

Changes in Health Care Financing

Over

The Next Four Years

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Health Care Financing

- Trends in health care financing are ominous.
- The fate of Medicare and Medicaid are related to solutions for everything else.
- This is one of the most important political issue for the next election (other than Iraq).
- Agenda Today: Set the stage.

Objectives

- Brief history of health care financing.
- Introduce basic health care financing concepts.
- Introduce current problems in healthcare financing, including:
 - rising medical expense;
 - rising rates of uninsurance;
 - perception of mediocre quality;
 - Perception of wasteful expense.
- Set the stage for the political debate over the next three years.

Wages versus Premiums

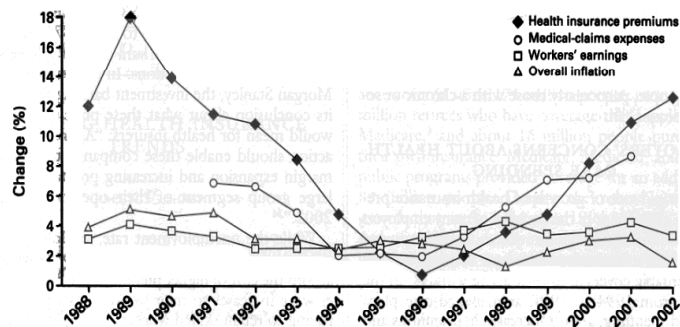
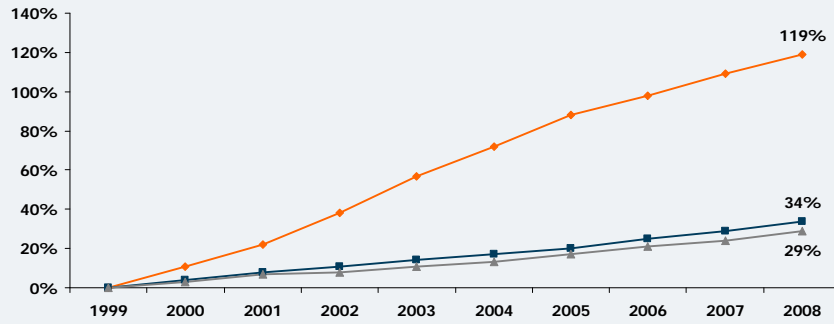


Figure 1. Changes in Health Insurance Premiums, as Compared with Overall Inflation, Workers' Earnings, and Medical-Claims Expenses, 1988 through 2002.

Data are from the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, the KPMG Survey of Employer-Sponsored Health Benefits, and the Bureau of Labor Statistics. The change from the previous year is statistically significant for 1997–1998, 1998–1999, 1999–2000, 2000–2001, and 2001–2002. Significance tests were not performed for the years before 1997 or for workers' earnings or overall inflation. The sample included firms with 200 or more workers only.

Source: Iglehart JK. Changing health insurance trends. NEJM 2002; 347(12):956-962

Cumulative Changes in Health Insurance Premiums, Inflation, and Workers' Earnings, 1999-2008



Note: Due to a change in methods, the cumulative changes in the average family premium are somewhat different from those reported in previous versions of the Kaiser/HRET Survey of Employer-Sponsored Health Benefits. See the Survey Design and Methods Section for more information, available at <http://www.kff.org/insurance/7790/index.cfm>.

—◆— Health Insurance Premiums
—■— Workers' Earnings
—▲— Overall Inflation

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 2000-2008; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2008 (April to April).



History of Health Insurance

Origins of Health Insurance

- 1847 - Mass Health Insurance Co.
- 1848 - Rail Road Passengers' Assurance Co
- 1883 – Bismarck, Anti-Socialist movement
 - Health Insurance Act
- 1890 - St. Lawrence Life Association
- 1860-1920 - various expansions on idea
- 1929 - Justin F. Kimball
 - concept of prepaid group health care for teachers in Dallas School District (later known as Blue Cross Plan)
- 1940's – Health insurance as employment benefit

Medicare History

- Repeated efforts to pass national health insurance
 - Teddy Roosevelt (tried to emulate Bismarck)
 - Harry Truman
 - Hill-Burton Act
 - Lyndon Johnson
 - Compromised and tried to provide coverage for persons who would otherwise have been uninsured: elderly, impoverished.
- Three Layered Cake from a smoke filled room.
 - Wilbur Mills, Arkansas, Chairman, House Ways and Means

Source: Corning PA, The Evolution of Medicare: from idea to law. USDHEW, report 29, 1969.

