The U.S. Health Care Mess
Understanding the Issues

By Dr. Richard Kelley and Dr. Chuck Kelley

The quality of health care in the United States is among the best in the world, but unfortunately, the system is starting to crack at the seams. Since employer-paid health care is such a large component of the wage and benefit package for members of our ‘ohana who work in the U.S., it is important we all understand the issues involved.

Outrigger and OHANA Hotels & Resorts offer members of our Hawaii-based ‘ohana three different general health-care insurance plans, plus separate plans for vision and dental care. According to a 2005 Kaiser Family Foundation Survey, the average premium for family medical coverage is $10,880 across the U.S., as reported in the Wall Street Journal. (Its value to an individual family varies widely, depending on how much medical care is used, but it is often much greater if you think about the price of doctor and hospital bills that the insurance covers.) Generally, this benefit is not subject to income taxes, Social Security taxes, or Medicare taxes, making it even more valuable.

In addition, we sponsor a “cafeteria plan” that allows members of our ‘ohana to put aside a portion of their pay before taxes, so they can pay for some of their additional health-care expenses, such as co-pays and deductibles, with pre-tax dollars.

On the whole, we have been able to offer employees a health-care benefit package that is one of the very best in the world in terms of access, quality, and out-of-pocket cost. We are, indeed, fortunate.

Unfortunately, the cost of health care and health-care insurance has been rising far faster than inflation for many years. According to an Associated Press article in the Honolulu Star-Bulletin on Wednesday, in 2004, Americans spent nearly $2 billion on health care, or 16 percent of the country’s gross domestic product (GDP—or total national spending for all goods and services). By 2015, it is projected that Americans will double that spending to $4 billion, or 20 percent of GDP—one dollar out of every five spent in our country! There are a number of reasons for this skyrocketing growth.

- Developments in life-saving technology and medicine are advancing—fortunately—almost exponentially. Many of these advances, however, are very costly.
- People are living longer, and our growing population of senior citizens often needs prolonged and intensive health-care services.
- Medical malpractice insurance premiums are soaring, and many surgical specialists are charged $60,000 to $100,000 per year for coverage, according to Hawaii Insurance Commissioner J.P. Schmidt. The cost of these premiums is, naturally, passed on to patients and insurers in their bills.
- Legislatures in many states, if not all, mandate that health-care insurance plans meet certain minimum standards of coverage. This might include things like pregnancy, neonatal care, and long-term rehabilitation. When such coverage is mandatory, it drives up premiums for those who do not need specialized coverage of this kind or who prefer to accept the financial risk if they ever need that type of care.
- Massive government programs, such as Medicare and Medicaid, pay less than market rates for health care. To survive, physicians and hospitals shift costs to other patients, typically those who enjoy employer-paid health-care insurance.
• The ever-shifting state, federal, and insurance company rules governing eligible charges and reimbursements are so complicated that it takes an army of clerks to administer them. These costs are also passed along to consumers.

• Under federal law, a hospital with an emergency room (ER) cannot refuse care to anyone who comes to the ER door. Hospitals are losing hundreds of millions of dollars annually providing emergency care to all sorts of people without health-care insurance and, in turn, shift those costs to, guess who—people with employer-paid health-care insurance.

• Finally, the really big problem is that it is usually somebody other than the patient who is paying for the delivery of health-care services, so there is no “market discipline” in the system. Patients with health-care insurance typically go to a physician or a hospital, receive treatment, make a relatively small co-payment, and leave. There is little or no discussion of cost. Weeks or months later, a complicated final billing arrives in the mail. It is hard to understand. The patient is delighted if all costs were covered and frustrated if more is still owed, but there is little that can be done at that point.

The basic model is flawed and creates ever-ballooning costs with no end in sight. Sooner or later, the system will fall apart. Many would argue, when looking at the unequal distribution of health care and at our inadequate public health measures, that the system is already failing.

Before World War II, America’s health-care system was a predominately “fee-for-service” system, where individual consumers negotiated directly with physicians over the cost of services. Prices were controlled by supply and demand. Those who could not afford necessary medical care were taken care of by charity organizations or free clinics of the U.S. Public Health Service. The present U.S. health-care system was born towards the end of World War II when wages and prices were frozen by federal regulations as part of the war effort. There was a loophole in the wage freeze, however, which allowed employers to give employees a raise by adding a tax-exempt benefit, such as employer-paid health care, without violating the regulation. Within a short time, most people who worked for a large employer were given comprehensive health-care coverage, and they no longer worried about the cost of routine medical services. This became standard practice.

Now fantasize for a moment that, instead of health care, the federal government had allowed employer-paid groceries as a benefit during the time of frozen wages and prices. Why not? Everybody in our country has a “right” to adequate, high-quality groceries, people might say.

Those same people might add that the disabled, aged, and poor are particularly vulnerable to lack of food and, therefore, government should add “Grocerycare” and “Groceryaid” as entitlement programs to provide free or low-cost food for certain groups.

Now read the “Grocerycare” Fable on page 5. It draws a picture of how grocery stores might look if they were operated like today’s hospitals. The story will help you understand why our health-care system is in such a mess.

It will take a lot of hard work and courage to turn the system around. As pointed out by Charles Farrell in the Wall Street Journal, “There are two primary ways to address burgeoning [health-care] costs: increase competition for services by making consumers the direct purchaser of health care; or ration care through strictly applied benefit schedules.” Rationing is exactly what has happened in government-sponsored health-care systems in the United Kingdom and Canada, for example. Some people idealize such systems, but they overlook the inherent flaws of rationing. Long lines in waiting rooms—a common occurrence—is an inconvenience. Long delays for life-saving procedures—another common occurrence—is much worse.
In the meantime, take a moment to appreciate the really wonderful health-care benefits Outrigger and OHANA Hotels & Resorts provide their employees. Use these benefits wisely, so that we can continue to provide them and make Outrigger and OHANA a great place to work and grow!