HEALTHCARE REFORM
A STUDY OF NATIONAL COVERAGE

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Abstract

This paper will examine health care reform, its place in American history and struggle to reconcile the battle between costs and coverage while maintaining quality. America is a society that has built itself around one core concept – competition. The question I pose in this paper is, “Does the new health care bill and or a public option increase competition?” I will evaluate this by conducting an event study that takes the 10 largest publicly traded managed care companies, and analyzing their stocks’ returns and reactions to news events surrounding the recent health care reform bill. Let the market decide.
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Introduction

Challenges facing health care reform are threefold – coverage, cost, and quality. Those who are critical of the system often argue on two points – that America has left 47 million people uninsured, and it is the only developed country in the world without national health insurance. We are, however, a global leader in quality for both medical technologies and procedures. But, as Chairman Ben Bernanke pointed out “health care is not only a scientific and social issue; it is an economic issue as well”. In terms of cost, U.S. health care spending reached approximately $2.3 trillion in 2008 or about $7,681 per person (Centers for Medicare and Medicaid Services, 2008); the United States spends more on health care than any other country in the world.

This paper will examine health care reform, its place in American history and the struggle to reconcile the battle between costs and coverage while maintaining quality. America is a society that has built itself around one core concept – competition. The question I pose in this paper is, “Does the new health care bill and or a public option increase competition?” I will evaluate this by conducting an event study that takes the 10 largest publicly traded managed care companies, and analyzing their stocks’ returns and reactions to news events surrounding the recent health care reform bill. Let the market decide.
History of Health Care Reform

Universal Health Care Enters American Political Consciousness

In 1912, Theodore Roosevelt ran for office as a Progressive. Roosevelt saw that other developed countries had foundations for a welfare state, beginning with Germany in 1883 (pnhp.org, 2010), and so he made a promise during his campaign to implement some form of national health insurance. Germany, as he saw it, “has done in the way of old-age pensions and insurance (things that) should be studied by us, and the system adapted to our uses” (Goodridge & Arnquist/The New York Times, 2010).

Roosevelt, however, lost the race for presidency to Woodrow Wilson. This is not to say that the idea of national insurance was extinguished with Roosevelt’s defeat; in fact it had resurfaced throughout time by leading political and economic thinkers. For example, famed economist Irving Fisher spoke in favor of it in 1916 saying, “At present the United States has the unenviable distinction of being the only great industrial nation without compulsory health insurance” (Jill Lepore, 2009). Mr. Fisher, however, made the fatal mistake of purporting its benefits by citing Germany’s example as Roosevelt had also done in 1912 – war was on the horizon.

In 1917 we entered World War I, which killed any idea of health care reform. National health insurance was popularly introduced into a reform bill in 1915; however, opponents of the bill used political propaganda, drawing from the war to devastating effect. In California for example, national health insurance referendums, even after being passed prior to the war, faced ugly opposition afterwards with slogans like, “Born in Germany”. Propagandists quickly voted this “German” ideal of universal health coverage out of American political consciousness. However, WWI was not the only
antagonist of health care reform; private insurers also opposed the efforts of progressive thinkers as well. The bread and butter of the insurance industry back then was in covering funeral expenses to quell fears the working class had of being buried in a shallow grave. When health care reform included plans to cover those final expenses, the private insurance industry fought back. Because reformers lacked the political savvy to see that covering funeral expenses could destroy the insurance industry, the national health insurance proposal lost the support of powerful private interest groups, and didn’t have strong legs to run on until the 1930s.

FDR’s New Deal

In the 1920s, the Committee on the Costs of Medical Care – a board of economists, physicians, and lobbyists – proposed that everyone have adequate medical care (Hoffman, 2002). The committee was formed during the boom-bust cycle of the late 1920s, and quickly fell apart with the arrival of the Great Depression. One would think that with a depressed economy, and a resulting increase in the number of people lacking medical care/coverage, such a committee would actually see a revival in activism; but there were other more pressing issues weighing on the minds in Washington.

There was one major reason why FDR failed to include sweeping health care reform in his New Deal for Americans in 1935 – unemployment was at an all time high, reaching levels upwards of 25%. While there was a very noticeable gap in the quality and coverage of medical care in the country, creating jobs was priority number one for the government at that time. In 1937, however, a second committee called the Technical Committee on Medical Care organized to develop another health care reform agendum.
FDR’s second chance to enact sweeping health care reform came in 1939, with the Wagner National Health Act – the brainchild of the Technical Committee on Medical Care. The Wagner Bill supported national health insurance funded by the federal government and managed at the state level. However, this time, the opposition was not only greater in number but also in preparedness. Opponents included the American Medical Association (AMA), because doctors didn’t want to be paid a salary by the government; and the private health insurance industry that managed to shoot down health care reform when it threatened to cut its funeral expenses’ cash cow prior to the 1920s. However, the real killer of FDR’s initiative the second time around was in history repeating itself – the arrival of another war. WWII caused a shortage in the labor market, which forced companies to compete creatively in the hiring arena. And so, in an effort to attract talent – or simply able bodies – companies moved away from increasing salaries and started extending health and medical benefits. Not only did employees value this coverage as a way to mitigate risk, but they also preferred employer contributions as a part of compensation because it lowered a worker’s tax burden (Krugman & Wells, 2006).