Available on www.ssa.gov



Saint Lyndon signing the Act, July 30, 1965, Independence, Missouri

Some Terms

- Insurance
- Prepaid Group Care
- Social Insurance
- Adverse Selection
 - Sickest individuals will tend to select plans with lowest co-pays and deductibles, thus driving premiums up.
- Moral Hazard
 - Third party payment will tend to encourage utilization.
- Social Justice vs Market Justice

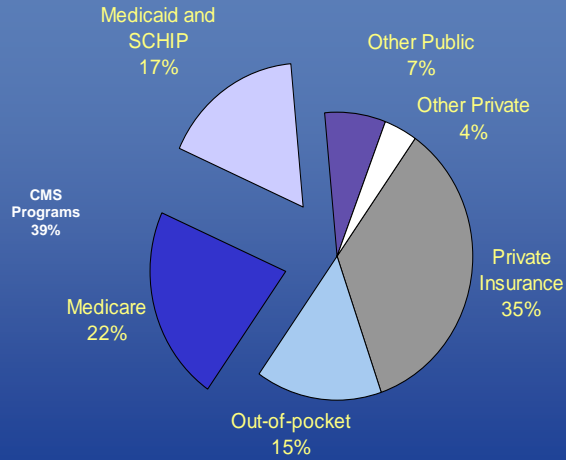
The Major Themes

- Social Justice
 - Shared responsibility
 - Concern for communal well-being
 - Equity or “Equality”
- Market Justice
 - Individualism
 - Self-Interest
 - Personal Effort
 - Voluntary Behavior
 - “Freedom”

Macro View of Health Care Financing



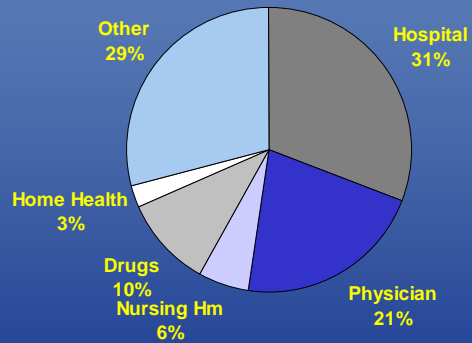
The Nation's Health Dollar, CY 2006



Total National Health Spending = \$2.1 Trillion

Source: MedPac, 2008 ChartBook

The Nation's Health Dollar, CY 2006



Total Health Spending = \$2.1 Trillion

Major “Payors”

- Medicare
- Medicaid/SCHIP
- Veterans Admin.
- Dept of Defense
 - Active Duty
 - Retirees & Dependents
- Indian Health Service
- Railroad Retirees, etc.
- Private “Insurance”
 - Employer-Based
 - Individual
- Local/State Hospitals
- Workers’ Comp.
- Self-Pay

Where are the Dollars From?

- Federal, state local governments pay 45% directly
- Another 10% paid by federal government in tax subsidies
- Taxpayers pay >50% of all health care costs (directly or indirectly).
- The rest is paid by the people –
 - Either directly, as premiums,
 - Or Indirectly as wage replacements.

Problems



Problems

- Healthcare inflation outpacing wage inflation.
- Perception of poor quality.
- The uninsured.
- Waste.
- New technology does not replace older technologies.
- Excessive administrative costs.

