Senator McCain’s Healthcare Plan:
A Special Report on the Consequences for Hospital Patient Care Funding
$77 Billion Windfall to Insurers and Banks Would Endanger Hospital System, Patient Care

There’s no dispute about what’s wrong with the U.S. healthcare system—it costs far too much and delivers far too little quality care. Of the $2.4 trillion the United States will spend on healthcare in 2008, experts say that as much as half that money is wasted—in large part due to inefficient delivery systems, administrative costs, and enormous profits to the insurance and drug industries. As a result, spending for patient care in U.S. hospitals is already under fierce financial pressure.

Reforming the U.S. healthcare system has reached the critical point. For patients, nurses, and healthcare workers, real reform requires lowering costs and improving quality by ensuring that more federal and taxpayer dollars go into delivering care.

Unfortunately, Senator John McCain’s healthcare plan would be a step in the opposite direction. McCain’s plan would shift even more healthcare dollars into administrative fees and profits for the insurance and financial industries—some $77 billion a year.

Draining an additional $77 billion would significantly increase pressure on hospitals and healthcare providers to cut corners on patient care.

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<th>$77 BILLION SQUEEZE ON HOSPITAL SYSTEM, PATIENT CARE</th>
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| $77 Billion | Removed from Healthcare System Each Year |

Senator McCain’s healthcare plan would eliminate employer-paid health benefits and increase the role of insurance companies and managed care organizations within the Medicare program.

McCain’s plan would give insurers more freedom from consumer protections, and direct Americans into the private insurance market as individual consumers, without group purchasing power, and jeopardize the largest funding source for hospitals. While McCain’s plan assumes that such a transformation of the U.S. healthcare system will ultimately improve quality and lower costs, too much evidence exists to the contrary.

This issue brief calculates how Senator McCain’s plan drains $77 billion out of the healthcare system.
Ending Employer-Paid Health Benefits = $21 Billion in Higher Administrative Costs and Bigger Profits for Insurance Companies

Workers would lose employer-paid health insurance and have less purchasing power as individual consumers in the private market.

McCain’s plan imposes a new tax on Americans for receiving employer-paid health benefits—the economic effects of which ultimately will force most people to purchase their own insurance in the private market. Private market plans cover less, increase patients’ burden for out-of-pocket expenses, and divert more healthcare dollars into administration and profits for insurers.

In the private market, 29% of each healthcare premium dollar goes toward administrative costs and profits of insurance companies—more than twice the 12% overhead rate of employer-paid group plans.

Shifting an additional 17% of insurance premiums into administrative costs and profits will take an additional $21 billion out of healthcare each year. (See Appendix A for data and calculations.)

Privatizing Medicare = $41 Billion in Additional Fees and Profits to Private Insurers’ Medicare Plans

Seniors would move from traditional Medicare structure into private insurance plans.

Less than 25% of the 44 million Americans currently enrolled in Medicare are covered by private insurance plans, known as Medicare Advantage. Like President Bush, McCain favors a healthcare system run by private insurance with no government involvement in programs such as Medicare. However, as our current experience with Medicare Advantage reveals, private plans cost more to administer than traditional Medicare.

Private Medicare Advantage plans put 13% of revenues into administrative charges and profits and just 87% into paying for healthcare. By contrast, the administrative costs for traditional Medicare are just 2%, and 98% of the money goes into healthcare.

McCain’s vision of privatizing government programs such as Medicare would take another $41 billion of taxpayer money out of healthcare and transfer it to private insurers’ administrative fees and profits. (See Appendix B for data and calculations.)
Banks Gain New Fees and Foothold in the Healthcare Business = $15 Billion in Fees to Banks and Financial Firms for Health Savings Accounts

Americans would be incentivized to open a Health Savings Account to pay for increased medical expenses.

Health Savings Accounts (HSAs) are another critical element of McCain’s plan. HSAs allow people to pay for medical expenses with tax-free money—but they also carry a cost. Similar to 401K plans, HSAs are offered by banks and investment firms that charge significant fees to administer the accounts. After the initial start up fee, account holders must pay both account management and asset management fees. Hospitals, physicians’ offices, and other providers then pay transaction fees each time a patient uses an HSA to pay for services (like credit/debit card transaction fees).

