

ECONOMIC DYNAMICS OF THE PUBLIC OPTION IN HEALTH CARE

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1 INTRODUCTION

In the CBO report to Congress on HR 3962 they state:

"By 2019, CBO and JCT estimate, the number of nonelderly people who are uninsured would be reduced by about 36 million, leaving about 18 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants). Under H.R. 3962, the share of legal nonelderly residents with insurance coverage would rise from about 83 percent currently to about 96 percent. Roughly 21 million people would purchase their own coverage through the new insurance exchanges, and there would be roughly 15 million more enrollees in Medicaid than the total number projected for Medicaid and CHIP combined under current law. (Under the bill, CHIP would no longer exist in 2019.) Relative to currently projected levels, the number of people purchasing individual coverage outside of the exchanges would decrease by about 6 million, and the number obtaining coverage through employers would increase by about 6 million."

The issue frankly is how many people will sign up, why, and what are the ensuing dynamics between a Public Option, PO, and Private Plans, PP. This will most likely be a market wherein people make choices, unless Congress makes it impossible to compete with a PO. The latter is perhaps a very real possibility given the nature of Congress.

The Public Option, PO, has been proposed and there has been no analytical study of what may be the market dynamics as a result of its introduction. We have commenced a study of this effect. Specifically we have constructed a model of the market dynamics of a PO and what the participation could look like under varying conditions. We will be presenting the results in a White Paper shortly. However given the intensity of the discussions we felt that an early discussion was warranted.

The analysis consists of the dynamics of patients and providers in a PO and in a private plan, PP. Specifically we look at the dynamics over time of a PO compared to a PP. We assumed that persons and providers were either in a PO or a PP. That they moved back and forth over time due to observable from the prior time interval. These driver from one to the other were either attractants or repellents.

For the person selecting a plan the attractant is the price difference between a PO and a PP. The greater the difference the more the person went to the PO. On the other hand the repellent was the quality as reflected in patients per provider. The person looked at the difference in patient per provider in a PO and a PP and the greater the difference the greater the repellent effect. Thus as more people went to a PO due to price the more patients per provider resulted which in turn became a repellent.

For the provider there are just repellents. First is the reimbursement, which is plan dependent only and not dependent upon patients. Second is the load of patients per provider.

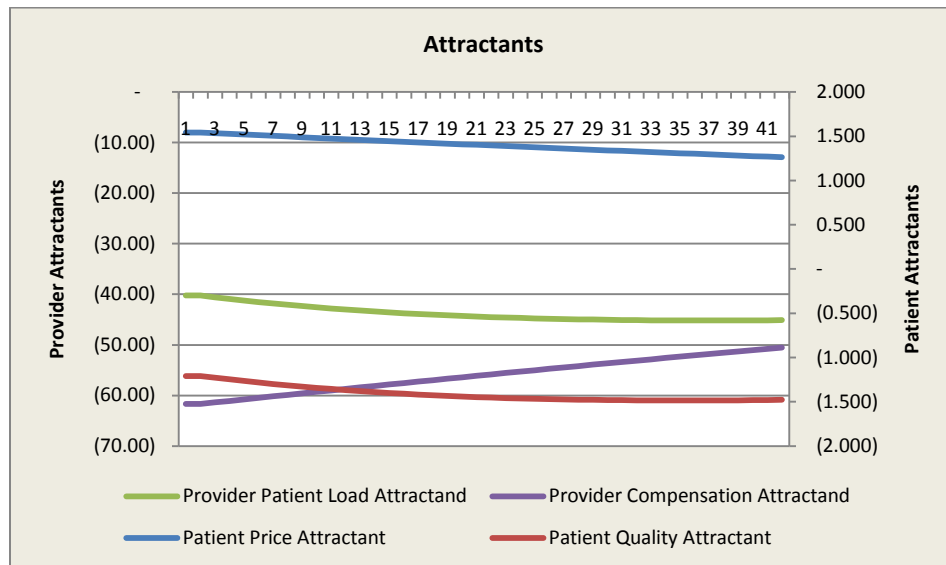
We combined these into a dynamic model of the type:

$N(k+1) = a N(k) + \text{Attractant}(k) - \text{Repellent}(k)$, where N is the number of persons say in a PO

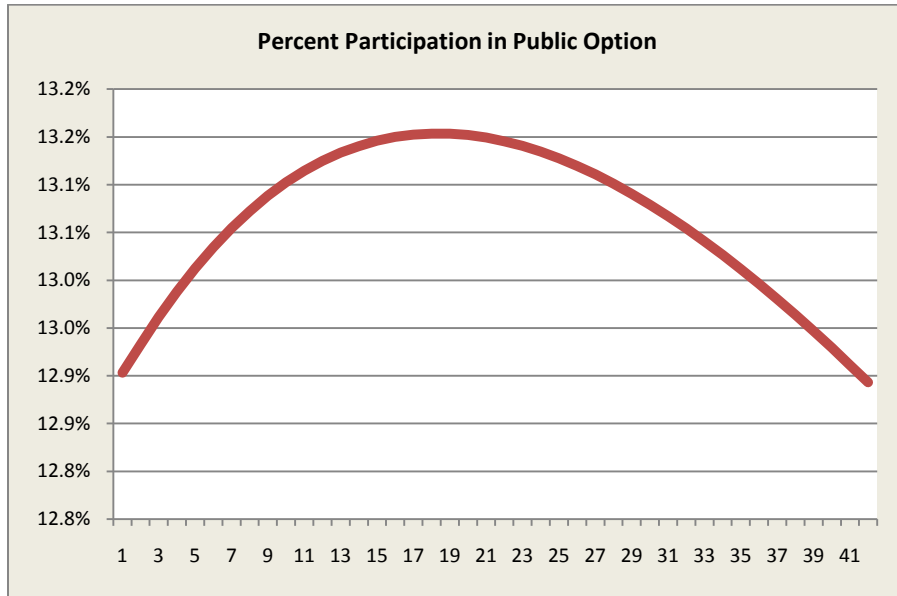
and

$P(k+1) = b P(k) + \text{Attractant}(k) - \text{Repellent}(k)$, where P is the number of providers.

Calculations for attractants, repellents are negative attractants, are shown below:

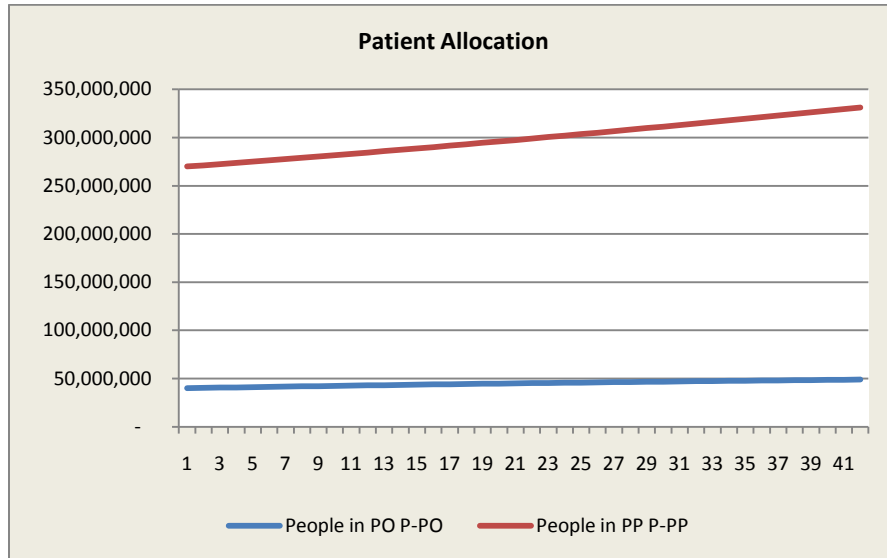


These are of course subject to change but they demonstrate the viability of the approach. Now using these values we can determine the percent of the people who will participate in a PO plan and we show its dynamics below:

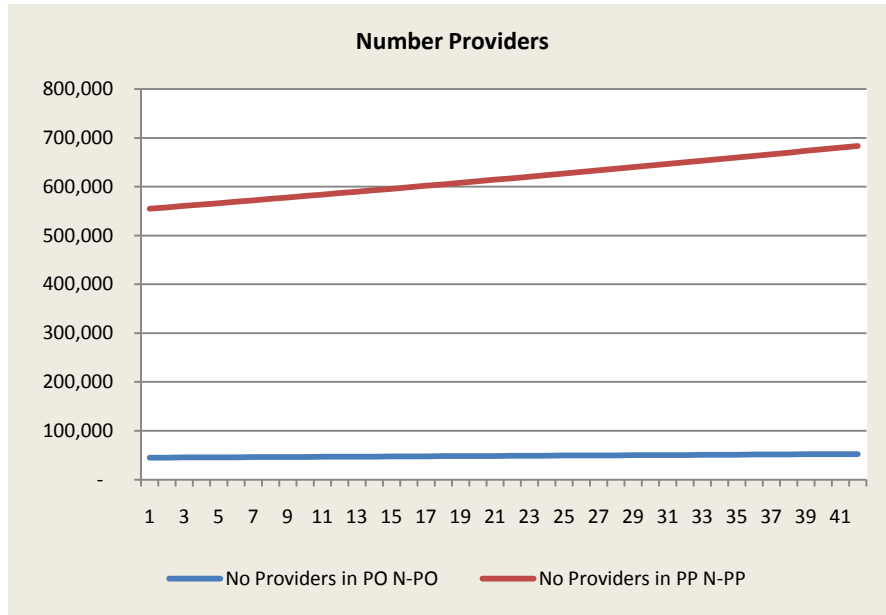


Note that this shows an increase and then a decrease. This effect is first driven by cost, lower costs of the plan, and then driven by the lower quality where subscribers leave the plan.

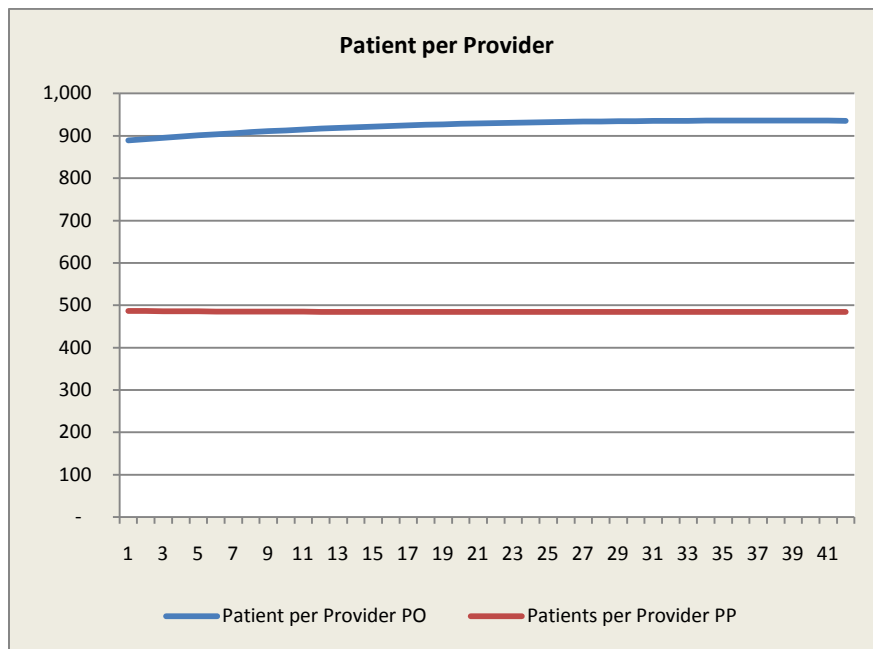
We now depict the patient participation.



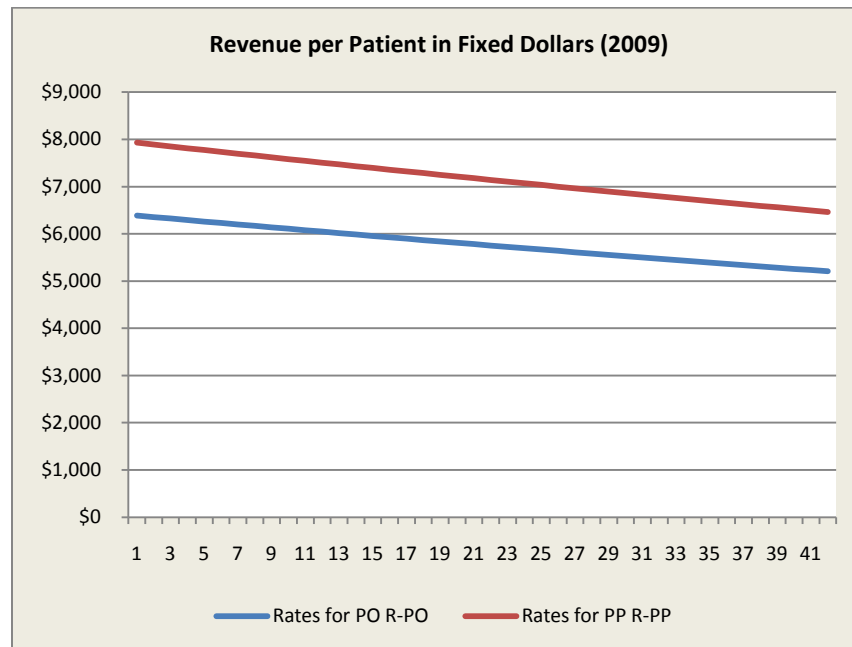
The following is the provider participation. In all analyses we have found low provider participation. This is similar to what we see in Medicaid and what we are beginning to see in Medicare. There is a growing refusal by many, especially the most competent physicians, to participate. If one wants good care one must pay.



The patient per provider ratio has the most impact in our analyses. The numbers are shown below for this example.



The revenue per patient is also a factor but seems to be secondary. We depict that below:



We believe that detailed studies of this type are essential. We also believe that systems type analysis are not what the economists do. They fall into two camps. The macro type who conjure up slopes of trends, which are meaningless and fail to account for the dynamic factors or the econometric types who used old data to project new trends, which have the seeds of their own destruction already sown.

The major concern we have is the providers ability to opt out of a PO. We have not yet studied the massive 1990 page Bill in detail, but that is a concern.