Truman's Fair Deal

Harry Truman became President of the United States of America in 1945. On the heels of the Wagner Bill failure, President Truman proposed a new referendum on national health insurance that expanded Social Security. The difference this time was that it marketed itself as a federally run system as opposed to one managed on the state level. It was sponsored in Congress by Robert Wagner (D-NY), James Murray (D-MT), and John Dingell (D-MI) – and became popularly known as the W-M-D bill (Poen, Monte M., 1989). The opposition came in the form of the AMA and private insurers, and
yet again the national health care initiative fell victim to war propaganda. This time it was spirited away by accusations of socialism during the start of the Cold War and infamous Red Scare of the late 1940s early 1950s. The fight against “socialized medicine” became symbolic of the movement against Communism in America (Paul Starr, 1984).

Truman felt confident after winning his campaign for reelection in 1948, and securing a Democratic majority presence in the House, that national health coverage was finally on a path of least resistance. Unforeseen opposition, however, arose in the most unlikely of places – labor unions. As companies began offering greater benefits to workers, unions felt the momentum of negotiating power shift into their favor. To compound upon this, employer health contribution benefits became tax exempt in 1954, which weakened demand for national coverage and created huge incentives for companies to offer health benefits at the same time.

**Johnson’s Great Society**

Reformers of the past needed a new platform to administer health care change, and realizing that a national overhaul might not be the most politically expedient method, chose to work toward smaller initiatives – providing for the nation’s poor and elderly.

In 1965, President Johnson created a public option as part of his *Great Society* plan in the form of Medicaid and Medicare. Medicaid is a program funded by the state and federal governments that supports people who are too poor to afford health insurance. Medicare, on the other hand, is an insurance program for people who are above the age of 65. There were two parts of the Medicare plan enacted at the time. Medicare Part A was created to cover in-patient (hospital) care, and Medicare Part B to cover outpatient care like doctor fees (Medicare.gov, 2009).
Albeit bold and a step in the right direction – depending on which side of the political fence you sit – the bill that formed this public option was designed to pay providers any fee that was “reasonable and customary” in order to garner enough support be voted through. Consequently, costs spiraled out of control. The costs of Medicare doubled every four years between 1966 and 1980 (Joe Curl, 2010).

**Nixon vs. Kennedy**

While the economy grew through the late 60s and early 70s, a new enemy of the economy reared its ugly head in the form of inflation. Now, not only was the price of health care rising – health care costs grew nearly 300% from only 4% of the federal budget in 1965 to 11% by 1973 (kff.org, 2009) – because of expanded coverage and a lack of cost controls, but so was the general price level. In 1971, President Nixon considered the state of health care to be critical, and froze wages and prices to fight inflation. This, however, didn’t deter Nixon from pushing for national health insurance. In 1974 he was quoted as saying, "Without adequate health care, no one can make full use of his or her talents and opportunities. It is thus just as important that economic, racial and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job" (Carroll, 2009). Judging by party politics today, one would say that was spoken like a true Liberal. Even more surprising at the time, was the opposition Nixon faced to provide national coverage – Ted Kennedy! In a Washington Post article, Steve Pearlstein described Ted Kennedy’s regret over not trying harder to compromise with Nixon over health care reform saying, "Asked about his greatest regret as a legislator, Ted Kennedy would usually cite his refusal to cut a deal with Richard Nixon on health care.” (Pearlstein, 2009)
Nixon’s greatest enemy of his push for health care reform, however, was himself. The Watergate scandal later took headlines, and Nixon’s proposals lost credibility.

**Clinton’s HSA**

The main reason a single-payer system garnered so little support up until the 1990s was primarily political. Reform was always attacked on the common basis of contributing to bigger government. Again, the United States is a nation that has thrived on individuality and competition, so anything promoting centralization of something as personal and important as health care is bound to run into heavy opposition. That “big government”, “socialized medicine” propaganda throughout time was the single biggest obstacle to passing not only incremental reform like Medicare-Medicaid in the 60s, but also sweeping reform like national coverage.

Bill Clinton’s political savvy entered the scene in the early 1990s with his Health Security Act, which promoted universal coverage and federal regulation to “manage competition” and costs. The similarities between this bill and Ted Kennedy’s in the 1960s vs. Nixon are striking. To name just one – businesses and individuals would be issued health security cards. Ultimately, the complexity of the bill itself led to its failure to garner enough support – reaching upwards of 1400 pages of legalese would stump even the most determined and one-minded congressmen from passing any bill, let alone something as important and contentious as universal health care. To move reform forward, however, President Clinton reverted to an old standby – incremental reform. This strategy led to passing the Children’s Health Insurance Program, which built up Medicaid’s influence by expanding coverage to a greater number of ill and ill-provided for children.
Summary

There are many recurring themes and arguments for and against health care reform spanning almost one century of political debate. The most obvious in favor of reform is coverage. Proponents argue that health care is a right not a privilege, and should be treated as such regardless of cost. The most obvious arguments against national health insurance seem to be greater in number and clout – special interest groups like the AMA and private insurers, and the freedom to choose.