Wages versus Premiums

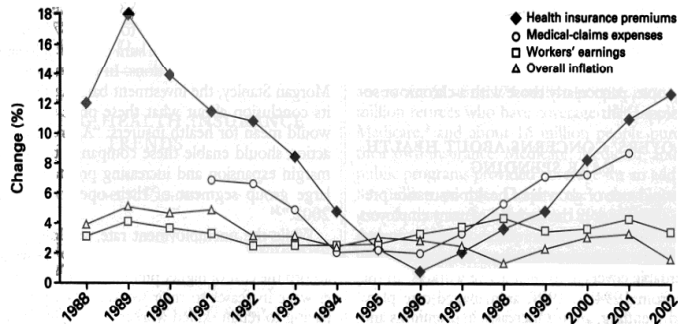


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Quality of Care

- A Rand Study showed that only 54.9% of patients received recommended care
 - Using 439 indicators of quality for 30 acute and chronic conditions.
- Concluded that deficits in care pose serious threats to health of the American public

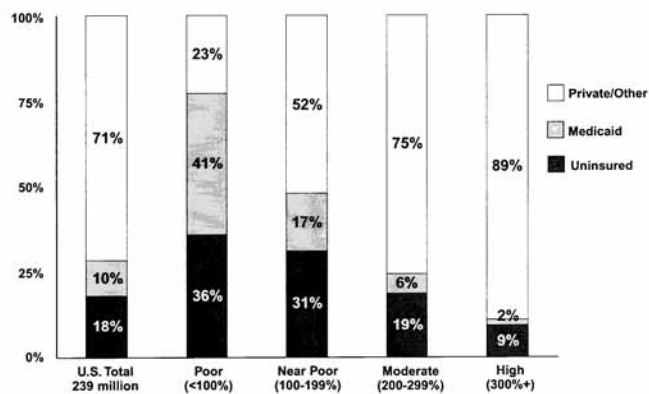
McGlynn EA, et al. The Quality of Health Care Delivered to Adults in the United States, *New England Journal of Medicine*, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645.

Uninsured

- Over 40 million in US
- Steadily increasing as health care costs continue to outpace wage inflation.
- Strongly related to income, early retirement, chronic illness.

Nonelderly Americans without health insurance are mostly in poor or nearly impoverished families. About one in three in families with incomes below 200% of the poverty level lacks private or public health coverage.

Health Insurance Coverage of the Nonelderly, by Poverty Level, 1998



Note: The federal poverty level for a family of three in 1998 was \$13, 650
Percentages may not total to 100 due to rounding
SOURCE: Urban Institute, 1999
DATA: Current Population Survey, March 1999
See Table 1

Source: Kaiser Family Foundation, UNINSURED IN AMERICA, p. 11.

Current Conditions in Texas

- 25.1% of Texans or 5.6 million were without health insurance in 2004 – one out of every four.
- 15.7% or 46 million Americans were without health insurance in 2004.
- The problem will worsen as the population in Texas increases from 22 million in 2003 to a projected 51.7 million in 2040.

Who are the Uninsured?

- Many adults do not qualify for Medicaid in Texas.
- Medical Indigence in Texas is currently defined as those living at or less than 21% the federal poverty line – less than \$1700 a year for a single adult.
- The State Children's Health Insurance Program covers children who make at or less than 200% the federal poverty line, but their parents are not covered.

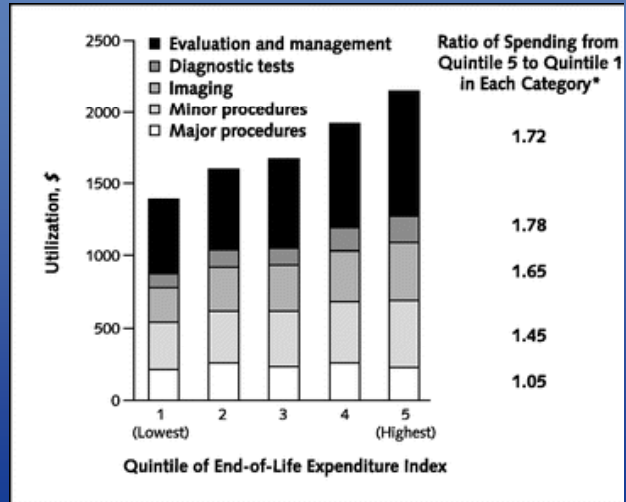
Who are the Uninsured?