The CBO has issued their report on the latest health care plan, HR 3962. The CBO states:

"According to CBO and JCT's assessment, enacting H.R. 3962 would result in a net reduction in federal budget deficits of \$104 billion over the 2010– 2019 period (see Table 1). In the subsequent decade, the collective effect of its provisions would probably be slight reductions in federal budget deficits. Those estimates are all subject to substantial uncertainty. The estimate includes a projected net cost of \$894 billion over 10 years for the proposed expansions in insurance coverage. That net cost itself reflects a gross total of \$1,055 billion in subsidies provided through the exchanges (and related spending), increased net outlays for Medicaid and the Children's Health Insurance Program (CHIP), and tax credits for small employers; those costs are partly offset by \$167 billion in collections of penalties paid by individuals and employers. On balance, other effects on revenues and outlays associated with the coverage provisions add \$6 billion to their total cost."

The CBO presents a good summary of the PO part of the Plan which they summarize as:

"Policies purchased through the exchanges (or directly from insurers) would have to meet several requirements: In particular, insurers would have to accept all applicants, could not limit coverage for preexisting medical conditions, and could not vary premiums to reflect differences in enrollees' health. The options available in the insurance exchange would include private health insurance plans as well as a public plan that would be administered by the Secretary of Health and Human Services (HHS). The public plan would negotiate payment rates with all providers and suppliers of health care goods and services; providers would not be required to participate in the public plan in order to participate in Medicare. The public plan would have to charge premiums that covered its costs, including the costs of paying back start-up funding that the government would provide."

The CBO report as usual is the best summary. It is worth a first read. However it will be essential to best understand the dynamic market behavior of the plans.

2 BASIC PRINCIPLES

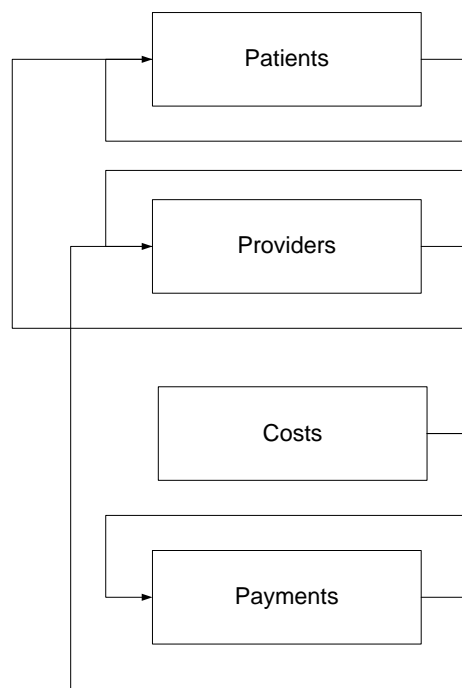
In this section we present the framework of the model and then in the following section we detail an analytical version. We introduce a simple but dynamic model of a two element market composed of a PO and a PP. The consumer gets to select one. The consumer makes a choice once a period and can move freely back and forth.

The consumer selects the plan on the basis of its price and its quality in some form of combined utility function. We select a simple one for this analysis. In a similar fashion the providers can select to opt in or opt out, namely the providers are either PP or PO. There is no mixing of services. This may be the most extreme position in this model.

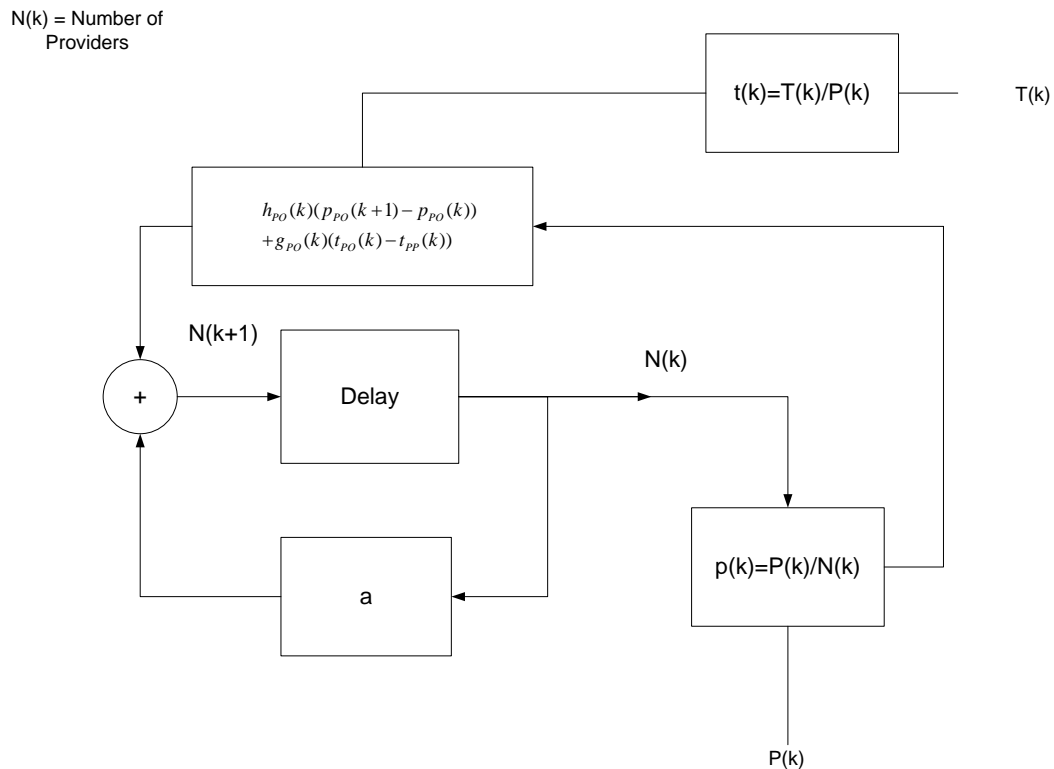
2.1 Basic Variables

We start with a high level definition of the variables. We show them in the Figure below. Simply they are patients, providers, costs and payments. They are all interrelated as one would expect. The costs are assumed to be exogenous and beyond control. As we have stated before we believe that they too can be controlled.

The patients can choose one plan or the other and they switch based upon some preference or utility function on a set date. The providers can likewise do them same. Thus the model shown below also indicates the feedback inherent in its makeup.