The AMA and private insurance companies were both against compulsory health insurance from the very beginning of the 1900s when a government option was promoted that ate into life insurance revenues from funeral expenses. The AMA, on the other hand, does not want physicians to be salaried employees of the government. In fact, the AMA is a cartel of sorts that restricts the supply and demand of physicians into the market in an attempt to protect physician pay.

In terms of the freedom to choose, Ronald Reagan spoke out against national health insurance in 1961 saying:

“The doctor begins to lose freedom…First you decide that the doctor can have so many patients. They are equally divided among the various doctors by the government. But then doctors aren’t equally divided geographically. So a doctor decides he wants to practice in one town and the government has to say to him, you can't live in that town. They already have enough doctors. You have to go someplace else. And from here it's only a short step to dictating where he will go…All of us can see what happens once you establish the precedent that the government can determine a man's working place and his working methods, determine his employment. From here it's a short step to all the rest of
socialism, to determining his pay. And pretty soon your son won't decide when he's in school, where he will go or what he will do for a living. He will wait for the government to tell him where he will go to work and what he will do.”—Ronald Reagan 1961
Challenges Facing Health Care Reform

Coverage

Facts:

- > 20 million U.S. workers are uninsured. The major reason is that since 1979, employer based coverage has been on the decline, which has seen the number of uninsured workers rise to 17% in 2008 vs. 7% without coverage in 1979 (Center for Economic Policy and Research CEPR).

- 36% of families living below the poverty line are uninsured. Minorities have the highest rates of being uninsured. For example, 34% of Hispanic Americans and 21% of African Americans remain uninsured as compared to only 13% of Caucasians (Rowland & Hoffman, 2005).

- 47 million people are left uninsured in America.

- A Harvard Medical School study conducted in September, 2009 reported that Americans old enough to be considered part of the labor force that remain uninsured, have a 40% higher risk of dying than those who buy into the private insurance market.

Reasons behind the lack in coverage

There are two specific market failures that have led to a lack of adequate coverage in America (whitehouse.gov, 2009); those two include problems that are associated with adverse selection and externalities.

- Adverse selection – Adverse selection occurs when bad outcomes result from buyers and sellers having asymmetric information. Adverse selection, as it
applies to the insurance industry, means that as someone demands more insurance
the risk of loss associated with that person also goes up. The insurer suffers here
because of conditions or behaviors known only to the person being insured or
regulatory limitations that try to expand coverage by prohibiting insurers from
insuring only healthy people for example. In order to mitigate these risks
insurance companies will conduct a process known as underwriting. What
underwriting essentially does is it allows an insurer to charge a risk premium.
These premiums drive up the cost of coverage, protecting the private insurance
companies, but at the expense of those who will ultimately go without care as a
result.

- **Positive externalities** – An externality is when a transaction occurs between two
  parties and a third uninvolved party reaps some reward, or suffers some cost as a
  result of that transaction. As it applies to the insurance industry, when one person
  buys health insurance and assumingly becomes healthier as a result of having
greater access to good medical care, then other people can benefit as a result. For
example, assume John has a terribly contagious disease that if left untreated could
kill him. Fortunately John bought health insurance. You are John’s neighbor, and
are in grave danger of catching whatever John already has. Would you buy
insurance in case you get sick? Probably not, because John has insurance, and if
he seeks medical attention wouldn’t be contagious for very long or might even be
cured by the following week. It’s therefore easy to see how a simple positive
externality could translate into a lack of coverage, albeit by free choice.
Cost

Facts:
- Half of all bankruptcies are caused by medical bills. Three-quarters of those filings are people with health insurance. (Tamkins, 2009)
- U.S. health care spending is approximately $2.3 trillion per year, or $7,681 per person. The United States spends more on health care than any other country in the world. (Centers for Medicare and Medicaid Services, 2008)

Health Care Spending as a Share of GDP

The U.S. spends more on health care than any other developed country. However, the problem is not so much how much we spend, but rather the rate at which we spend it. Per capita health care spending has outpaced per capita income growth, and if left unchecked will soon outstrip it altogether. While we have reaped the benefits of increased demand for health care in terms of technological advancements and innovations, both households and the government will feel the pinch as we see ballooning budget deficits. As shown in the figures below, health care spending as a percent of GDP almost doubled between 1980 and 2008.
Impact on the Deficit

Growth rates are more important in economics than static or spot rates. Take for example, the size of the U.S. economy vs. China. The U.S. has the largest economy in the world with a per capita GDP of $46,900 and a GDP (PPP) double that of China’s (cia.gov, 2009). However, China experienced an estimated 8.7% (2009 est.) growth rate
in GDP vs. the -2.4% in the U.S. The point is that we may be the most powerful economy in the world, but with global superpowers like China pacing growth rates at multiples higher than our own, we will be overtaken at some point in the future. Similar to the relationship between China’s economy outpacing our own and ultimately overtaking us as the world’s greatest economic superpower, the rate of rising health care costs is outpacing the growth in per capita income. Health care spending per capita has risen over 40% in the past ten years (whitehouse.gov, 2009). Health expenditures, according to the figures above, are expected to almost double to $4.3 trillion by 2018. With costs of care rising for individuals, and an aging population, the stress put on the government will place an enormous burden on deficit spending. For example, in 1975, Medicare-Medicaid totaled only 6% of federal spending, but today that figure has ballooned closer to 25%.