McCain’s plan is designed to incentivize every American to open an HSA:

- Private market health plans provide less coverage, have higher co-pays and co-insurance, and high deductibles where out-of-pocket spending may exceed $5,000 per individual and $10,000 per family per year. Once workers and their families are shifted into the private market, HSAs become necessary to cover their enormous out-of-pocket expenses.

- McCain’s plan includes a restricted tax credit for healthcare expenses. As currently described by McCain, taxpayers will not receive a personal check for the tax credit. The government will send the credit directly to the insurance company. Any remaining portion of the credit will be deposited into an HSA.

For years, bankers have eagerly anticipated the huge fees they will reap if HSAs take hold as McCain intends. As early as 2001, the consulting firm Booz-Allen called HSAs “the [financial industry’s] next trillion-dollar opportunity.” Recently, Diamond Consultants estimated that if 15-20 million people were enrolled in HSAs, banks and the financial industry would take in $2.5 billion a year in account management, asset management, and transaction fees alone.

Under McCain, if only the 90 million households that currently have employer-paid plans open an HSA, another $11.1 billion –$14.7 billion would be siphoned away from healthcare into the pockets of bankers and financiers each year. (See Appendix C for data and calculations.)
Plan Shifts Additional Healthcare Dollars to Non-Healthcare Uses

$77 billion only includes the drain on healthcare dollars that are easily calculated. In addition to the diversion of healthcare dollars to the insurance and financial industries, McCain’s plan will create a new healthcare market for many outside profiteers. Banks and the financial industry are already positioning themselves for the new healthcare market—where HSAs are expected to hold as much as $75 billion in assets by 2010.\textsuperscript{16} Credit card companies selling new healthcare credit cards—with interest rates as high as 26.99% – will also become more prominent as patients bear more responsibility for the direct cost of healthcare.\textsuperscript{17} This new market will require new IT hardware and software vendors to integrate insurance and banking databases, thousands of outside administrators to handle all the new paperwork from each physician’s office and hospital, and armies of management consultants to help people navigate this complicated new healthcare world.\textsuperscript{18} Beyond the new healthcare market, McCain’s plan also creates a costly new role for government bureaucracy as the IRS will need more staff and more resources to administer and audit the new tax credits.\textsuperscript{19}

Patients and Healthcare Delivery System Hardest Hit

The $77 billion additional healthcare dollars McCain’s plan would divert out of the healthcare system would hit patients and caregivers hardest. Financial pressures in our current healthcare system already severely constrain adequate spending for patient care, resulting in:

- Short-staffing—more than 100 studies now document a link between hospital short-staffing and worse patient outcomes\textsuperscript{20};
- High RN turnover—$20 billion healthcare dollars are wasted every year because the poor staffing and other patient care conditions that cause high RN turnover are not fixed\textsuperscript{21};
- Inadequate supplies and equipment—another way that lack of resources negatively affects patient care;
- Budget-driven practices such as discharging patients “quicker and sicker”—putting patients at risk of being bounced right back into the hospital;
- Preventable medical errors such as patient falls, bed sores, and more;
- Inappropriate assignments, inadequate training, and less experienced staff; and
- Dangerously long work days.

Patient care simply cannot afford to have more scarce dollars drained out of healthcare.
### Appendix A

**Source of $21 Billion Higher Administrative Costs and Bigger Profits for Insurance Companies**

In 2007, there were a total of 36.7 million family policies, and 46.2 million single policies, in employer-paid or group health plans in the United States.*

#### Average Group Market Costs

<table>
<thead>
<tr>
<th>Premium</th>
<th>Administration (12%)</th>
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<tbody>
<tr>
<td>Family Policies</td>
<td>$12,106</td>
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<tr>
<td>Single Policies</td>
<td>$4,479</td>
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<td>Family Policies</td>
<td>$1,453 (12% of $12,106)</td>
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<tr>
<td>Single Policies</td>
<td>$537 (12% of $4,479)</td>
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#### Average Individual Market Costs**

