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Public option predicated on failure

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In government, there's nothing like failure to ensure a program will be tried again. A new coat of rhetorical paint, some rearranging of the deck chairs on the previously sunken ship and everyone's ready to give it a go again.

What officials believe when they reinstitute all or a major portion of a previously failed program falls into one of three categories, occasionally all three: The program was not sufficiently funded, those implementing the prior effort were just not as clever as those now attempting it and, finally, the public was not smart enough to appreciate it.

All three of these things are present in the Colorado Legislature and governor's office attempt to resurrect what was essentially a deceased portion of the Affordable Care Act to lower health insurance premiums in Colorado, particularly in mountain communities, that increased because of the original implementation of the Affordable Care Act.

That concept is that of "reinsurance" and it's being promoted with enough starry-eyed exuberance to give more sober members of the public pause.

Reinsurance in its workings is complex but its concept is not. In the original Affordable Care Act the phrase "reinsurance" described the program where the federal government created a pool of money (by creating, I mean getting it from you) that would be available for insurance companies to dip into to reimburse high cost claims they were required to absorb under the Act. That federal program expired in 2016 and I think all of us can see what a tremendous job it did in controlling premiums.

The libertarian Cato Institute determined that during this period, "Premiums increased 18-25 percent per year from 2013 through 2016, well above the trend of 3-4 percent from 2008 to 2013. By 2017, premiums had doubled — a cumulative increase of 99 percent or 105 percent, depending on the source — from pre-Obamacare levels."

Now, our governor would like to institute this program on the state level, creating a pool of money by charging new fees on providers such as hospitals and diverting funds from other state programs, such as affordable housing.

This is to allow health insurers, particularly in communities where there are not many sources of insurance, the ability to offset their costs and thus lower premiums in those areas. If this were to happen, and there is no guarantee that it will, it will likely only lower costs for one year. The next year insurers, as they did in the federal program, will recalibrate and again raise premiums — driven by the necessity of trying to fund a failing approach to health care.

What this program will do, is make it appear to some consumers that the Legislature is helping lower premiums and not replace legislators during the 2020 elections when the presidential race will likely bring a high percentage of conservative voters to the polls.

It will also ultimately fail for the same reasons the Affordable Care Act was constructed to fail: so that after 2020, the Democrats in the state legislature (should they still maintain a majority in both houses) can claim that a public finance option is the only feasible method of addressing health-care funding.

This time would be much better spent in determining why health care has become so expensive. One reason would be the expansion and subsequent increased workload associated of the International Classification of Diseases, version 10 (ICD – 10) which is the coding that must be submitted by physicians and treatment providers to be reimbursed by Medicare/Medicaid and private insurance in order to be paid. The classification will often determine the amount paid for the visit or procedure.

ICD – 9 had about 3,800 codes identifying medical procedures and 14,000 codes connected to types of diagnosis. In a truly bizarre example of bureaucratic reasoning, the Centers for Medicare and Medicaid Services decided that greatly enlarging the number of codes would capture more data and be more efficient.

Therefore, the ICD – 10, which began implementation in 2015, has 70,000 procedure codes and around 69,000 diagnostic ones.

They include such useful codes as V97.33XD: Sucked into jet engine and W61.62XD: Struck by duck. There's even a code for the increasingly important "spacecraft collision injuring occupant."

There are many other wastes of time and money that medical providers must wade through to get paid and yet we keep being told the solution is more government involvement and public money.

Perhaps if we stop requiring so many ultimately pointless things from the private sector to satisfy the public one, things might get cheaper to provide.