How is the U.S. health care dollar spent?

Total = $2.3 Trillion

Figure 3: National Health Expenditures, 2008. Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group
What drives spending?

- **Technology and Prescription Drugs** – Major advances in medical technologies and science allow physicians to now diagnose and apply treatments, tests and surgeries for diseases that weren’t treatable in the past. Innovation is also costly. It can be expensive because both biomedical technology and new drugs are complex, and have research and development costs to the tune of hundreds of millions of dollars. These costs, especially in the pharmaceutical industry, need to be recouped by the companies that brought them to market. Healthcare is widely considered by economists to be a normal good, which means that, as household income rises, so will demand for that good. Advancements in medical care, technology, and drugs can therefore be likened to Coca-Cola rolling out a new line of soft drinks; expanding consumer options can increase demand for those drinks (drugs) as a whole.

- **Medical Malpractice** – The inherently litigious nature of Americans is driving up health care costs. Malpractice insurance premiums have risen to levels that compromise physicians’ incomes. As a personal example, my father’s friend who practices cosmetic surgery to treat burn victims has seen rising premiums coupled with cuts in Medicare-Medicaid reimbursements that have forced him to shut down his private practice. The other problem is that many physicians, fearful of being dragged through the legal process on sometimes bogus claims of medical malpractice, will over-treat their patients by prescribing superfluous tests and medications. This practice is known as defensive medicine.
• **Disease and Aging** – This group includes those people who are essentially the patient outliers. What I mean by outliers is that they are the ones who use a disproportionately large piece of the health care pie on some of the most advanced and expensive technologies and overall care. Examples would be colon cancer patients who are prescribed Avastin as treatment and pay upwards of $50,000 a year to use it (Berenson, 2006); or the elderly, who need to be placed into nursing homes. They represent 5-20% of the patient population, but consume 25-50% of available resources (National Institute of Health Policy, 2003).

• **Administrative Costs** – Private vs. public health care options differ greatly on their abilities to limit administrative costs, which account for almost 7-10% of health care expenditures. The public option wins out here, with one manager – the federal government – Medicare administrative costs can stay below 2%. Compared with other OECD countries, the U.S. has health care administrative costs that are seven times greater per person (Peterson & Burton, 2007).

**Quality**

Good things have contributed to an elevation in costs like demand for quality healthcare, and improvements in medical technology and the biosciences. However, costs have reached levels that prevent affordability and therefore adequate coverage of American citizens. And yet, despite these relatively high levels of spending, Americans are in fact no healthier, and do not live longer than people in other developed countries (Rand Corp, 2005). In fact, statistics show that when compared with foreign nations like Japan, the Japanese spend far less on healthcare yet enjoy both lower infant mortality rates and longer life spans (see figure below). Many proponents of the current system
will point to our global leadership in quality health care, but the reality is that we need to evaluate our ability to deliver the benefits of those advances to patients. While economics teaches that consumers generally get what they pay for, my research shows that America has reached a frontier of diminishing returns in health care expense as it relates to quality.

![Figure 4: Life Expectancy vs Health Care Spending in 2007 for OECD Countries.](http://flagscatter.com)
For or Against the Public Option

The World vs. U.S.

Payment Models

While there are many models that countries subscribe to across the globe, there are essentially four underlying patterns across all of them that can help us understand the important differences. According to a *Frontline* report with *Washington Post* foreign correspondent T.R. Reid, the three relevant models include the Beveridge, Bismarck, and National Health Insurance.

The Beveridge model was named after William Beveridge – a founding father of the UK’s National Health Service. This model is primarily government funded and administered. Just like other public goods for which positive externalities exist but free rider problems do as well like the military, taxpayers share the burden of financing national health care. According to the PBS documentary *Sick Around the World*, every one of Britain’s citizens will at some point take advantage of national health insurance, but the stunning fact is that not one of them will pay for a visit or procedure – no matter how routine or costly. Because the system is government owned, officials can and have driven prices lower by dictating what doctors do, how much they can charge, and what they should be paid. In comparison with the fragmented American system and the political clout of organizations like the AMA, it is not difficult to see why such a system has not reached universal appeal here in the states as it has in the UK.

The Bismarck model was named after Otto von Bismarck – he unified Germany in the 19th Century and created the concept of a welfare state. He marketed his *Staatssozialismus (state socialism)* programs as *practical Christianity*, which put into
practice Health Insurance; Workman’s Compensation; and an early form of what we would recognize today as Social Security. None of these programs existed at that time on a national level.

