitude towards health care cost. In the Fifties and early Sixties John Q. Public asked, "Do I really need this, Doc?" Today he demands, "Shoot the works, Doc, someone *else* will pay for it." Thus unbridled demand and supply restriction = rising costs.

We will present seven ideas in the form of resolutions to the A.M.A. House of Delegates.[3] A National investment firm officer has endorsed our proposal in principal[4] and we have been informed that Blue Cross in our State will work with us on this proposal.

The bottom line of these proposals will be reduction of health care cost, a correction of price distortion at the point of consumption, a change in attitude by all as to concern for price and *no reduction in access to care.*

It is a fact that a basic fault in our current system for medical cost payments lies in the attempt to utilize the insurance mechanism for payment of shallow first dollar costs. Corrections of this fault are made in deductibles and co-payments whose mechanics, when analyzed, are really a rejection of first dollar coverage.

Medical insurance is without question the most confusing type of insurance an individual will try to carry. The variations in covered loss, benefits, limits and policy type make it impossible for the average person to make a reasonable comparison between policies. Today 80 percent to 90 percent of Americans have some form of insurance, but it is a rare person who can tell you what loss is covered let alone whether his policy is best suited for his needs.[5]

Basic to the cause of this condition in the insurance industry is the fact that total coverage of shallow first dollar cost is not a marketable product. To market it (at a saleable premium) exclusion, limits on benefits, co-payment, deductibles and stop limit payments must be factored in, because all claims will require the payment of the first dollars expense. The net result. . .a bad buy.

The exact opposite is found in major medical excess liability or castastrophic coverage. The occurance of claims in a zone above $3,000 is so low that when spread as a risk, premium cost is extremely low. Consider, however, that a good insurance policy that markets first dollar costs currently has a premium in a range of $600 to $1,000 for a family of four. Projected over a 50 year time frame a family of four paying an annual premium cost of $800 will pay $40,000, medical care expenses in that time frame.

There is a better way, an idea proposed by John A. Pugsley.[5] If dollars spent for shallow first dollar coverage were invested in savings, the interest earnings, more so if made tax free, would more than pay the annual cost of cheap catastrophic insurance. Such low cost catastrophic insurance is available right now to physicians in Louisiana as a group.

The idea of tax free interest earning is currently advocated by all presidential candidates of the Republican Party save one. This concept is presented in resolutions Numbered 1 and 2. Statistics indicate that 40 percent of America's 55 million families currently have personal earnings to support self insurance for first dollar small cost.[5] With average medical cost experiences the vast majority of families would not only create a self funding catastrophic coverage but would also create a tidy sum cash value of savings return over a lifetime.

It is a fact that a second basic fault arising from attempted first dollar coverage by insurance occurs when multiple coverage is bought which

duplicates other coverage. Resolution Number 3 addresses this matter.

It is a fact that current tax treatment of premium cost creates incentive to buy more and more shallow first dollar insurance. This tax treatment is the basic reason why labor unions negotiate each new contract with increased health insurance demands in lieu of wages increase.[1] Such tax treatment subsidy by government cost $4 billion in 1974 and is up to $12.7 billion in 1979.[7] This will progressively increase by a self-feeding cycle. This subsidy is far in excess of $8.5 billion overhead and profit of the entire private insurance sector. Consider that the savings of this $12.7 billion in federal spending would almost balance Carter's $15 billion deficit budget.[7] Resolution Number 4 addresses this problem.

It is a fact that co-payment in the zone of low occurance catastrophic insurance is counter productive since it reduces the already low premium cost only an insignificant fraction and bears no control on overutilization in this zone. The payment of the co-payment in a true catastrophic medical expense could be a catastrophy in itself.[8] Resolution Number 5 addresses this problem.

It is a fact that in the catastrophic insurance zone - claims $3,000 or more - occurance is so low and premium cost so small, private insurers have no need for Federal reinsurance. *To ask for such is sheer folly and invites Federal control over the private sector insurance industry.* Resolution Number 6 addresses this problem.

As a substitute to attempt first dollar coverage by insurance we have proposed a savings investment strategy. There are many investment options that could be used. In the current market place, the high yields, liquidity and low risk factors make investment funds perhaps the most attractive option available. Some vendors of health insurance may wish to market a health insurance policy as a combination cash value policy to cover front end cost with catastrophic policy premium cost paid in part or whole by the interest earnings.

To discipline the enrolled, withdrawal of cash would be prohibited except to cover medical expense until such time as the cash value would be in excess of the front end deductible and a predetermined multiple.

