

The future of health care



Illinois State Association of Health Underwriters

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Agenda

1. A quick history of health insurance
2. The role of tax policy
3. Healthcare spending in the U.S.
4. International comparisons
5. Health care financing, health care, and health
6. The case for competition and consumerism
7. Market-oriented healthcare reform ideas
8. Moving toward a “21st Century” system with universal access
9. Key questions to ask



1. A quick history of health insurance

- The first modern group health insurance plan was formed in 1929.
- Blue Cross and Blue Shield entities begin offering group health plans in 1932.
- Several large life insurance companies entered the health insurance field in the '30's and '40's.



1. A quick history of health insurance

- WWII wage freezes imposed by the federal government.
- Employee benefit plans proliferated in the '40's and '50's. Strong unions bargained for better benefit packages, including tax-free, employer-sponsored health insurance.



1. A quick history of health insurance

- Social Security was expanded in 1954 to provide disability benefits.
- Medicare and Medicaid were implemented January 1, 1966 during the Johnson administration.
- ERISA, passed in 1974 as a pension reform bill, reinforced the employer's role in providing health benefits.



1. A quick history of health insurance

- 1970s: Private health insurance moves toward comprehensive major medical insurance.
- The Federal HMO Act was legislated by Congress in 1973.
- PPOs, HMOs, and POS plans emerge during the '80s and '90s as the prevalent form of private health insurance.



1. A quick history of health insurance

- By 2001 93% of private insurance was of the managed care variety.
- Over the last 5 years, the clear trend has been away from HMOs and toward CDHPs (consumer-driven health plans).



1. A quick history of health insurance

- In 1940 the total US population was 127 million. About 12 million Americans (9.4%) were covered by some form of private health insurance.
- At the end of 2006 249.8 million (84.2%) were insured, and 47.0 million uninsured (15.8%)*.



* Source: Census Bureau publication - **Income, Poverty, and Health Insurance Coverage in the United States: 2006** - <http://www.census.gov/prod/2007pubs/p60-233.pdf>

1. A quick history of health insurance

- Sources of health insurance coverage:

Source	U.S.	Illinois
Employer	54%	59%
Individual	5%	4%
Medicaid	13%	10%
Medicare	12%	12%
Other Public	1%	1%
Uninsured	15%	13%



Source: Kaiser Family Foundation, *Health Insurance Coverage of the Total Population, U.S. (2005), states (2004-2005)*

2. Role of tax policy

- The biggest tax break that the American people get is the invisible tax exclusion that protects the value of health insurance premiums from their income at work.
- In the Administration's FY08 federal budget proposal the economic value of the tax exclusion for job-based insurance is pegged at \$160 billion. Contrast this with the value of the deduction of mortgage interest, which is "only" \$89 billion.



2. Role of tax policy

- Health insurance tax equity is clearly needed. Individuals who don't have job-based coverage should at least receive the same tax break on their health insurance premiums that the self-employed and citizens with job-based coverage receive.
- Advanceable and refundable federal health insurance tax credits are a targeted solution for lower-income citizens. A major demographic of the uninsured are those who make too much to qualify for government health programs but cannot afford health insurance even when subsidized by their employers.



For more information on health ins. tax credits visit <http://www.nahu.org/legislative/uninsured/credits.cfm>

3. Health care spending in the U.S.

- In 2005 (the latest year data are available) total national health expenditures rose 6.9% -- two times the general rate of inflation.
- Total spending, public and private, was \$2 trillion in 2005, or \$6,700 per person, representing 16 percent of the gross domestic product (GDP).
- U.S. health care spending is expected to increase at similar levels for the next decade reaching \$4 trillion by 2015, or 20 percent of GDP.



3. Health care spending in the U.S.

- Do we spend too much? Who is “we” and what is the “right amount”?
- Data from around the world show that people tend to spend a bigger part of their incomes on healthcare as they grow wealthier. *(OECD 2004)* Health is what economists call a “superior good,” which means spending rises faster than income.
- Higher spending on healthcare is responsible for some part of the significant increases in lifespan and reduced disability during the past half century. *(Cutler 2004, Gratzner 2006)*



Source: “Ten Principles of Health Care Policy”, 2007, Heartland Institute

4. International comparisons

- In the U.S. we invest much more in saving prematurely born infants and extending the life of our elderly than do other countries. *(Wesbury 1990, Wennberg 2006)*
- Pregnancy, birth, and abortion rates among girls aged 15 to 19 are higher in the U.S. than in other developed countries. *(Singh and Darroch 2000)*
- Obesity rate for U.S. adult population is nearly double that of Canada and substantially higher than the EU. *(Anderson and Hussey 2000).*



Source: "Ten Principles of Health Care Policy", 2007, Heartland Institute

4. International comparisons

- Canadians live 2 ½ years longer than Americans; and Europeans live a little more than a year longer than we do. Reasons for this (other than a lack of access to health insurance) include...
 - Americans are 3 times more likely than Canadians to die in auto accidents, and 10 times more likely to die (than our neighbors to the north) as a victim of a violent crime.
 - Elaborating on a point made in the previous slide, Americans eat more and move less than people in other countries. More than 60% of Americans are overweight, and almost 40% are obese.