- 79% of uninsured adults in Texas work or are members of families where someone works.
- Only 37% of small employers (less than 50 employees) offer health insurance and only 35% of their employees actually enroll.
- For a family of four at the federal poverty line (\$20,000 a year), the average cost of health insurance is \$9,100 – almost half their income.
- Median income for a family of four in the US is about \$65,000

Bankruptcy

- Many bankruptcies are related to healthcare costs

Waste in Medicare



Source: Fisher et al. *Annals Internal Medicine*, 2003, 138:273-287

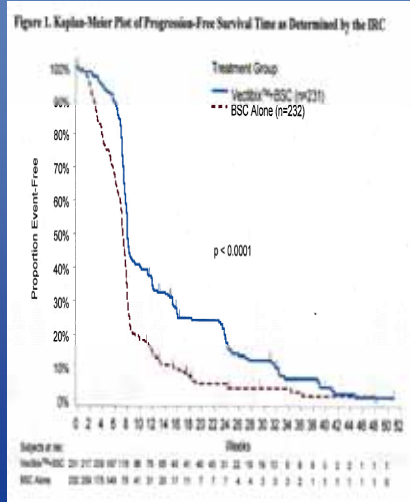
New Technology

- Often additive rather than replacing.
- Added costs rarely justified by slight improvements.

New Drug: Vectibix

INDICATIONS AND USAGE

- Vectibix™ is indicated for the treatment of EGFR-expressing, metastatic colorectal carcinoma with disease progression on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens.
- The effectiveness of Vectibix™ for the treatment of EGFR-expressing, metastatic colorectal carcinoma is based on progression-free survival (see CLINICAL STUDIES). **Currently no data are available that demonstrate an improvement in disease-related symptoms or increased survival with Vectibix™.**

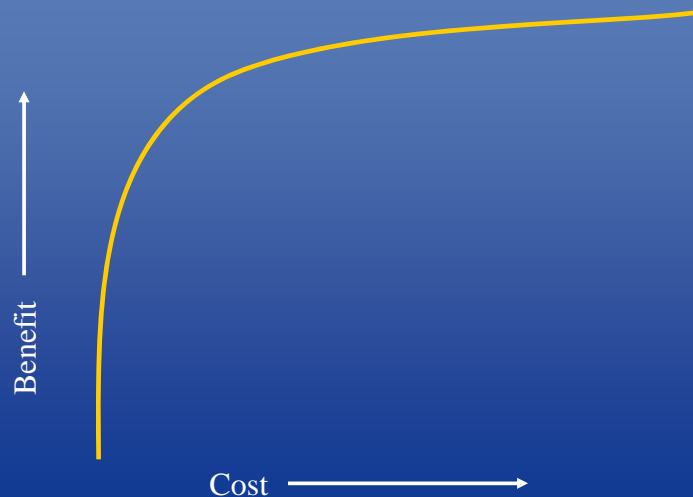


Cost Per Dose = \$6,000 including \$1,200 co-pay

New Machine: Proton Beam

- World's most expensive piece of medical equipment.
 - Units operational in California, Massachusetts, Texas, Florida and Indiana.
 - Units being planned in Pennsylvania, Virginia, Oklahoma.
- One controlled trial showing no difference in survival with proton beam radiotherapy versus 3D conformal for prostate cancer.
- Course of therapy comparison:
 - \$2,500 with 3D conformal RT
 - \$36,000 with PBRT

Flat of the Curve



Administrative Costs

- Estimate “System” Administrative Costs
 - Canada: 17%
 - US: 35%
- Health Plan Administrative Costs
 - Traditional Medicare: 2% to 5%
 - Private Insurance (PPO, Managed Care):
 - 8% to 17%
- Difference mainly in marketing and identification of insureds.

Woolhandler, NEJM, 349:768-75, 2003

Current State of U.S. Healthcare

- Pluralistic system
 - Majority of care publicly funded.
 - Increasing proportion of care publicly funded.
- Costs increasing faster than wages.
- Mediocre quality.
- Waste as evidenced by quality neutral geographic variation in costs.
- 14.6% (41 million persons) uninsured.
 - Strongly related to income and size of employer.
- Racial disparities in health and healthcare.
- Marginal value of new technology
 - “Flat of the Curve” Medicine.
- Excessive administrative Costs

Solutions: What to watch over the next three years



Next Three Years

- Three “venues” to watch
 - States, Medicare-fixes, National Health Insurance and other federal initiatives
- States
 - Will try to expand coverage to reduce uninsured.
 - Tweaking regulations for private and group insurance.
 - Some states will mandate health insurance.
 - Will try to maximize federal Medicaid match.
 - Will seek funds from a “provider tax”.
 - Massachusetts, California, Pennsylvania
 - Example States: Vermont, Oregon, Massachusetts
 - Texas?