An additional option could be that increased cash value would buy a cheaper and better quality catastrophic coverage by a higher deductible. The economic soundness of this concept has been questioned by none as applied to those of economic means to self insure their first dollar costs. As already pointed out, this could be done with ease by 40 percent of the American families.[6]

Lastly let us consider the indigent. It is a fact that our society has created a welfare mess. On a recent Milton Friedman "Free to Choose" program it was pointed out that if the cost of Federal welfare was offered as a cash benefit, $32,000 would be given to each eligible beneficiary as an annual cash payment. For 25 years Mr. Friedman has offered the idea of negative income to benefit the poor. Borrowing from this idea, the establishment of interest bearing investments designed to pay the cost of

shallow first dollar health insurance coupled with catastrophic insurance could be established to some extent for the indigent. There can be little doubt that such policy as an alternative to the current medicaid program would greatly benefit both the indigent and the taxpayer. Resolution Number 7 addresses this idea.

There should be little doubt that one of the primary drive forces in the rising cost of health care is the method of health insurance policy structure. If this nation were to legally allow fire insurance to be written in the identical manner of health insurance coverage — first dollar coverage, no co - payments, no coordination of benefits and provider (building contractors) insurance - then this nation's citizens would soon seek to become rich by building and burning buildings. Soon all America would go up in flames. It is small wonder we have a rising cost of health care problem. National health insurance - in catastrophic or any form - administered by federal government is not a solution. It would only magnify the problems as outlined above.

Today, the cost of health care is the cost of insurance. **To manage the cost of health care must therefore be to manage the cost of insurance.**[9]

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Proposal

The rising annual bill for the health care of Americans is a matter of rightful concern, both to consumer and provider.

One of the primary contributions to this rise is the huge sum collected each year by government and commercial insurance underwriters over and above what they actually spend to purchase health care goods and services. The Louisiana State Medical Society believes that great savings to the public can be effected in the billions of dollars currently being laid out for overhead, bureaucracy, red tape and waste incurred by administration of counterproductive federal regulations.

The economic health and well - being of the nation and the individual will benefit from a program which attacks the non-medical expenditures that are inflating the cost of health care.

Our proposal is that the individual realize substantial savings by a more prudent spending of his health care dollar. We recommend that he:

1) purchase a major-medical or catastrophic coverage policy which carries minimal exclusions and has no provisions for co-payment.
2) cancel all insurance coverage below that level.
3) replace such low-level, or first-dollar coverage with a fund of his own money invested at the best possible rate of interest and readily availabe for reimbursement for medical expenses when necessary.

In explanation, catastrophic insurance is a relatively inexpensive form of protection and the only way for most people to provide for the really crippling major medical expense that will strike a very few during their lifetimes. The deductible amount which marks the point at which the coverage begins must be tailored to the individual buyer and should be at the same point as the top of the cash fund which he maintains as self insurance. The higher the tax base of the individual, the higher the front end deductive he should seek.

We advise the cancellation of first-dollar type policies because of the small return made to the average buyer when compared to the cost of premiums over the years of his experience. These policies represent the most common type of health insurance. They are the most expensive to purchase and the premium must be paid each year weather benefits are collected or not. No equity or cash value is accrued to a customer who enjoys good health and makes few demands on his insuror. *They represent a poor investment for the individual even when purchased in group form and financed by an employer in lieu of higher wages.*

The major innovation offered here is the maintenance of a cash fund bearing interest and available for withdrawal in case of medical expense below the limit of the catastrophic policy but still too heavy for the

individual's budget. Investment funds are seen as the answer, and a favorable reaction has already been given us by a major investment brokerage firm.[4] These funds offer great safety, good yield, and do not require long-term commitments of one's cash. Investment capital may be placed in "commercial paper" instruments which currently return interest in the 9 percent — 12 percent range. Your local banker and savings and loan institution can give you good advice in these investment strategies. For the investor in a higher tax bracket, tax - free bonds may be utilized, paying 5 percent - 6 percent until such time as congress may make all investment returns tax free.

This combination of invested cash and catastrophic coverage can be developed and marketed as a package to the buyer with several options available to the vendor. Some may choose to administer both components from within their own organization. Banks, savings and loan institutions and others could share in the administration. administration.

The Louisiana State Medical Society stresses that it will not be associated with any such plans which may be marketed. Its interest lies in the development and promotion of a concept to lower the total cost of national health care and encourage the individual to enhance his financial future through saving. Any information or materials which might be developed by the Society will be shared impartially with outside interests who may request them.