Source: Obesity: World Health Organization, 2006. NOTE: Obesity is commonly defined as a Body Mass Index (BMI) of greater than or equal to 30.

4. International comparisons

- The U.S. spends more on its healthcare than other countries, although all countries are experiencing high rates of spending growth.
- America's health care spending drives much of the world's medical innovations.
- If we take the international health results and expenditures data at face value, they imply that greater access to health care does not in and of itself improve health outcomes (after accounting for lifestyle factors).



4. International comparisons

- Health outcomes improve with income even under single-payer systems. Informed estimates suggest this gradient is no steeper in the U.S. than it is in Canada.
- Some of the health care savings of other systems occur through price effects (e.g., doctors are paid an average of \$60,000 in France) and do not involve real resource savings.
- American health outcomes look much better once they are adjusted for race and other demographic factors, including violence and car crashes. Some groups -- such as Asian-American women -- have remarkably good health outcomes.



4. International comparisons

- Recently public opinion surveys were conducted in 26 single-payer countries. In 25, majorities of respondents identified health system reform in their countries as an “urgent priority.”
- In Great Britain, in a November 2006 survey over half the respondents rated the NHS worse than in 1996.
- Isn't it comforting to know that we are not the only ones in the Western developed world who have problems with their healthcare systems?



4. International comparisons - Canada

Does universal coverage = universal access?

- A lawsuit reached the Supreme Court of Canada in June, 2005. A Quebec businessman who waited 12 months for a hip surgery wanted to pay out of his own pocket to get it done in Canada but was not permitted. The Supreme Court agreed that the system wasn't working. In fact the full quote from the decision is as follows:
 - *“We conclude, based on the evidence, that prohibiting health insurance that would permit ordinary Canadians to access health care, in the circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with life and security of the person as protected by Section 7 of the Charter.”*



4. International comparisons - Canada

- Another lawsuit was filed in September of 2006 by a Calgary man who paid for a state-of-the-art hip replacement in the U.S. after being told he was too old to qualify for it under Alberta's provincial health plan.
- "The principles in the Canada Health Act are either upheld or we stop pretending like they're being upheld and we have some kind of different system," British Columbia Medical Association president Dr. Margaret MacDiarmid said.



Source: "B.C. taking action against urgent-care clinic"

http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20061130/bc_clinic_061130/20061201?hub=Canada

4. International comparisons - Canada

- It has been reported in the news recently that private health clinics offering urgent care services are opening up in British Columbia. Such clinics are clearly breaking the law, since the private payment for services covered under the Canada Health Act, by statute, is not permitted.
- The Urgent Care Centre in Victoria, British Columbia, opened its doors in December of 2006. It placed an ad in the Yellow Pages, boasting that it provides treatment "for conditions requiring prompt attention."



Source: "B.C. taking action against urgent-care clinic"

http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20061130/bc_clinic_061130/20061201?hub=Canada

4. International comparisons - Canada

- Critics say the clinic's debut will further open the door to increased privatization of services in British Columbia, which leads other provinces when it comes to for-profit health care.
- Mike McBane, spokesman for the Canadian Health Coalition, said private health insurance can't be too far behind if clinics charging fees for services paid under Canada's Medicare system are allowed to flourish.



Source: "B.C. taking action against urgent-care clinic"

http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20061130/bc_clinic_061130/20061201?hub=Canada

4. International comparisons - Canada

- Recently mothers in British Columbia had to be flown to hospitals in Washington to receive treatment. Three mothers were airlifted in the first weekend of October alone. Said one mother from her Seattle hospital bed, "I just want to go home and see my kids. I think it's stupid I have to be here."
- Canada's health care system is hurting, government officials admit, citing not enough money for more equipment and staff to handle high risk births.
- Sarah Plank, a spokeswoman for the British Columbia Ministry of Health, said a spike in high risk and premature births coupled with the lack of trained nurses prompted the surge in mothers heading across the border for better care.



