LETTING INSURANCE WRITE THE BILL: HOW BAD IS THAT?

Ezra has written a thoughtful follow-up to my complaint that discussions of the role of insurance company in writing our legislation neglect to discuss profit. I agree with parts of it and disagree with others. The most important point Ezra makes—which explains his focus on providers to the exclusion of insurance companies—is this passage:

> The insurance industry is not a particularly profitable industry. To be more specific, they're the 86th most profitable industry as measured by profit margins, with an average margin of 3.3 percent. That's lower than drug manufacturers (16.5 percent), health information services (9.3 percent), home health care (8.4 percent), medical labs and research (8.2 percent), medical instruments and supplies (6.8 percent), biotech firms (6.7 percent), generic drug manufacturers (6.6 percent), and much else. That's not to pretend that 3.3 percent is nothing, but it's hard to see how that's a primary driver of health-care spending, much less the *growth* in health-care spending.

With that in mind, let's take a step back to the question that started this series of posts—Matt Yglesias' question, "how bad is that?" if the insurance industry writes our health care reform bill. With now several bills on the table along with the Max Tax framework and the President's framework, how bad is it to let corporations necessarily motivated by profit maximization write the bill?

Short of our entire political system changing tomorrow such that single payer became feasible

(which would make Ezra, Yglesias, and me all very happy), what we're going to do instead is put tens of millions of people into the health insurance system who aren't currently there. The question is, how to do it for the best outcome at lowest cost to taxpayers and individuals. Some of those people will be put into the system via Medicaid, though a great many will be put into the system directly via insurers. Importantly, those put into the system via insurance will be mandated to buy insurance. Some will be subsidized by the government, though others will not.

So the insurers will be getting tens of millions of new customers, and those new customers with financial constraints will be subsidized by the government but others will not.

Now, in his first post, Ezra wrote:

> If you want cost control, though, you're going to have to follow through on one of these strategies, and that's going to mean making providers and patients really angry. Both like the health system better when it's got unlimited amounts of money flowing through it. It's actually easier for me to imagine a system with private insurers that holds costs down than a system with the current provider reimbursement rates and relatively passive insurers (be they private or public) that holds costs down.

Of course, that's not entirely right. Patients whose health care is provided by their employer "like the health system better when it's got unlimited amounts of money flowing through it." Patients who have to pay out of pocket—like many of the ones who will be mandated to buy insurance—don't really like that so much. And it's not just patients and providers that like a system that's got unlimited amounts of money flowing through it. So do insurers (assuming you understand this to be a system as a whole). Even

assuming insurance companies only make that 3.3% profit and setting aside things like huge executive incomes, the insurance companies have an incentive to have as much money flowing into the system that it can take its 3.3% profit on.

And that's one of the baseline problems with letting the insurance companies write the bill: they have just as much incentive as providers to see that as much money gets flowing into the system as possible. And, they have an incentive to make sure that as much of the money put into the system as possible stays in their pocket. For those affected by the mandate who will not be subsidized or will only be partially subsidized, it is actually the patient, and not the insurance company, with the most urgency to cut the amount of money flowing through the system. But the patient doesn't get to write the bill; the insurance company does, and it appears that it is with these patients that the insurance companies stand to make some of their highest profits.

That's one of my gripes with the Max Tax. It sets out-of-pocket caps higher than other bills and sets lower amounts (73% if they are to be subsidized) that insurers have to cover. The result will be that more middle class families go into debt. As it's written, the Max Tax (frankly, most the bills) amount to a mandate that is simply not affordable for some middle class families. But the Max Tax throws in a bit more mandated costs that will go to insurance company profitability. The extra thousand or more dollars included for insurance companies means a lot to a family otherwise faced with surviving off of less than $8,000 for utilities, transportation, education, clothing, and debt. To me, you don't have to get any further than this money—taken from middle class families who will still go into debt under this scheme and giving it to insurance company profit—to demonstrate "how bad it is" that the insurance company wrote the bill.

The other big difference with a bill written by

insurance companies is that it includes no apparent means to challenge the insurance companies to limit how much money they ask to be put in the system in the first place—something the public option would help to do. Now, Ezra argues the exchange will be enough to bring costs down.