There are two distinct advantages to the investment fund concept of cash value health insurance. First, there is a far smaller profit to the administrator in the actual handling of the fund. The fee for this service is usually small, and less of it is required for overhead, because no claims review is necessary in the disbursement of an investor's own money in return for a validated voucher or receipt for medical expense.

Second, the money contributed and not withdrawn for health care expense will remain in the individual's own account, drawing interest compounded daily and enriching his estate. It is usual practice that he will receive a monthly statement showing his growth in dollars from the fund. It is anticipated that this attractive savings plan, once initiated, will encourage the investor to make continuing contributions, even when his deductible amount is already on hand. The plan by premium charge may even require this, perhaps up to the point at which he has a fund equal to a multiple of the deductible. After this he would be free to draw up on the fund to improve his standard of living.

In addition, it seems likely that the investor will soon form the habit of covering minor bills out of his pocket rather than disturbing his working capital and then having to replace it. He will draw on his investment fund only when he finds it necessary. Either way, he is using his own money and there will be less inclination to over-utilize health services than if he had prepaid his costs through an insurance premium

calculated on the average utilization of others, plus overhead and profit. While his experience must be expected to vary from year to year, over a lifetime of health care expenditures the average American will find himself far ahead.

In setting up a suitable plan, the buyer must first decide on the amount that will be his cash investment and will also be the lower limit of his catastrophic policy. This figure will usually be in the range of $2,000 to $10,000. The more he puts up in cash, the lower his insurance premium. There will be a point at which his cash investment will annually earn sufficient interest to pay his premium, making the plan self-perpetuating and self-supporting so long as he is able to pay his health care expenses without drawing on his cash account.

The optimum beginning would see the investor paying into the investment fund his deductible amount in a lump sum. For those whose resources would not allow a lump sum investment, the annual investment of a sum equal to premium cost of first dollar coverage would in time build the investment fund value to the desired level.

While initial establishment of the deductible amount may represent some financial burden to the buyer, it should be kept within reasonable limits that can be tolerated in view of the beneficial position to follow. Once this has been taken care of, his health care can be expected to become less expensive. Unless his outlay is considerably above the average, over his lifetime, then health care will be cheaper than insurance premiums at this level. There will be exceptions of course; but for *most* people it will be the economical way. There will always be a few at the upper end of the actuarial charts for whom insurance would have been a better investment, but the odds will greatly favor the individual. Annual expenses will be defrayed, perhaps covered or exceeded in many years, by the interest earned by the nest egg in the money market fund.

Below the catastrophic level, self-insurance is the wisest path for most people who can establish the necessary cushion to protect them against the possible bad year.

We believe that the investment fund idea could also have practical application in the subsidization of health care for the indigent, those in the Medicaid program.

Medicaid

This system is currently a program of health care subsidization funded by federal, state and local taxes and administered by a hodgepodge of state and federal regulations and paid fiscal intermediaries. The rising cost to tax payers was near $22 billion in 1978.

Based on certain options in the separate states, eligibility for benefits

varies widely from the situation in Arizona, where there is no Medicaid program, to that in New York, where early guidelines made even the administrators of the system eligible for its benefits. Obviously, there are indigent citizens deserving of aid who are being neglected. On the other hand, with taxable income as the principal criterion, many individuals of considerable means or net worth are eligible for assistance from public treasuries. Examples would be the children-students of the wealthy and the man who lives well on the earnings of a portfolio of tax free investments.

In-kind payments from other government aid programs such as food stamps or rent subsidy are omitted from the calculation of income for the purpose of determining eligibility. In this way, many so-called indigents enjoy a higher standard of living than others who are just slightly above the cutoff point for aid. Those admitted to the Medicaid program are given plastic cards to present, in lieu of payment for medical services, to doctors who participate in the program. To the holder, the cards represent free medical care and over-utilization is inevitable. Cards are often loaned to others who do not qualify for aid, and this practice inflates the cost further.

Government has attempted to control this unbridled demand for services by countless regulations designed to restrict the supply. Runaway demand and limiting supply combine to raise costs. In addition, the mass of regulations require more and more nonmedical personnel to administer and enforce. Increasingly large precentages of the total outlay are going for the employment of these bureaucrats, both in government and in the fiscal intermediaries. It is a fallacy that fattens itself. *(Cost excesses are invariably attacked with more regulations.)*

Payment schedules are imposed on providers in an effort to hold down costs. When a fee less than market value is paid in such programs, providers naturally are inclined to avoid the beneficiary as a patient. This further restricts supply. In the hospital, less than market value payments must be passed along to the non mediaplan patients.