Source: Fox News, October 10, 2007 - <http://www.foxnews.com/story/0,2933,300939,00.html>

4. International comparisons - Canada

Here is what a Canadian-style single-payer system would look like, based on the Canadian experience (and after adjusting for differences in population):

- Scrap most technological equipment, including 330 Lithotripters, 6,000 MRIs, and 23,750 CT Scanners
- Make 1/2 of the drugs approved by the FDA in the past 5 years illegal
- Give 10% more of your gross income to support “free health care”
- Cut national research & development by \$77 Billion (25%)
- Never again be allowed to visit a specialist or even get a test without first getting a referral from a family doctor
- Put 7,730,000 people on waiting lists



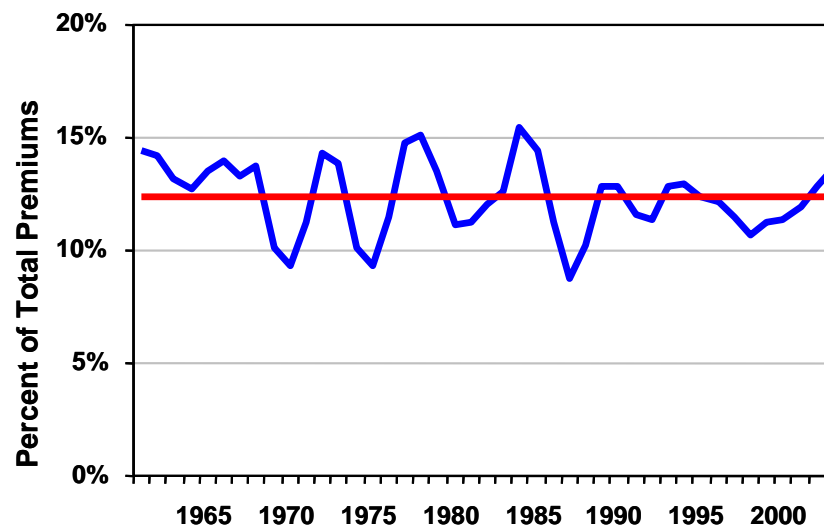
5. Health care financing

- One of the most common, and least challenged, assertions in health care financing debates is that Medicare administrative costs are about 2% of claims costs, while private insurance companies' administrative costs are in the 20%-25% range.
- Medicare's actual administrative costs are 5.2% when the hidden costs are included, according to a technical paper recently done by Mark Litow of Milliman, Inc.
- Further, because of the higher cost per beneficiary, Medicare administrative costs *appear* lower than they really are. If the numbers were adequately "handicapped" for comparison with the private sector, they would instead be in the 6% to 8% range.



5. Health care financing

- According to CMS estimates, the administrative costs, taxes, profits, and other non-benefit expenses of private health plans have averaged 12.4 percent of premiums over the last 40 years. This includes all types of health insurance purchased privately, ranging from employer-based coverage to individually purchased plans, Medigap and long-term care insurance, but do not include private health plans operating in Medicare or Medicaid.



Source: CMS Office of the Actuary, January 2005



5. Health care financing

Where Does Your Health Insurance Dollar Go?



*Includes prevention, disease management, care coordination, investments in health information technologies and health support.
 **Includes the inpatient costs of hospitals and the outpatient costs of hospitals and free-standing clinics.

Based on a PricewaterhouseCoopers' analysis, *Factors Fueling Rising Healthcare Costs 2006*.
 © 2006 America's Health Insurance Plans



Source: America's Health Insurance Plans (AHIP)

5. Health care (cost of)

System inefficiencies

- Duplication of procedures and overuse of high-end procedures that add little value BUT increase spending unnecessarily
- System rewards quantity, not quality, of care, which contributes to widespread variations in the way health care is delivered, from failure to deliver needed care to huge numbers of unnecessary procedures that drive up costs and endanger patients



5. Health care (cost of)

- Preventable medical errors – 44,000–98,000* people die in hospitals each year because of errors.
- The Institute of Medicine (IOM) estimates that medical errors cost Americans approximately \$37.6 billion each year, and about \$17 billion of those costs are attributable to preventable medical errors.
- 25% of physician visits (costing \$11.4 billion annually) and 55% of emergency-room visits (costing \$14.7 billion annually) are unnecessary, according to the American Institute for Preventive Medicine.



Source: November 1999 report of the national Institute of Medicine.

5. Health care (cost of)

Medical malpractice

- Medical liability insurance costs are on the rise, directly affecting health care costs in this country.
- An even more costly side-effect of rising medical malpractice insurance rates is when doctors order more tests, medications and referrals than are medically necessary to protect against accusations of negligence.
- Medical liability costs and defensive medicine, combined, currently account for 10% of health care costs.