Next Three Years, con't

- Medicare
 - Addition of quality measures.
 - Addition of incentives for EMR.
 - Reduction in payments to Part C?
 - Tweaking Part D.
 - Tweaking various payment processes
 - Especially physician payment formula.
 - Demonstration Projects:
 - Health Home Demo
 - Acute Care Episode
 - Additional taxes doubtful over next 2 years until after mid-term elections.

Next Three Years, con't

- National Health Insurance
 - Last major reform effort – 1992.
 - Congressman Rangel has used the term “Medicare for all”
 - Chairman of the House Ways and Means
 - New York Times has frequent op-ed pieces on funding for health care.
 - This may command a great deal of rhetoric over the next two years.
 - No definitive action likely until after the mid term election because of related taxes.
- Other Federal Initiatives: Tax incentives?

Rationing

- Currently,
 - Rationing is by access to insurance
 - Numerous studies show that uninsureds are less healthy than insureds
- Is there a better way to ration health care?

The Debate

- Democrats
 - Will speak on terms of “Social Justice”
 - Universal coverage
 - “Equality”
- Republicans
 - Will speak on “Market Justice”
 - “Freedom”

The President-Elect



Obama's Plan

- “Play or pay” mandate for business (offer insurance or pay a tax).
- New national health plan (like Medicare) for uninsureds, small business.
 - Choice of private insurance plans.
- Mandate for children.
- Subsidies for lower income.
- More federal regulation of private insurance.
- Federal reinsurance program to protect business.

The Players

- The President
 - Provides leadership – “the Bully Pulpit”
 - Provides the urgency to act; motivation.
 - Does not provide the final specifics.
- Congress
 - Will develop a compromise.

Chairman Rangel



The Compromise

- Where will Congress draw the line?

Social
Justice

Market
Justice



Single Payor,
Government Run
Program

Corporate Driven,
Profit Oriented
Market

The Proposals

- Senator Baucus
 - Medicare buy-in for age 55 and older.
 - Medicaid for all below poverty line.
 - CHIP for all <250% of poverty line.
 - Tax credits to small businesses and individuals.
- Senator Kennedy
 - ?
- Representative Dingell
 - ?

Real Question

- As a society, how will we address the rising costs of healthcare?
 - Market justice
 - May guarantee lack of access for rising proportion of individuals until rate of increase in costs abates.
 - Social justice
 - May mean some loss of freedom for some:
 - Physicians, hospitals, drug and device companies, insurance companies.

Physician-Patient Relationship

- Inherently unequal
 - Knowledge or expertise gap
 - Fact of illness
- Fiduciary relationship
 - obligations assumed by physician
- Social Justice or Market Justice?
- Moral Hazard – The physician and patient will want to use whatever technology “may” improve patient no matter what the expense or proven effectiveness.

Ways to Influence Costs

- Physicians garner only 22% of medical expense, but they collectively “drive” more than 80% of the expense.
- Haley’s Law of Healthcare Cost Control
 - Success in controlling healthcare costs depend on success in controlling physician behaviors.
 - If you control Physician Behavior, you control health care costs.

The Real Question

- Given the nature of the physician patient relationship and the attendant “moral hazard”, it would seem that the only way to control costs is for an entity outside of that relationship to define and enforce limits.
 - Should that outside entity be a government entity ultimately driven by a representative, deliberative political process involving compromise;
 - Or should that outside entity be a profit oriented corporation?

References

- John Winthrop: A Modell of Christian Charity (1630).
- www.coderedtexas.org
- www.health08.org
- Bending the Curve at www.kaiserfamilyfoundation.org
- 2008 Data Book at www.medpac.gov