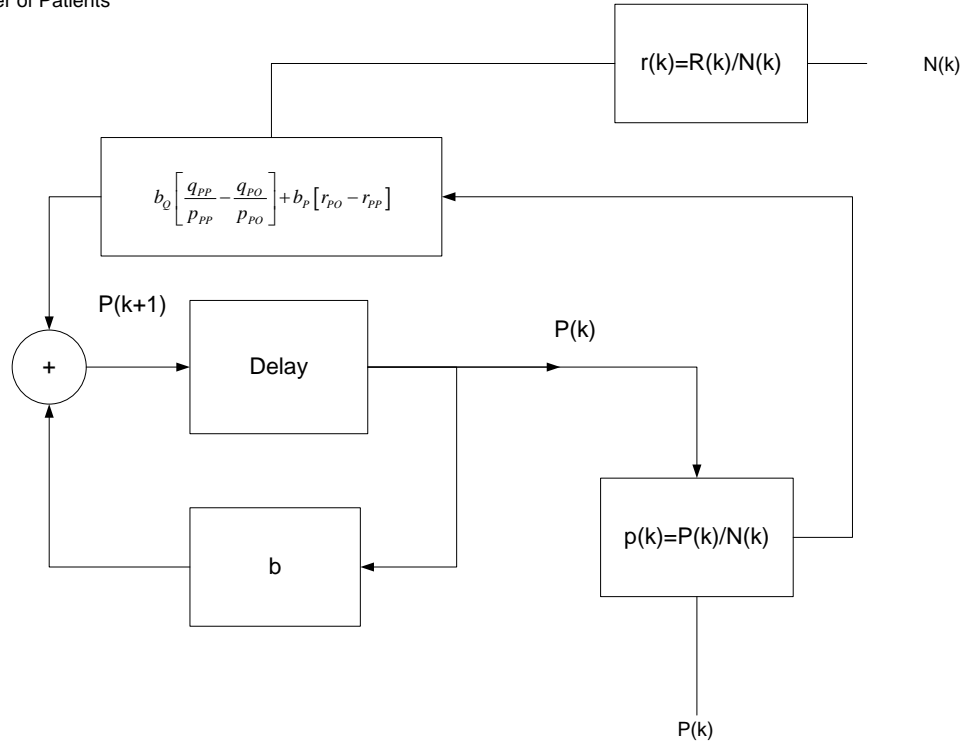


Now we look at the provider model. The system generating it is shown below. We will now demonstrate its operation.

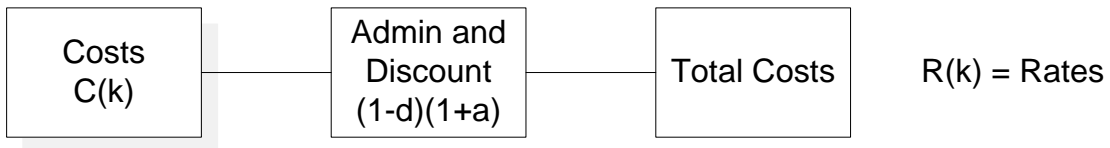


In a similar fashion we demonstrate the patient model as shown below. It is similar to and linked to the provider model.

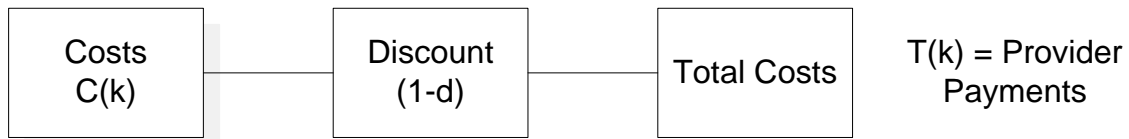
$P(k)$ = Number of Patients



The third element is the exogenous cost model. We will assume no increase in costs other than those of patients. If we did the change would be nominal since the selection function would be adjusted for inflation and cost increases. That is we normalize cost in the selection process. However we also believe that we can relieve that restriction and will do so later.



Finally we have the payments to providers.



These are the elements.

2.2 Economic Interpretation

Now we briefly discuss the economic principles in this approach.

First is the attractants, or in reality the repellants for providers in the PO. Here they repellants are twofold; lower compensation and higher patient load. The lower the compensation the more who leave the PO. We see this in Medicare and we see it also beginning in Medicaid. The second is the patient load. Having just too many patients is a recipe for loss of participants. Typically a provider may have 1,000 patients of which 200 maximum are seen in a week and 20% or less are the most common visitors. The typical internist may have 20% of his patients he sees solely for a checkup.

The attractant for the patient is cost. The lower the price the more they may want to select that option. Yet this is not a bright line test. We assume that it is using a classic demand function. Yet in reality it is much more complex. The repellant for the patient is quality in terms of patients per provider. The higher that number the lower the quality and the greater the repellant effect.

3 THE MODEL

We now develop a simplified model for what might occur with the implementation of a public option.

3.1 Provider Model

We start with the following. Let $N(k)$ be the total number of health care providers at time k . They are divided into three groups:

$N_{PO}(k) = \text{Number in Public Option}$

$N_{PP}(k) = \text{Number in Private Plans}$

$N_D(k) = \text{Number Dropping from Profession}$

$N(k) = N_{PO}(k) + N_{PP}(k) + N_D(k)$

$N(k+1) = N(k) - N_D(k)$

3.2 Patient Model

Now let us also assume that we have a total Population $P(k)$ and it is also divided into two groups as follows:

$P_{PO}(k) = \text{Number in Public Option}$

$P_{PP}(k) = \text{Number in Private Plan}$

$P(k) = P_{PO}(k) + P_{PP}(k)$

$P(k+1) = (1 + \alpha)P(k)$

Now we also have ratios of People per provider, p , as follows:

$$p_{PO}(k) = \frac{P_{PO}(k)}{N_{PO}(k)}$$

and

$$p_{PP}(k) = \frac{P_{PP}(k)}{N_{PP}(k)}$$

3.3 Pricing Model

Now let us focus on the costs. Let $C(k)$ be the exogenous total true costs of providing health care for the total population. Now let us define the prices charged for health care is defined as $R(k)$ and delineated as follows:

$$R_{PO}(k) = (1 - d_{PO}(k))(1 + a_{PO}(k))c(k)P_{PO}(k)$$

and

$$R_{PP}(k) = (1 - d_{PP}(k))(1 + a_{PP}(k))c(k)P_{PP}(k)$$

where

$$c(k) = \frac{C(k)}{P(k)}$$

where d is the discount and a is the administrative overhead

These costs can then be written on a per person basis as follows:

$$r_{PO}(k) = \frac{R_{PO}(k)}{P_{PO}(k)}$$

$$r_{PP}(k) = \frac{R_{PP}(k)}{P_{PP}(k)}$$

Now the price per person per plan will be a determinant in the selection of such a plan. It will, however be one of many determinants.

3.4 Payment Model

Consider now the total payments made to providers for the care provided:

$$T_{PO}(k) = (1 - d_{PO}(k))c(k)P_{PO}(k)$$

and

$$T_{PP}(k) = (1 - d_{PP}(k))c(k)P_{PP}(k)$$

The problem with the above is that if the discount on the PO is significant then for the providers to recover costs the discount for PP must be negative! Otherwise costs will never be covered. We also assume that:

$$C(k+1) = C(k) + a_C C(k)$$

The economics creates a flow of patients from one plan to another based solely on the price charged, to a degree. That is:

$$P_{PO}(k+1) = P_{PO}(k)(1+\alpha) + b_{PO}(r_{PP}(k) - r_{PO}(k))[P(k) - P_{PP}(k)]$$

and

$$P_{PP}(k+1) = P_{PP}(k)(1+\alpha) + b_{PP}(r_{PO}(k) - r_{PP}(k))[P(k) - P_{PO}(k)]$$

such that

$$P(k+1) = P_{PO}(k+1) + P_{PP}(k+1)$$

which equals:

$$P_{PO}(k)(1+\alpha) + P_{PP}(k)(1+\alpha) + (b_{PO} - b_{PP})(r_{PP}(k) - r_{PO}(k))P(k)$$

if we have:

$$b_{PO} - b_{PP} = 0$$

we have the identity.

This states that if the Public Option is cheaper than the Private Plan there will be a steady migration. We can modify this with some base return depending upon quality and income. We defer this until later. In our first model we drive this by price only.