5. Health care (cost of)

Cost shifting

- Cost-shifting is a “hidden tax” imposed when providers of medical care adjust the prices they charge to private insurance companies in order to offset losses from partial or non-payers. These losses are primarily attributable to uncompensated care costs and declining reimbursements from Medicare and Medicaid, and have a significant impact on private health insurance premiums.



5. Health care (cost of)

Cost shifting

- In the State of Washington, where Medicare pays about 25% less than private insurers, hospitals in 2004 charged private payers \$738 million to make up for underpayments and physicians charged private payers \$620 million to make up for shortfalls — almost \$1.4 billion. That translates to \$902 per family insurance policy, or 13% of all commercial hospital and physician payments. Results were similar in California, where employers and employees paid about \$951 per family insurance policy to cover losses from Medicare and Medi-Cal.



Source: Margaretann Cross. *Managed Care December 2006*. "Confronting the Medicare Cost Shift."

5. Health care (cost of)

Increased utilization

- In 2006 higher utilization of services accounted for 43% of the year-over-year increases in the costs of health care, fueled by factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles.



5. Health

Population health management

- Here is a summary of strategies that are being implemented in private plans:
 1. Incentives/penalties for healthy/unhealthy behaviors.
 2. Full coverage for preventive care benefits.
 3. Health coaches/onsite health centers
 4. More communication/more tools
 5. More health savings accounts/fewer plan options



6. The case for competition and consumerism

- Many health policy analysts believe making consumers aware of the actual cost of health services will improve the relationship between the consumer (i.e., patient) and the physician.
- Once consumers control payment for most services, they will become more inclined to shop for services and inquire about the cost and quality of that care, which in turn should lead to improved quality and increased patient satisfaction.



6. The case for competition and consumerism

- Many do not believe it is appropriate to rely on market mechanisms for financing and delivering healthcare. **But economic forces work in healthcare just as they do in other markets.** To wit...
- **Price controls lead to shortages.** Medicaid programs set fees for doctor visits below market prices and often below the cost of the visit. As a result, there is a shortage of doctors willing to treat Medicaid patients.



Source: "Ten Principles of Health Care Policy", 2007, Heartland Institute

6. The case for competition and consumerism

- **Competition reduces prices.** While health care costs overall have risen dramatically in recent years, prices for Lasik and cosmetic surgical procedures, items not covered by insurance, have fallen.
- When Wal-Mart reduced the price of several hundred generic meds to \$4 for a month's supply, other pharmacies quickly followed suit.



6. The case for competition and consumerism

- **Emerging trend - Convenient care clinics.**
Wal-Mart now has 76 RediClinics in 12 states, with plans to expand this to 400 clinics by 2009 and 2,000 within 5 years. CVS, Walgreens, Target, and others are following suit.
- Prices vary for services from flu shots (\$15-\$30), to care for allergies, poison ivy and pink eye (\$50-\$60), and tests for cholesterol, diabetes and pregnancy (less than \$50).



Source: "Customer Health Care", WSJ Commentary, May 14, 2007, Page A17 / <http://www.convenientcareassociation.org/>

6. The case for competition and consumerism

- A Harris Interactive poll conducted in March for The Wall Street Journal said that 22% of those visiting convenient care clinics are uninsured. Wal-Mart says that half of its clinic visitors are uninsured.
- Retail clinics are also attractive to 4.5 million people with Health Savings Accounts who have health insurance with higher deductibles and want an affordable option for some of their routine care.



Source: "Customer Health Care", WSJ Commentary, May 14, 2007, Page A17 / <http://www.convenientcareassociation.org/>

6. The case for competition and consumerism

- **Consumer Driven Health Plans (CDHPs)** got a “jump start” in June of 2002 when the Internal Revenue Service confirmed the favorable tax treatment of employer-provided coverage and medical care expense reimbursements under health reimbursement arrangements (HRAs).
- **Health Savings Accounts (HSAs)** were created shortly thereafter following the passage of the Medicare Modernization Act in December of 2003.



6. The case for competition and consumerism

- There are more than 10 million Americans with account-based health plan arrangements - 4.5 million with health savings accounts (HSAs) and 6 million have health reimbursement accounts (HRAs).
- In 2006 the Treasury Department projected more than 21 million HSAs by the end of 2010 if the HSA rules were to be revised, which occurred in Dec., 2006.
- The average HSA established now will have a \$22,000 balance ten years from now. Unspent balances in HSAs will help employees better plan for and afford health care in retirement.