<table>
<thead>
<tr>
<th>Premium***</th>
<th>Administration (29%)</th>
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<td>Family Policies</td>
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<tr>
<td>Single Policies</td>
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<table>
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<tr>
<th>Premium***</th>
<th>Administration (29%)</th>
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<tr>
<td>Family Policies</td>
<td>$1,732 (29% of $5973)</td>
</tr>
<tr>
<td>Single Policies</td>
<td>$780 (29% of $2691)</td>
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</table>

#### Additional Administrative Cost of Individual Market Policies

- Family Policies: $1,732 (Individual Market)—$1,453 (Group Market) = $279
- Single Policies: $780 (Individual Market)—$537 (Group Market) = $243

If all group market insurance policies were converted to individual market insurance policies, an additional $21.4 billion would go toward administrative costs.

36.7 million (family group policies) x $279 (additional administrative costs) = $10.2 billion
46.2 million (single group policies) x $243 (additional administrative costs) = $11.2 billion

Total = $21.4 billion

* Calculations are based on the Peter Harbage analysis of 2007 enrollment data that differs slightly from the 2008 figures referenced elsewhere in the brief.

**Premiums in the individual market are significantly lower because families are responsible for a much greater share of their healthcare expenditures—higher deductibles, co-pays, co-insurance and out-of-pocket limits are the norm.

***The AHIP Non-Group premiums are calculated for 2006–2007. To bring them in line with KFF's 2007 group market numbers, they were grown by 3%. So:
AHIP Single: $2613*1.03=$2691
AHIP Family: $5799*1.03=$5973

Appendix B
Source of $41 Billion Additional Fees and Profits to Insurers' Private Medicare Plans

Federal Spending on Medicare breaks down as follows:

Total Federal Spending = $461 billion
Medicare Advantage = $91 billion
Traditional Medicare = $370 billion

Overhead Rate of Medicare Programs
(Administrative Costs; Medicare Advantage also includes profits)

Traditional Medicare = 2 percent
Medicare Advantage = 13 percent
Additional Medicare Advantage Overhead = 11 percent

If all of Medicare were subject to the additional 11 percent overhead rate of Medicare Advantage, the additional amount the federal government would spend on Medicare would equal roughly $41 billion per year.

$370 billion + 11 percent ($370 billion x .11) = $40.7 billion

Appendix C
Source of $15 Billion to Banks and Financial Institutions for Health Savings Accounts

Diamond Consultants estimate that 15 million to 20 million Health Savings Accounts (HSA) will generate the following annual revenues:

Account Management Fees = $457 million
Asset Management Fees = $800 million
Transaction Fees = $1.2 billion

Total Annual Fees = $2.457 billion

If 15 million accounts generate $2.457 billion in fees, then each account would generate $164 in fees.
($2.457 billion/15 million) = $164

If 20 million accounts generate $2.457 billion in fees, then each account would generate $123 in fees.
($2.457 billion/20 million) = $123

Currently, 90 million households have employer-paid insurance policies.* If all 90 million households with employer-paid insurance open an HSA, and thus generate an account fee of $123 to $164 each—the total amount of fees that would go to banks would be $11.1 billion to $14.7 billion per year.

90 million x $123 = $11.1 billion
90 million x $164 = $14.7 billion

Difference in numbers due to rounding.

* Figure is based on projected total of employer-paid health policies for 2008. This estimate differs slightly from the data used by Peter Harbage because his estimates were based on data from 2007. Regardless of the enrollment projections, the additional fees generated per-person or per-account do not change.
Notes

4. Harbage.
5. Harbage.
7. Health08.org.
15. Congressional Budget Office, CBO’s Health Insurance Simulation Model.
17. B. Grow and R. Berner, “Fresh Pain for the Uninsured: As doctors and hospitals turn to GE, Citi, and smaller rivals to finance patient care, the sick pay much more,” Business Week, December 3, 2007.
20. For a review of 100 studies linking RN staffing to patient outcomes see Sean P. Clarke, “Making the Business Case for Nursing,” Nurse Leader (August 2007).