This model is not government owned, but remains government regulated; in fact, for countries that subscribe to this model like France, Japan and Switzerland, doctors and hospitals are often private entities. State regulated health plans are supported by a split contribution from both individuals and employers. These individual and employer mandates cover up to 68% of overall healthcare costs (Grant, 2010). The Bismarck model uses an insurance system similar to the way America does, the key difference of course, is the mandate for universal coverage. It is essentially a group of more than a few hundred insurance “funds” that are revenue neutral and tightly regulated by the government to control costs.

The National Health Insurance system as we are familiar with it is used in countries like Canada. This model is government run and reflects both government ownership as seen in the Beveridge model and a privately run delivery system i.e. hospitals and doctors as seen in the Bismarck model. The Canadian banking system, which is highly centralized and therefore much simpler to manage, enjoys much lower administrative costs, and so does their health care system. Some of the famous attributes of this single payer system include not only long wait times, and the rationing of care and services the government will pay for, but also an impressive negotiating power that has driven down pharmaceutical prices for consumers.
Summary

We are a mosaic of these four systems. We implement the Beveridge model to cover veterans, a single payer (NHI) model to cover the elderly via Medicare, and the Bismarck model via employer contributions and benefits to cover American workers (Frontline PBS, 2008).

Three Country Models – the UK, France, and Switzerland

The UK

I chose the UK because it represents the purest form of equitable health care coverage – socialized medicine. Because this is an example where the government both pays for and delivers health care, the term socialized medicine can be applied. The National Health Service (NHS) is funded by distributing tax money to pay providers. One would think that in the absence of a profit motive, competition wouldn’t exist. This isn’t necessarily true. Hospitals and providers compete to garner greater tax payments from the government. By expanding its client base, a hospital ensures its survival by becoming an important hub of health care the government needs to sponsor. This is, in a way, similar to the principal agent problem of “empire building” – by emphasizing the size of your department and the number of resources it demands you ensure the survival of your group.

Of course, to balance out the benefits seen by their system in terms of low administrative costs and universal coverage, sacrifices must also be made in other areas such as quality. This is similar to the concept of an impossible trinity in international economics (see figure below).
The impossible trinity states that a country can allow only two of three monetary policies to occur – free capital flow, a fixed exchange rate regime, and monetary policy autonomy. In health care, the impossible trinity would be cost, coverage, and quality. The UK can insist on universal coverage, and possibly attain lower costs as a percent of GDP than America, but quality will inevitably suffer as a result. For example, waiting lists for treatments and procedures are a major problem. According to a Cato Institute report, some studies show that 20% of colon cancer patients, who are diagnosed as treatable initially, wait so long for treatment options to become available that they are deemed incurable by the time care is actually provided (Tanner/CATO Institute, 2009). The other major problem is rationing care. Ultimately, the government determines who will receive expensive care options to cut costs, which ultimately means that the people who actually know what they’re doing – the doctors – are losing autonomy. This rationing of care is infamously touted in the U.S. as a “death panel” because the rationing of expensive treatments and procedures can often mean the difference between life and death.
France

I chose France because, "The French approach suggests it is possible to solve the problem of financing universal coverage...[without] reorganizing the entire system," says Victor G. Rodwin, professor of health policy and management at New York University (BusinessWeek Health, 2007). France is very similar to the United States in two ways. First, it draws from both private and government insurance options. Second, its goal is to provide universal coverage without sacrificing choice. The element of choice is hotly debated when a public option is talked about in the United States because it determines the doctors who treat us and limits their freedom to determine proper treatment options.

Another interesting aspect of French health care is that it is socially responsible, because it leaves no person uninsured. The French even have measures to ensure that no one ever files for bankruptcy because of medical bills. For example, cancer, diabetes and others suffering from chronic diseases are fully covered. In sharp contrast to this, a colon cancer patient in the United States would pay $48,000 a year for treatment while someone in France would pay nothing. This social and health care support comes at a steep price, however. The French allocate 11% of GDP to health care spending; only the United States and Switzerland spend more in comparison – 17% and 11.5% respectively (Tanner/Policy Analysis, 2008).

The French government finances universal health care by issuing employer and individual mandates – a 21% tax on workers’ income, half of which is covered by employer contributions (Shapiro, 2008). In order to contain costs, the French have cut physician pay to roughly one third that of physicians in the U.S. – the average French doctor earns $55,000 compared to $146,000. If a similar pay structure were adopted here
in the U.S. it would cause a shortage in the number of doctors, because of the tremendous
debt from attending medical school and the rising costs of both medical malpractice
insurance and lawsuits. So how have the French made it work?

There are still strong incentives to become a doctor in France for two reasons.
First, the government will pay for you to go to medical school, which leaves future
doctors debt free after graduation. Second, the French legal system does not like to
award monetary damages to those suffering an injury. This means that the French do not
have the same tort-reform issues that doctors struggle with here in the U.S.; consequently,
costs associated with medical malpractice, like insurance and legal expenses, are much
lower. For example, specialists in the U.S. like Neurosurgeons can pay malpractice
insurance premiums to the tune of up to $300,000 a year. Of course, those surgeons are
“overpaid” relative to their foreign counterparts; how else is it possible to shoulder costs
like that?