We now define quality of care in terms of the ratio of physicians per patient. The logic is that the more patients per provider the less care and attention the patient will obtain. Also the quality may be determined by the quality of the provider themselves. Thus we may add a provider quality to this. One could also assume that the provider metric is dependent on the payment per provider. Let Q represent a quality metric. Thus we have for one possible quality metric the following which depends on the p ratio only:

$$Q_{PO}(k) = \frac{q_{PO}(k)}{p_{PO}(k)}$$

and

$$Q_{PP}(k) = \frac{q_{PP}(k)}{p_{PP}(k)}$$

where Q may depend on total compensation as well. Namely:

$$q(k) = f(T(k)) = fT(k)$$

or some other form, such as an additive form.

We can see that if we add the quality metric to the patient growth then we have the following general concept:

1. Patients flow to the PO if the cost is lower.
2. Lower costs mean lower payments and this drives out providers.
3. Less providers then increases patients per provider and thus reduces quality.
4. Lower quality drives out patients from the PO into a PP even at a higher cost.

The attractant is given by:

$$\text{Price Attractant} = b_p(r_{PP} - r_{PO})$$

That is if the PP has a larger price than the PO then the driver is the positive cost difference weighted by some constant b.

Now the quality attractant is:

$$\text{Quality Attractant} = b_Q(Q_{PO} - Q_{PP})$$

But we have just shown that:

$$\text{Quality Attractant} = b_Q \left[\frac{q_{PO}}{P_{PO}} - \frac{q_{PP}}{P_{PP}} \right]$$

Thus the combined attractant is:

$$\text{Total Attractant} = \text{Quality Attractant} + \text{Price Attractant}$$

$$= b_Q \left[\frac{q_{PP}}{P_{PP}} - \frac{q_{PO}}{P_{PO}} \right] + b_P [r_{PP} - r_{PO}]$$

$$= b_Q \left[\frac{1}{P_{PP}} - \frac{1}{P_{PO}} \right] + b_P [r_{PP} - r_{PO}]$$

$$= b_Q \left[\frac{N_{PP}}{P_{PP}} - \frac{N_{PO}}{P_{PO}} \right] + b_P \left[\frac{R_{PP}}{P_{PP}} - \frac{R_{PO}}{P_{PO}} \right]$$

Note that in the above, the denominator for the attractants is the P values from the prior interval. Thus the attractant for P(k+1) is inversely dependent upon P(k). Now as r of the attractant for the PO gets smaller than the r of the PP then the price attractant increases.

However, and this is a complex issue, the quality attractant depends upon P in the PO and N the physicians in the PO, which if the payment decreases the N decreases and thus the quality attractant decreases as well. That is the price attractant depends positively upon R, the rate charged and negatively upon R the rate charged in the quality element.

There is a point where quality attractant equal price attractant and at that point there is indifference between the two. We define this below:

Quality Attractant = Price Attractant

$$b_Q \left[\frac{q_{PO} - q_{PP}}{p_{PO} - p_{PP}} \right] = b_P [r_{PO} - r_{PP}]$$

$$b_Q \left[q_{PO} - q_{PP} \frac{p_{PO}}{p_{PP}} \right] = b_P p_{PO} r_{PP} \left[\frac{r_{PO}}{r_{PP}} - 1 \right]$$

or simplifying as before:

$$b_Q \left[1 - \frac{p_{PO}}{p_{PP}} \right] = b_P p_{PO} r_{PP} \left[\frac{r_{PO}}{r_{PP}} - 1 \right]$$

We can further reduce this equality condition by including the dynamical relationship between N, P, R, and T. We defer that until later.

3.5 Provider Model Again

Finally we define the migration of providers also by the measure of compensation as well as patients per physician.

$$N_{PO}(k+1) = N_{PO}(k) + h_{PO}(k)(p_{PO}(k-1) - p_{PO}(k)) + g_{PO}(k)(t_{PO}(k) - t_{PP}(k))$$

and

$$N_{PP}(k+1) = N_{PP}(k) + h_{PP}(k)(p_{PP}(k-1) - p_{PP}(k)) + g_{PP}(k)(t_{PP}(k) - t_{PO}(k))$$

where

$$t_{PP} = \frac{T_{PP}}{P_{PP}} \text{ and } t_{PO} = \frac{T_{PO}}{P_{PO}}$$

thus

$$N_D(k+1) = N_D(k) + [N_{PO}(k+1) - N_{PO}(k)] + [N_{PP}(k+1) - N_{PP}(k)]$$

This can be simplified as follows:

$$N_{PO}(k+1) = N_{PO}(k) + h_{PO}(p_{PO}(k-1) - p_{PO}(k)) + g_{PO}(t_{PO}(k) - t_{PP}(k))$$

and

$$N_{PP}(k+1) = N_{PP}(k) + h_{PP}(p_{PP}(k-1) - p_{PP}(k)) + g_{PP}(t_{PP}(k) - t_{PO}(k))$$

and

$$N_D(k+1) = N_D(k) + [N_{PO}(k+1) - N_{PO}(k)] + [N_{PP}(k+1) - N_{PP}(k)]$$

4 ANALYSIS OF EXAMPLES

We presented an example in the introduction and here we will present another such example in a bit more detail.

4.1 Limitations

Before commencing it is necessary to delineate the limitations of the model. They are:

1. **Limited Complexity:** The current model detailed in the previous section is a simple and non-complex design. It uses few attractants with simplistic form. The issue of attractants for demand may in fact depend upon much more complex quality measures albeit dependent on the simple pricing dependencies as described. However, on the price elasticity, it may be much more complex and depend on income, that is the elasticity will be population segment dependent. Richer people will be willing to pay more for a plan and also have a greater sensitivity to the quality metrics. We do not know the full details of this interaction.
2. **Minimal Elasticity Design:** The elasticity design as discussed above for the gross attractants may be carried many layers down including salaries, income, and a wealth of other demographics. Also the model shows changes made on an annual basis.
3. **Uncertain Constants:** The specific values we have used are arbitrary at this time. There does not appear to be an research to assist in this matter.
4. **Limited Lag Structure:** We assumed that single lags reflect the behavior. This may not be the case. Multiple lags may exist, namely memory may be a key factor in the system.
5. **Lack of Stochastic Elements:** There are no random process factor here, no noise or uncertainty. One would expect that there will be erratic changes modeled by point process models.

4.2 Base Constants

The following Table depicts the constants for the model, their selected values, and the units in which they are measured.