> The answer to these problems, at least to my way of thinking, is not so much the public plan (though I think it would be a good inclusion) but the health insurance exchanges. And I do talk about them. Often. Loudly. In all different ways.
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> Expanding the exchanges is where insurers – both public and private – get the size for administrative efficiency and negotiated discounts. Expanding the exchanges moves us towards a system where people see how much of their money is being spent on health care and thus understand the need for cost control and the damage being done by the status quo. Expanding the exchange is even the key to a strong public plan, because the public plan is nothing without a large customer base to give it strength.

Scarecrow has written challenged the view that an exchange is enough in the past (here, here).

For me, there are two key points on this.

First, without a public option, you sacrifice one tool to keep insurers honest with regard to regulation. Now, the public option, as currently laid out, doesn't do that. And there's a risk that insurers will find some way to game the system and incent high cost patients to enter the public option. But the public option at least establishes a threat that insurers could lose more lucrative patients, as well. If regulation won't be enough to prevent insurers from cherry-picking or denying coverage, competition might be. As such, the public option

represents a hypothetical tool—one that would have to be beefed up to be effective—but one that may be necessary to force real compliance.

Then there's the question of controlling total money flowing in the system. Best as I understand Max Tax and some of the other plans, while there are out-of-pocket caps on expenses, there are no hard and fast limits on premiums. As such, the pressure points to keep insurers from raising premiums are the following:

- There is virtually no pressure point to keep premiums low for those in the 133% to 400% level (particularly the 133% to 300% level), because the government will subsidize the plans.
- The pressure point for those over 400% of the poverty level is roughly 10% of their income. Once the cheapest policy (which under Max Tax would have to cover 65% of costs, including rules requiring coverage of preventative care) hits 10%, then an individual could opt out, though more affluent consumers would stand to lose savings if they didn't carry insurance. Given that family coverage is already over 10% of the income of families at 400% of poverty level, it seems there would be a lot of middle class families who would choose to

drop out.

- MaxTax taxes "Cadillac plans" 35%—but not those in the individual market (Obama last night said the tax should apply to "insurance companies most expensive policies," without specifying whether that included individuals). In the absence of such a tax on individual policies, insurance companies would have an incentive to shift group policies to lower premium lower benefit plans (they've got four years to prepare to do so, at a time when corporations are looking to cut health care costs anyway), while continuing to charge those Cadillac premiums in the individual market.
- The fees are actually not a big deal. At most levels of income, premiums will be more than 10% of income, which means people can just opt out. For those for whom this is not true—more affluent people—the $900 may be a much better deal than bad insurance.

> Perhaps I'm missing something. But none of these appear to be effective means to limiting how much goes into the system in the first place

(indeed, subsidizing plans without any limit on that subsidy appear to be an invitation for abuse).

The public option, at least in theory, could offer one more pressure point on insurers to keep those costs down.

All of which adds another point to my answer to "how bad is that?" By letting insurance companies write the bill, does it leave all sorts of pockets of coverage that insurance companies will exploit to maximize profit—which they will do under any scenario—without at the same time providing some means to counter that? Do those mandated, captive consumers become necessary profit points for the insurance companies, at the expense of affordability for them? To what degree does allowing the insurance companies to write the bill prevent us from limiting the total money going into the system, and as a result, move toward limiting costs all around?

And that's all before you get into the very important question of how you cut down on those sub-industries where profit is exorbitant, like Pharma. Ezra may well be right that insurance companies will do a better job of bringing down costs given whatever share of the money in the system they get than even Medicare. I agree with Scarecrow, though, that "a well-designed Public Option could exert positive influence on how the providers dealt with cost-efficiency issues." And a public option will not have, in the first place, gamed the political system to make sure as much money flowed through the system as possible.

But let me take a step back. One reason a single payer is not feasible right now is that the health care corporations have captured our political system (the other is that we'd have to replace that part of our economy before being able to forgo one of our few healthy economic areas). One of the reasons Pharma's profits are so high, and one of the reasons Obama felt the need to cut a deal with them on the side, is

because Pharma has captured our political system. One of the reasons we have been unsuccessful in cutting Medicare rates is because providers have captured our political system.

That, to me, is the biggest reason you don't send out a reform plan authored by a woman stuck in a revolving door between industry and Congress. Part of incrementally reforming health care (because that's all this is) necessarily has to be incrementally retaking our political system from the industries that have captured it. And allowing them—any of them—to take over the legislative process is not the way to do that.

We may well decide that we want to employ insurance companies to help us bring down the costs of health care. But that's got to be on terms in which we employ them. Not in which the federal government is just a source of potentially unlimited subsidies, in which they employ the government to maximize profits.