Astonishingly, the average French citizen still pays on average half as much as
someone in the U.S. for health care; and yet, France’s infant mortality rate is half that of
the U.S. at 3.9 per 1,000 live births vs. 7 in the U.S., and on average the French are living
2 years longer than we are (BusinessWeek Health, 2007). On these simple measures of
quality, France seemingly is able to deliver benefits to its citizens more cost effectively.

Switzerland

I chose Switzerland because it is considered to be one of the most capitalist and
freest market economies in the world, and has successfully implemented a managed-
competition system to provide universal coverage. This system is unique because the
Swiss government mandates that individuals purchase their own health insurance, but
does not require employers to share in those costs. This also helps to explain why the Swiss spend so much on healthcare as a percent of GDP – at 11.5% of GDP, only the U.S. spends more in comparison (Frontline PBS, 2008). That is to say that health care, from an economic perspective, is a normal good – as wealth increases so does the demand for quality health care. It seems that the U.S. and Switzerland have similar views regarding the importance of quality and market-oriented mechanisms to deliver care. How then is Switzerland containing costs? According to Regina Herzlinger and Ramin Parsa-Parsi of Harvard, “Cost control may be attributed to the Swiss consumer’s significant role in health care payments and the resulting cost transparency” (Tanner/Policy Analysis, 2008).

In addition to this, private insurers are tightly regulated and can compete only on price.

The reason the Swiss model is so effective, however, can in part be attributed to an important cultural difference – compliance. For example, it wasn’t a major leap to achieve universal coverage when it was introduced in 1994 because 95 percent of the population was already voluntarily insured. Another example can be found in auto insurance, which was deemed mandatory by the Swiss government and has near 100% compliance vs. the U.S. where it is also mandatory but only commands 83% compliance (The Council for Affordable Health Insurance, 2009). There is a clear cultural difference present, which could mean that for all of the similarities in how we view competition, free markets, and quality, the Swiss example still may not be perfectly translatable to the U.S.
Event Study

The political elephant in the room this year has been health care reform. The topic under the hottest debate has been the Democrats’ goal of implementing a public option – in a sense expanding Medicare to cover the nation. It is President Obama’s goal that by offering a public option to compete with private insurers he can lower/stunt the rapid growth in health care prices. The question I’m trying to answer is, "Will the new health care reform bill/public option create competition?" Instead of taking sides based on political affiliation or social philosophies, I wanted to let the market voice its opinion. The way I did that was by conducting an event study, which involved taking stock returns from the top 10 largest Managed Care companies and seeing how they reacted to news events surrounding recent health care reform. By using a simple T-Stat test, I then determined if those returns were significantly different than the market on those days. Below is a list of the companies I used in the study.

![Table of Companies](image)

Figure 5: 10 Largest Publicly Traded Managed Care Companies Ranked by Third-Quarter 2008 Premium Revenue

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Hypothesis

I anticipate that this competition between a public and private option offers a freedom of choice that is illusory. I believe the reality is that private insurance will be crowded out by the new health care reform bill via expanding coverage in Medicare and Medicaid, which will drive private payer prices through the roof for an equal level of care. According to a report issued by the actuarial consulting firm Milliman Inc., inadequate reimbursements by programs such as Medicare and Medicaid increase the annual cost of covering a family of four by $1,788 (Goldstein, 2008).

Managed care companies and private alternatives simply would not exist if a public option were introduced. The way private insurers stay profitable is by balancing their pool of customers between the young and healthy and the sick and elderly. The insurance companies make all of their money from those who are healthy and don’t require care. By insuring enough healthy people, the idea is that their payments will offset the costs of covering the ones who get sick. This is essentially why Medicare is going bankrupt; because, it covers only the elderly who are usually the sickest, consume the most health care services, and incur the highest costs to treat in America.

There is a lot of risk in the insurance business. The way insurers mitigate this risk is simple – take every legally acceptable measure possible to expand coverage to those who are healthy and won’t need it, and charge the most you can or exclude entirely from coverage those who are sick and costly to insure. Infamous filters include “preexisting conditions”, where insurers can deny coverage or even drop you from their plans if you do not disclose a multitude of conditions that can make you riskier to insure. The
problem is that from a business perspective this makes perfect sense, but is ultimately a terrible way to conduct social policy and treat your fellow man.

The only way a public option will work is if the government (single payer) mandates coverage for everyone. What mandating coverage will do is spread the risk to a manageable level where the young and healthy people in society will finance expensive care treatments and procedures for those who are sick and elderly. If the public option fails to mandate coverage for all, then it will have to be heavily subsidized by taxpayer money. What worries me now is the growing popularity of tax proposals on items like soft drinks and fast food – which I think aren’t meant to curb America’s obsession with unhealthy eating but rather to slowly introduce creeping tax hikes. Because of this, I think it is unlikely a public option will be introduced.