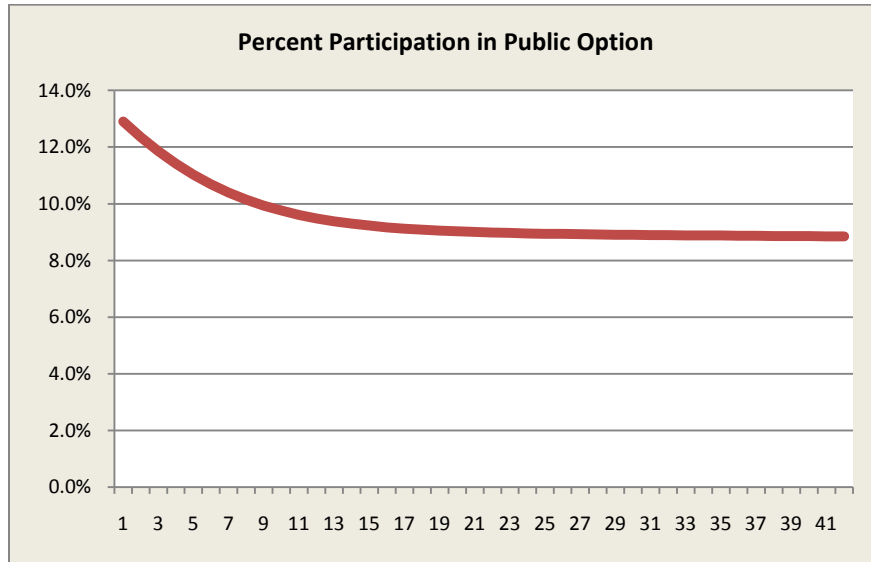
<i>Constant</i>	<i>Value</i>	<i>Units</i>
Population Growth Rate	0.50%	% increase pa
Annual Cost Increase	6.00%	% change pa
PO Discount	20.00%	% from Costs
PP Discount	5.00%	% from costs
PO Admin	10.00%	% of costs
PP Admin	15.00%	% of costs
Provider Growth Rate	0.50%	% change pa
Price Attractant Ratio	0.001	Change in patients per \$ per 1 M patients
Quality Attractant Ratio	10,000	Change in patients per quality of provider/patient per 1M patients
Provider Patient Load Factor	5.00	Change in No Providers per year per change in 100,000 patient load
Provider Reimbursement Factor	0.10	Change in No Providers per year per change in \$100,000 reimbursement
Annual Cost Increase in Care	0.00%	% annual change

As we have stated above the list is hardly inclusive. The values are reasonable yet most likely far from reality. The model is useful to ascertain the types of things which may happen. If we recall the first section we saw a percent adoption of a PO which increases and then decreases. We show another form in this section.

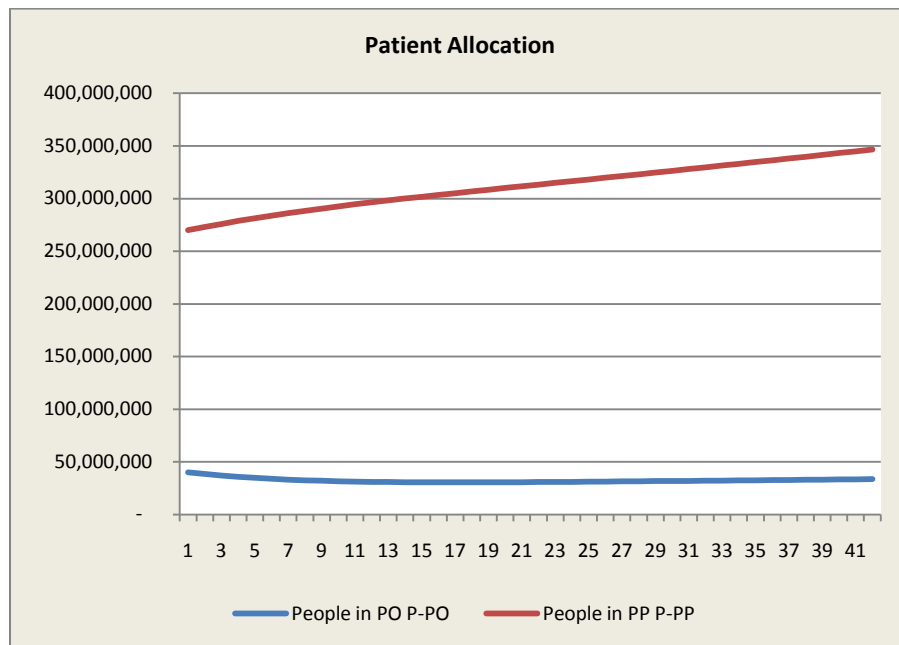
4.3 Model Results

The following are the results from these data set presented above.

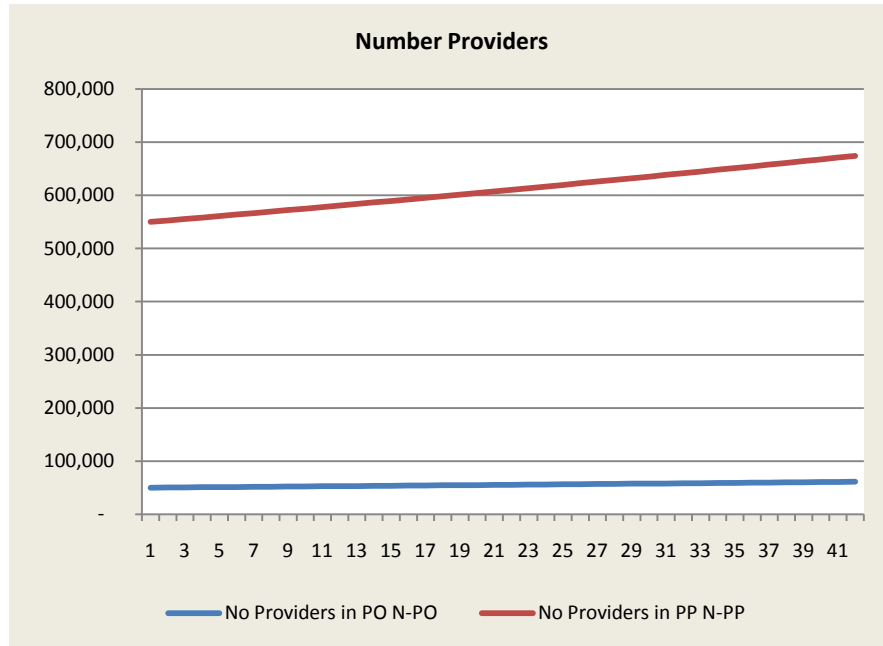
The first result below shows the change in percent acceptance of a PO. We suspect that the constants used here end with a stable point lower than the start. The model here may have stronger effects from quality where the consumers were willing to pay more.



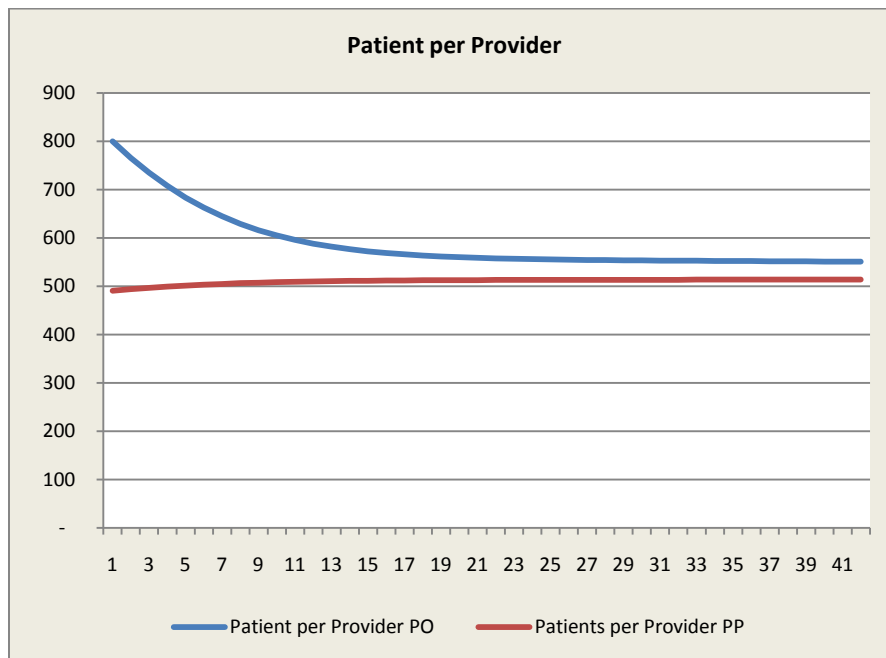
The following chart shows the split between the PO and PP. In this Figure it can be seen that all growth is in the PP and a loss in the PO.