* Sources: *America's Health Insurance Plans*, April, 2007; "Fact Sheet: Dramatic Growth of HSAs" - <http://www.treas.gov/offices/public-affairs/hsa/>

6. The case for competition and consumerism

- At the end of the day, tax-favored account-based plans should swing the pendulum away from third party payment and pre-paid healthcare and move us back toward more of a direct payment model, which the baby boomers grew up with when the family doctor used to make house calls and Dad handed the doctor a check or paid him with cash.
- Once account-based plans achieve critical mass (2010-2011?), their prevalence should help curb overutilization, a significant healthcare cost driver.



7. Market-oriented healthcare reform ideas

- America's Health Insurance Plans (AHIP) has put forth the idea of universal health accounts (UHAs).
- Like HSAs, the new UHAs would allow pre-tax deposits to be made by employers and employees. Employees would own the UHA funds, so there would be portability in the event of one's loss of employment.
- Individuals with UHAs would be allowed to purchase insurance coverage in the group and non-group markets.



7. Market-oriented healthcare reform ideas

- UHAs could be paired with any health plan and help uninsured citizens buy health insurance on a pre-tax basis.
- For persons with incomes less than 300% FPL, the federal government would make matching contributions of up to \$1,000 for individuals and \$2,000 for families.



7. Market-oriented healthcare reform ideas

- **An unusual partnership** including Wal-Mart, labor unions, AT&T, and several policy groups in February of 2007 announced four principles to create "a new American health care system by 2012." The "Better Health Care Together" campaign calls for universal coverage and promotes the idea that "businesses, government, and individuals all should contribute."



7. Market-oriented healthcare reform ideas

- Nearly 40 firms launched the Coalition to Advance Healthcare Reform on May 7, 2007 - www.coalition4healthcare.org/
- Members of CAHR believe there are five core elements essential to any meaningful reform.
 - Market-based healthcare system
 - Universal coverage with individual responsibility
 - Financial assistance for low-income individuals
 - Healthier behavior and incentives
 - Equal tax treatment



Source: www.coalition4healthcare.org/

7. Market-oriented healthcare reform ideas

Health Care Freedom Coalition

- Free Choice of Doctors, Hospitals, and Health Plans
- HSAs Option for all Americans
- Tax Fairness and Simplification
- Affordable Health Insurance for Small Business
- Buying Health Insurance Across State Lines
- Health Care Price Disclosure
- High Risk Pools for People Who Are Sick
- Convert DSH Payments into Health Insurance Block Grants
- Allow nonprofit, faith-based alternatives for health insurance
- More competition between facilities



Source: <http://www.grassrootinstitute.org/GrassrootPerspective/AffordableHealthCareAgenda.pdf>

7. Market-oriented healthcare reform ideas

The Healthy Access proposal from NAHU incorporates many of the same principles as the foregoing and provides specific recommendations with regard to...

- Constraining health care costs
- Providing access to coverage for all Americans
- Financing access
- For more information visit

<http://www.nahu.org/legislative/healthyaccess/index.cfm>.



8. Moving toward a “21st Century” system with universal access

- America can lead the way in creating a health care system that fits our 21st century economy by putting in place new policies that respond to consumer demands for more affordable, portable health insurance. The means to achieving this include:
 - **Tax equity**: The first step would be giving favorable tax treatment of health insurance to everyone regardless of how they buy coverage, whether on their own or employment-based.
 - **Refundable tax credits**: Offer refundable tax credits for those in lower-income categories who need additional help in purchasing policies.



8. Moving toward a “21st Century” system with universal access

- **Encourage purchase of private insurance**: Public program eligibles should be permitted to apply the value of the subsidies for which they are eligible toward the purchase of private health insurance, whether on their own or employment-based.
- **Alternatives to job-based coverage**: Create new opportunities for citizens to purchase group health insurance through organizations that may be more stable forces in their lives than their jobs, such as churches, labor unions, and professional and trade associations.



9. Key questions to ask

- What are the appropriate roles for governments, individuals, and businesses?
- Do the policy proposals address the underlying causes of unnecessary health care spending, or just try to impose caps and mandates?
- Do the reforms empower consumers to make better choices, or leave them with less control over their health care and fewer choices?



9. Key questions to ask

- What role should personal responsibility play? What happens if we discourage it?
- What are the other possible unintended consequences of what is being proposed?
- What will things look like not next year or 5 years from now, but rather 10, 20, and 30 years from now?



Be sure to check out...

www.isahu.com/future.htm





Thank you