Results

Contrary to my initial beliefs, Managed Care companies’ stocks actually went UP in value, or at the very least, outperformed the market on days when important announcements about health care reform were made. Seventeen events were used in the study, all occurring within a one year time horizon. Finding a sample base of companies was easy, but determining which events out of hundreds of news stories to include as relevant and market moving was quite difficult. While it is obvious that I would want to include dates the health care reform bill was voted on, what about press events and bipartisan senate meetings? The red numbers denoted in the figure below show that more than half of the reactions to the group of events I chose were significantly different than the returns for the market respectively.
What the data tell me is that managed care companies see health care reform as good for business, but that wasn’t always the case. In fact, managed care stocks did terribly when the Senate Health Panel approved an iteration of the health care bill that introduced a government/public insurance option (see event 15 below). On 7/15/2009, the average return for managed care stocks was significantly different than the market’s – registering a T-Stat absolute value of 8. On 12/21/2009 the Senate voted through a health care reform bill, however, this time managed care companies reacted positively to the news. The difference the second time around was that this particular bill did not include a public option.

**Events**

1) 3/23/2010 – The most sweeping social legislation enacted in decades becomes law with President Obama's signature

3) 3/18/2010 – Congressional Budget Office says health care bill comes under budget

4) 3/3/2010 – President Obama calls for an Up or Down vote through on health care measure

5) 2/22/2010 – President Obama lays out first detailed legislative proposal for overhauling health care

6) 1/19/2010 – G.O.P victory in Massachusetts, Democrats lose crucial 60member vote after Kennedy death

7) 12/24/2009 – Senate passes sweeping health care bill 60-39

8) 12/21/2009 – Senate Passes 60-40 to pass health care reform without a public option

9) 11/7/2009 – Health Care overhaul bill passes 220-215 in the House

10) 9/29/2009 – Senate Finance Committee rejects democrat government insurance plan to compete with private insurers

11) 9/9/2009 – Rare joint congressional meeting held to garner support for sweeping healthcare reform

12) 7/31/2009 – Last crucial House panel "energy and commerce" approves $1trillion healthcare overhaul

13) 7/23/2009 – Harry Reid delays voting

14) 7/17/2009 – Two House panels pass bill

15) 7/15/2009 – Senate health panel approves bill/requires Americans to purchase insurance and introduces government plan

16) 7/14/2009 – Health Choices Act introduced

17) 6/5/2009 (Kennedy issues bill: public insurance/company plans)

**Tying Returns to Expectations**

It is interesting to see how private insurers react to news about health care reform, and judging by the results it seems that managed care companies reacted positively to news of it moving forward. I tried to measure the reaction of private insurers to different
news events that I assume reflect the probability of passing health care reform; however, wouldn’t it make more sense to instead focus on the probability itself? The problem, of course, is how to determine the probability of something like a political event taking place. Poll the public? That might work, but there could be bias reflected in the political opinions of the people voting. The great thing about market oriented analysis is that investors vote with their wallets. If only people could trade political events as if they were stocks.

Enter Intrade.com. This is a website that creates markets, or betting structures around events that you might initially think to be untradeable. For example, your local weather man might say a blizzard is imminent; wouldn’t you rather have information on such an event that reflects all possible knowledge? Of course you would. Suppose you live in New York, Intrade.com actually has a contract trading around the possibility of Central Park accumulating more than 55.0 inches of snowfall between Nov 01, 2009 and Apr 30, 2010. For the purpose of this paper, it just so happens that there is also a contract centered on “obamacare” health reform passing (see figure below).
Figure 2: “OBAMACARE” contract

The great thing about this contract is that it shows prices that can be interpreted as the near exact probability the public assigns to passing Obama’s health care plan. For example, when Ted Kennedy died and the G.O.P won the Senate in Massachusetts, the Democrats lost their crucial 60-member vote. The obamacare contract, in response to this news, sensibly showed a mere 20% probability of being passed at that time. At the other end of the spectrum, when President Obama signed health care reform into law the contract closed at a value of 100 illustrating that obamacare had a probability of 1 or was a sure thing at that point in the race to pass reform. Now look at the up-spike in the contract on 3/18/2010. News came out on this day that the Congressional Budget Office estimated the cost of overhauling health care at $940 billion. Democrats were excited about this because it came out to be less than anticipated, which meant that fiscally conservative democrats would then be more likely to support the bill than they might have been before. This improvement for the Democrat Party was reflected in the up-
spike that day, nearly doubling the probability of passing “obamacare” from 35% to 65%. My event study also showed that this day scored an 8.32 T-Stat value, where managed care stocks returned a mean of 3% vs. the market losing -0.03% on the day. To put this into perspective, the order of significance in a T-Stat reading is an absolute value greater than 2.