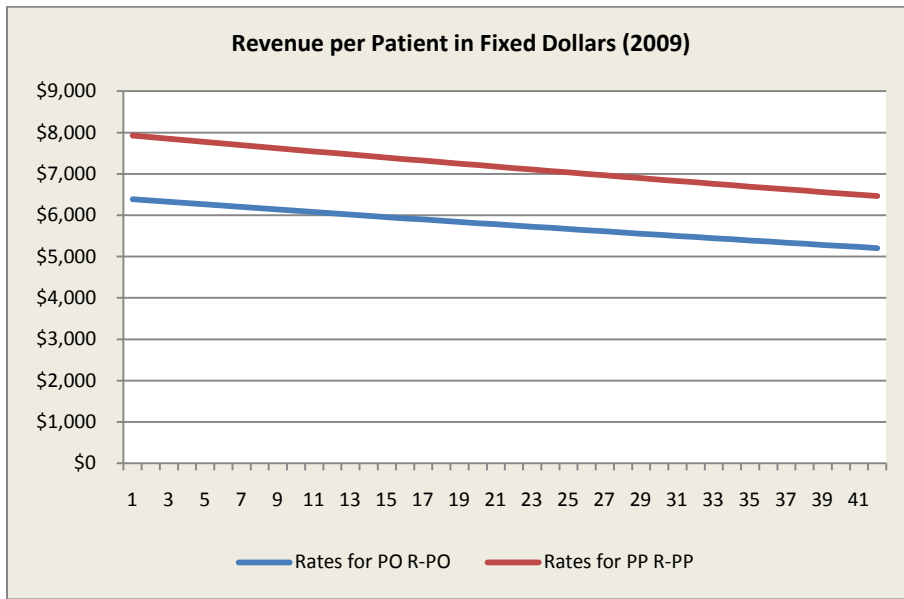
The same analysis for the providers is shown below. We have seen that in most configurations the growth always occurs in the PP and not in the PO.



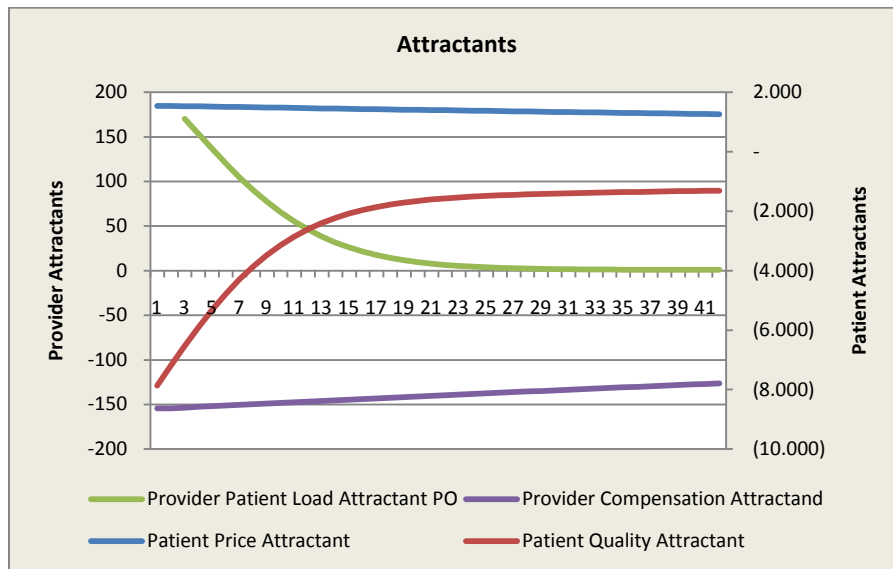
The ratio we see controls quality is the Patient per Provider. This we show below. It is the quality gap which drives patient's "perceptions" of quality. It is not clear what the true metric for quality is as perceived by the patient.



The following is the revenue per provider. This is one of many factors driving the providers from the PO to the PP. The second is also the patients per provider or load. There may be many more and we are yet to understand them.



Finally we shows the attractants and their dynamics over time. It may be worth comparing these to what we presented earlier.



5 CONCLUSIONS

5.1 The Process of Negotiating

In looking at the Health Care debate has progressed I was reminded of the work by Amy Gutmann and Dennis Thompson on what they have called Deliberative Democracy. I will use their latest book, *Why Deliberative Democracy*, as the source for my current comments.

The authors state (p 7):

"...we can define deliberative democracy as a form of government in which free and equal citizens (and their representatives) justify decisions in a process in which they give one another reasons that are mutually acceptable and generally accessible with the aim of reaching conclusions that are binding in the present on all citizens but open to challenge in the future."

Gutmann and Thompson then apply their definition to three examples of which I will discuss. They are:

1. **Iraq War:** In essence their argument was that the process failed to meet the requirements of a deliberative democracy by delimiting the discussion and having certain issue inadequately revealed and discussed. They contend that the debate should have lasted longer. In my view there were other issues as well. One was that the "Bush Doctrine" of a pre-emptive war was not fully understood by the populace, albeit the US had done this before, yet not to this scale. Second there was a strange tension in the US between the lingering strain of 9/11 and the massive separation politically of anti-Bush and everyone else in the electorate. I here argue that the political separation was "anti-Bush" and everyone else because I believe that those not anti-Bush were not necessarily pro-Bush, just anti-anti-Bush. One then wonders in such an environment how the above definition could ever function in the first place.

2. **California Governor Recall Referendum:** They then critique the 2003 California Referendum on the Governor and basically state that the Referendum process is inherently flawed. They state without any basis in fact that "Because neither the procedure nor its results could be said to be democratic in the simplest procedural sense....judicial intervention to correct some of the defects may be called for..." (p 60) This is amazing because the Referendum process is in and of itself a full Democratic process, rant with chaos and confusion, yet a process where one person and one vote counts. It may make California look like Italy but alas it may truly be such. Gutmann and Thompson disdain the true chaos of democracy if one takes their words at face value.

However one of the more concerning comments in this section regarding California is the Gutmann comment on Educational systems for she seems to believe that the function of educational institutions is to train people to think correctly. Furthermore to train them to think cohesively in a manner compliant with her definition of deliberative democracy. She states:

"To prepare their students for citizenship in a deliberative democracy, schools should aim to develop the capacities of the students to understand different perspectives, communicate their understandings to other people and engage in the give and take of moral argument with a view toward making mutually justifiable decisions." (p 61)

This is highly laudable but she seems to mean that in the context of certain strictures and world views.

3. Cervical Cancer Testing: The authors then discuss a case as to whether an HMO should be made to pay for a patients test for cervical cancer which goes beyond the standard Pap test. Here they apply the principles of deliberative democracy to having a free and open discussion including the HMO to decide this. One may look at this in another manner, namely if the test gives one more comfort, then one may just pay for the test themselves and not demand that the HMO do so. Or better one may choose another plan which may already pay for it. This argument for deliberative democracy is trumped by a simple economic rule: if something has perceived value to me then I can and should pay for it. It is not one where I am owed something and if I just haggle long enough I will get it. Thus this third example is specious at best.

