

Health Reform – FAQs

Folks are confused, not only by the wide differences of opinion regarding the prudence of Obamacare, but by the alleged “facts” and “projections” used to support such opinions. Below are a few FAQs.

Are 30-50 million uninsured Americans failing to receive preventive and early primary care because they lack financial access to such care?

No. Some do, but nobody knows the actual number. Many receive such care from hospitals, health centers, free clinics and practitioners at no cost or supported by resources provided directly through government and philanthropy. Many individuals (often, 40% or more), insured or not, fail to seek care because of educational, cultural, geographical, practitioner unavailability or other non-financial reasons.

To provide a “guesstimate”, consider a recent Los Angeles Department of Public Health study that found that 54% of uninsured low income women received recommended mammograms compared to 68% on Medicaid and 79% with private insurance. This would suggest a gap of 14% - 25% or 4.2 - 12.5 million, or about 8.5 million.

How many deaths, costly serious illnesses and emergency room visits would be avoided if those currently uninsured - but who would avail themselves of early primary and preventive care (“guesstimate” of 8.5 million) - became insured?

Again, no one knows. There are too many confounding factors and variability among risks and conditions to even advance a “guesstimate.” For each, one has to consider not only the relatively low probability that such early care would discover new “treatable” conditions but that the influence of such treatment per se – as contrasted with genetics, life-style, treatment compliance, etc. - would be the dominant factor that controlled outcome. Especially difficult is the case of many uninsured, relatively healthy, young Americans, who view themselves as “invincible” and who are likely to continue many high - risk life-style practices regardless of medical advice. In the case of Massachusetts, the number of emergency room visits and costs

increased with implementation of universal coverage because of the scarcity of certain practitioners, another influencing factor.

How much money would be saved if those currently uninsured - but who would avail themselves of early primary and preventive care (“guesstimate” of 8.5 million) - became insured?

Probably, little to none. Assuming no extension in life-expectancy, some interventions, e.g., immunizations, have been shown to be cost-effective in reducing health care costs. Many improve health status and the quality of life (a worthwhile outcome). They also increase life-expectancy - which usually increases the consumption of health services and costs in the long term. Moreover, in some situations individual access to such primary care is not necessarily the most cost-effective approach. Consider the potential huge cost savings associated with the prevention of diabetes and other conditions attributable to the rising obesity rates in children. Community interventions and specialty medical care, even costly bariatric surgery, likely are more cost-effective.

Will the cost of individual insurance premiums and federal outlays be stabilized or decreased?

This is highly unlikely but depends upon the assumptions one makes. If those currently uninsured by choice, especially the young (who consume relatively few health services), are forced to purchase comprehensive private health insurance, premiums should stabilize or decrease. This, in turn, could allow more government plan cost-shifting to private plans, stabilizing government outlays, but decreasing the likelihood of private premium decreases. The recently proposed large private plan premium increases in California (largely precipitated by cost-shifting by a bankrupt state government) provide excellent examples.

Many young people may opt to pay a fine rather than purchase coverage, resulting in fewer dollars in the insurance risk pool than anticipated. They might also successfully prevail in a constitutional challenge to a statute that forces them to purchase “comprehensive” coverage or be fined. There are

several examples where an individual is required to purchase insurance or post a bond. If the public would be “stuck with the bill” if he or she suffered a rare, unanticipated, but catastrophic, event, e.g., mountain climbing injury requiring rescue, auto accident. However, I am not familiar with examples where the government has forced individuals to pre-buy coverage for relatively predictable, low-cost goods and services they prefer to purchase on their own or go without.

Finally, except in the case of certain hospital payments, there is a largely unanswered question of what happens to “direct” public and private resources that have been supporting the provision of primary care services for many of the uninsured, who theoretically could now pay for them. In fact, there are some proposals, e.g., Sanders, to actually increase such direct funding that would, in turn, increase federal outlays and the propensity for cost-shifting. The only true way to stabilize outlays and premiums is to decrease the volume of health services provided or reduce what practitioners and institutions are reimbursed, options which invite their own consequences.

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