There are two primary areas in which the money market concept can offer improvement in the system. One is to establish cost as a concern to beneficiaries of the Medicaid program. The other is to make administration less expensive.

With 1978 total expenses of the program at roughly $1,000 per person, suppose that the government deposited perhaps $300 of that amount in an investment fund in the name of the beneficiary each year. The account could then be administered, up to that limit, exactly as provided in our proposal. With proper authorization, the beneficiary could draw on this fund for his early health care expenses. He could consult the provider of his choice and pay him the market value for service, in cash. His incentive to spend wisely would lie in the provision that all unused equity, plus interest, would accrue to him at the end of

the year. We could expect him to regulate his own utilization of benefits until the fund was exhausted. Experience indicates that in many years, (probably most years), he could realize a profit for himself. Additionally, there would be no federal administrative cost for first dollar cost handled by the eligible beneficiaries.

The initial outlay might be less than the $300 we cite; it might be more. This is still to be determined. Whatever the amount, it would consitute a buffer zone of efficient application of the Medicaid program. Our thinking is that any amount, conceded annually to each beneficiary and used wisely, would be more economical to the nation than the current method.

When the amount on deposit in the investment funds has been depleted, as it sometimes will be during a year, then other measures would have to be utilized from that point. A catastrophic policy, either from that point or somewhere further up the scale, could be profitably adapted to the program. Bear in mind the $300 we cite is per person, thus a family of four, five , six or greater will have multiples of $300 to pay small costs. In view of the inordinately high cost of government administration at any level, the only function of government should then be the payment of the premium for catastrophic insurance.

We believe that such a plan, to whatever extent it can be applied, would provide many important controls and ensure the quality and availability of health care for the people concerned. The character of the mechanism should serve to eliminate many of the excesses and abuses being encountered. All these positive influences coincide with the goals which government has sought, fruitlessly and expensively, through regulation and inefficient enforcement supervision.

Want to Make a Bet?

Gambling is very popular in America, and most citizens are participants in one or more of the forms it takes. It is not all done in Las Vegas or Atlantic City, and many of the gamblers take bad risks without even the realization that they are, in fact, gambling.

Some gambling is legal; some is not. Gamblers, in the organized forms, fall into two categories. There are those who make bets and those who accept them. The second group must be regarded as the smarter gamblers, as they make their livings from the losses of the others. They are the ones who have learned how to correctly assess a situation and calculate the proper odds on winning and losing. This knowledge, together with the consideration of the amounts to be gained, as compared to the risk, enables them to make profitable decisions. Nobody wins every time, but the ratings reflect overall performance.

Buying insurance is a form of gambling. The buyer bets that he will get back more than he pays out, and the underwriter bets that he will not. In order to win, the buyer must take a loss on something else — his health, or his house, or his car or his life. There are individuals who will show a profit on the payment of premiums over the long haul but they are only a small minority of buyers as a group. Most will show a loss. There is one added consolation. Risk is limited. For this the buyer is willing to concede the amount of his annual premium. . .to forfeit the chance that he might also be able to save it.

Not buying insurance is also a gamble. The non-buyer bets that the money saved by not paying will more than cover the expenses he will encounter. He chooses to insure himself because he is aware that there is usually profit in it. He bets that he will escape being numbered in the small percentage of the group which will experience the bulk of total loss. He is willing to risk the small chance of a big loss to avoid the annual loss to premiums which mount up to a large lifetime deficit. It gives him more spending money as he goes along.

The wiser gambler finds a comfortable position somewhere between the two extremes. In the case of health insurance, he takes a limited risk at a level he can afford and buys inexpensive protection against the big loss he could not handle. Then he puts his risk money to work for him through investment. If his experience is not *too* much worse than average, and he can leave his nest - egg alone, it grows and enriches him.

Even this wiser gambler can be a loser, if his luck is bad enough, but at least he is not supporting the underwriter, and this puts the odds heavily in his favor. And that is what successful gambling is all about.

Conclusion - Our Advice to the American Citizen.

Never buy more coverage than you need. Since most families do not need first dollar coverage, stay away from any plans that embrace first dollar coverage. Seek limitless major medical catastrophic coverage with high maximal limits with few to no exclusions. Then make an investment of saving dollars to cover first dollar cost. Since the national admission rate to hospitals is 17.1 percent, this means that for 63.33 years of an average life of 76 years; a citizen will not incur a hospital bill. During these years you can build an estate, as this is your sensible buy.