The market data (event study) showed a surprising tendency to fluctuate in lock step with the expectations of investors (Intrade’s obamacare contract). For example, when President Obama called for an “up or down vote” on health care to cut through legislative red tape, it affected investors expectations on the likelihood of passing health care reform. The obamacare chart above shows that on 3/3/2010 when the up or down vote was petitioned for by the President, the probability of passing health care reform nearly doubled from 30% to 55%. My interpretation of this jump is that the public had the resolution to a nearly century-long debate in sight, and when given an ultimatum, sided with the President. This increase in probability exactly coincides with positive returns for the companies in my event study. Not only did managed care companies average a 0.65% return that day, but that return was also significantly different from the market’s according to a T-Stat test that measured greater than 4.
The Health Care Reform Bill

These are the changes that the Obama administration has included in the health care reform bill. I’ve included only the ones that I think will affect managed care companies.

Within the next six months

- **Elimination of preexisting conditions** – Insurance companies will no longer be able to deny coverage because of preexisting conditions. For those who have already been denied coverage, they can sign into a federally run insurance program that will serve as a temporary fix. The longer term solution, however, will be to implement an “insurance exchange” within the next four years. These insurance reforms are not limited to eliminating filters like preexisting conditions, but will also force insurers to provide standard benefit packages that will make the private insurance industry compete on the basis of price and not the underwriting process for those who are sick. This is very similar to the managed competition approach to universal coverage that the Swiss use.

- **Elimination of price gouging** – Insurance companies cannot put lifetime limits on the amount of health care they are willing to pay for. They also cannot charge higher prices for plans or drop entirely those who are covered and become sick.

- **Extended Family Plans** – The age-limit set for kids being covered under their parents’ plan has been extended – now young adults can stay under the same plan until the age of 26 (edlabor.house.gov, 2010). This especially will help new graduates who suffer debt burdens from student loans, lower pay scales, and even joblessness in the current economic environment, stay insured and healthy.
• Extended prescription drug coverage – Approximately four million people covered under Medicare spend more than $2700 – the upper limit that users are reimbursed on their pharmaceutical bill. Now those users will get a $250 rebate, with plans to close the gap in coverage by cutting drug prices for those in the gap by 50%.

The next 4 years and beyond

• Individual mandates – Penalties for those who don’t get insurance include a maximum fine of $2,085 per household, excluding those who cannot afford it of course.

• Employer mandates – Companies that employ more than 50 people will be required to provide health benefits to workers or face fines as well. Companies that fit this size criterion, but do not comply with this mandate will be fined $2,000 for each uninsured employee (edlabor.house.gov, 2010). Those who believe employer mandates are necessary, argue that most Americans who are insured have employer benefits that extend to health, therefore it only makes sense to expand this already popular way of insuring people. However, those who are against those mandates are afraid that it will act like a corporate tax that will incentivize companies to hire fewer people and pay their employees lower wages – this will hurt economic growth.

• Extended Medicaid coverage – Medicaid will be expanded to cover American households that earn less than or equal to 133% of the poverty line -- approximately $29,326.
• **Tax credits for low-income families** – People with incomes up to 400% of the poverty line will get income progressive tax breaks to help buy insurance (edlabor.house.gov, 2010).

• **Insurance exchanges** – As early as 2014, state exchanges will exist that will make insurance providers compete in an open marketplace. The plans themselves will be expanded to include, both preventative and treatment oriented prescriptions and visits to doctors and hospitals. By increasing transparency, requiring insurers to provide coverage regardless of your health history or risk, and expanding care provisions, prices should go down and more people should have access to quality care.

**Conclusion**

Why would managed care companies’ stock values go up if news came out that part of the plan is to expand Medicare-Medicaid options (a public option)? Perhaps, these stock returns are telling us that managed care giants know something, or have cut some sort of deal in the 2700 pages of legislation that protects them going forward. Based on the outlined changes above made to the health care system I can see why.

The government will both mandate coverage on an individual and company wide basis, which will increase the number of people who need insurance by the tens of millions. “Insurance exchanges” will be set up, and as I see it, will actually benefit the insurance companies. While the original plan was to implement a public option to compete with private insurers on those exchanges, there is reason to believe that no such option will exist in the near future. For example, look at March 18th, 2010 when Dennis Kucinich, who initially wouldn’t side with Democrats to vote for the health care bill
because it excluded a public option, but was eventually persuaded by the President and other members of his constituency to vote along party lines. This was a sign, Kucinich said regretfully, of the death of a public option. No wonder managed care companies see health care reform as positive! Millions more people will be forced to buy insurance or pay fines, and the government will make it easier to choose plans by creating exchanges for people to shop around for different insurers. We can therefore reasonably infer two things based on the reactions of managed care companies’ stocks in my event study. First, that the threat of losing a private option seems as likely as introducing a public option in the near future (slim); and second, that while insurance companies may be forced to compete in a similar way to the Swiss system, they will still have a place in health care going forward.
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• Sapphire inductee at the Smeal College of Business  
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Wharton School of Business Summer Programs  
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• At age 14 I was the youngest ever to be accepted into the Milken Young Entrepreneurs Program.  
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Professional Experience:
Shell Trading  
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Internship  
• Mitigated credit and market risk across four critical functions – Underwriting, Contract Negotiations, Margining Counterparties, and Prepay Management.

CMT  
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GFT Forex Trading Competition  
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Pennsylvania Real Estate License  
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Summer 2007  
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GeneroCity™  
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