Now how does this apply to the current Health Care debate. I believe that it is spot on. At least with Iraq there were confrontational hearings and an across the board vote with a large majority in favor. In Health Care it is like pulling hen's teeth to get the copy of the bill, it is discussed behind closed doors in an exclusionary manner, it is much less democratic than any other such process and it will have a down the middle party vote. One could not think of a less deliberative democratic process. Those opposing it are almost called traitors by the other side and the attempt is to marginalize them. One may then ask, where are the Gutmanns and Thompsons on this issue, for here is a truly critical issue calling for deliberative democracy.

5.2 Romer and Impacts

The head of the CEA gave a speech recently regarding health care. One must remember that this is the same individual who so correctly predicted the economic impact of the Stimulus, thus we suspect that her prognostications are to be less than accurate.

However it is worth seeing what she says:

"The Senate Finance Committee bill includes a tax on high-priced insurance plans, suggested by Senator Kerry. A policy along these lines, designed carefully, will encourage both employers and employees to be more watchful health care consumers. It will discourage insurance companies from offering high-priced plans that would otherwise eat up larger and larger shares of workers' wages. A policy such as this is probably the number one item that health economists across the ideological spectrum believe is likely to stem the explosion of health care costs."

When one analyzes the effect of the high cost plans they appear to impact Goldman Sachs and Union employees. For the most part Americans are on the budget plans. A high end plan is paid for by someone, the employer or even the individual. How taxing them reduces costs has never been explained. They cover a small percentage of people and they do not in any way drive up demand or increase incidence. There just is no line around the block waiting for colonoscopies.

She continues:

"Several of the current versions of health insurance reform include sensible payment reforms for doctors, hospitals, and other providers participating in Medicare. For example, bundling payments for an episode of care associated with an acute event, such as a heart attack or a hip fracture, is a common-sense change. It gives doctors and hospitals the right incentives to provide patients with efficient and high-quality care, and the information they need to manage the transition back home successfully. These incentives improve patient care and outcomes, while lowering costs in the long run."

As we have stated before and as we have detailed in our [Book on Health Care](#) the use of bundling will just memorialize the inefficient structure of hospitalized care and drive out physician based innovation. Bundled Care is a hospital controlled service and it forces collectives of low cost physicians which generally provide lowered levels of care. It maximizes the hospital's return.

She continues:

"Precisely because such reforms are so important for both cost containment and patient health, it is crucial to create an institutional structure that encourages and routinizes such innovations. That is why the President has endorsed the establishment of an Independent Medicare Advisory Council (IMAC). The IMAC would provide Congress each year with cost-saving recommendations that improve care and maintain benefits. By removing some of the political pressure around such reforms, the IMAC would make it easier for improvements to be made year after year..."

The IMAC in principle is not new for it is but a regeneration of what Medicare has been doing all along. By the time a person has gotten on Medicare two facts are clear. First they have contributed more than they will ever get back in benefits, the money having been spent by Congress. Second, the ability to modify any potential disease states is de minimus.

She continues:

"Recent CEA research suggests that the total fiscal impact of health care reform may be even larger than our baseline estimates suggest. As I have described, current draft legislation greatly expands access to health insurance coverage. This change is crucially important for state and local governments that currently pay for much of the care provided to the uninsured. Using a wide range of sources, including state reports, county records, and numerous phone surveys of local officials, the CEA has provided lower-bound estimates of the amount that sixteen states currently spend on care for those without insurance. We find that these sixteen states are spending at least \$3.6 billion per year (in 2007 dollars) on this uncompensated care. We estimated that they are spending another \$600 million on higher insurance premiums for state and local government employees because of the hidden tax uncompensated care adds to all private insurance premiums. All told, the states in our sample are spending at least \$4.2 billion on care for the uninsured each year."

First one must see that these are CEA estimates which we have seen are less than worthless. Second her analysis grossly neglects the issue of reducing demand, such as that of Type 2 Diabetes due to obesity. Ms. Romer, we wonder why?

5.3 Regulation and Its Impact

The Senate Finance Committee initially rejected the Public Option. It appears as if the Democrats on the extreme left still are holding fast but one is now led to ask what is the true meaning of their actions. To understand this better we must see what seems to be already agreed to.

The Plan as it seems to be evolving has the following characteristics:

1. The providers of insurance will be any and all existing insurance providers. There generally will be no limitation.
2. The offerings will be regulated by the Government in terms of what is covered and what price ranges can be charged.

3. There most likely will be a Government regulator akin to say the FCC, or in the old days the ICC which regulated trucking, the CAB which regulated airlines or the FERC which regulated energy prices.

Thus one could envision a health insurance infrastructure regulated like common carriers were regulated for years. They have to meet certain standards, they have to have cost justifications or even caps, they have to be open to all comers, thus the common carriage model, and they will cross state lines thus being regulated via a commerce clause set of rules.

To understand the dynamics of this one need but read the classic by Alfred Kahn, *The Economics of Regulation*, which was the seminal work which led to the elimination of regulation on airlines and trucking. Namely we could envision the recreation of a CAB or ICC for health insurance with such things as rate caps and regulatory rules akin to what we had in those industries.

Yet one should remember that when we had a CAB, airlines were costly but they ran on schedule and they were actually enjoyable. Now with unregulated airlines we have cattle cars and experiences that drive people to walk. Thus perhaps regulation is better than no regulation.

Thus one could expect a new Government Agency, akin to the FCC, a creature of Congress not of the Executive with some balance in representation, creating rules, managing costs and reducing everything to some common denominator. Is this good or bad? Clearly the FCC has had its downs and really downs, not very many if any ups, but the ICC and CAB actually made life better, air travel was better and moving furniture was less risky and one knew the costs. Thus the correct regulatory environment has merits. On the other hand look at the SEC, it has done a poor job at best. Thus it appears as if we are entering a new regulatory environment.

On the positive sides this may allow transparency, cost control, openness akin to a common carriage domain, and yet a political animal. As long as this new agency does not pick winners or losers, namely selecting treatments based upon some wisdom of a Government regulator, it may actually be a great benefit.

But one must remember that things do not remain static. The industry will then consolidate and seek regulatory relief and find ways to circumvent the restrictions. One need only read Steve Coll's book the *Deal of the Century* to see the end game. The dynamics of a regulated regime will play out. Namely we will see a dynamic as follows:

1. Initial compliance by all insurance companies.
2. The loss of small ones who cannot compete.

3. The consolidation into massive insurance providers as we see in telephony, ultimately being a mere handful if not one.
4. The control of regulation slips from regulator to the regulated as happened in AT&T.
5. Congressional action to break up the giant.
6. Re-institution of deregulation.

And the process continues. In a strange sense it is a material dialectic, pure Marxism carried out in thesis, antithesis and synthesis. Then it starts again.

If this is what is most likely to happen then why are the extreme left wing Democrats pursuing so much for a public option. Is it that they want competition or is it something else. "Thou dost protest too much..." is most likely the case. This natural evolution to a nationally regulated system delivers what we all seek, at least those seeking universal coverage. The public option is really the camel's nose in the tent for a Government operated health care system. So why are they not honest, because very few want that solution. We never nationalized AT&T.

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