Family Well-Being, Public Policy and Economic Growth: Lessons from the Past and Insights for the Future

Jack Ebeler, Alliance of Community Health Plans
September 19, 2006
OVERVIEW

- Review the basics
- The messiness of the US system
- Variations
  - US/International
  - Within US
- Issues for review

U.S. HEALTH CARE SPENDING MUCH HIGHER THAN OTHER COUNTRIES

Health Spending as a Percent of GDP, 2002

United Kingdom | Japan | OECD median | Australia | Canada | Germany | Switzerland | United States
---|---|---|---|---|---|---|---
7.7% | 7.8% | 8.5% | 9.1% | 9.6% | 10.9% | 11.2% | 14.6%

"U.S. Health Spending Habits Grab International Attention," *Health Affairs* July/August 2005  Note: Most recent data show that NHE as percent of GDP in the U.S. in 2002 were 15.4% not the 14.6% given in the graph.
WE HAVE A GROWING FEDERAL DEFICIT (IF TAX CUTS EXTENDED)

Assuming extension of the tax cuts and revision in the alternative minimum tax, the deficit will climb to > than $632 billion by 2016.

US HAS MIXED PUBLIC/PRIVATE COVERAGE, THAT LEAVES 1/6 UNINSURED

Fronstin, EBRI, November 2005
THE MESSINESS OF US HEALTH CARE FINANCING

US health care doesn’t fit well into neat categories of social welfare transfer financing

- Medicare
- Medicaid
- Private insurance
MEDICARE HAS BROAD ENTITLEMENT, PAYROLL TAX AND GENERAL REVENUES, BUT ALSO ...

- Tax on Social Security benefits for higher income beneficiaries goes to Part A
- New means-tested Part B Premium
- Part D low-income subsidy – lower premium, cost-sharing and no “donut hole”
- MSP programs
- And, Medicaid as a backstop
MEDICARE'S MULTIPLE SOURCES OF FINANCING & SHORTFALLS (AS % OF GDP)

- Additional gap
- General revenue
- State
- Premiums
- Tax benefits
- Payroll taxes
MEDICAID STATUS OF MEDICARE BENEFICIARIES, 2002

Total Medicare Beneficiaries in 2002 = 40 million

- Other Medicare Beneficiaries: 32.4 million (82%)
- Full Dual-Eligibles: 6.2 million (15%)
- Partial Dual-Eligibles: 1.3 million (3%)

MEDICAID ALSO HAS MULTIPLE FINANCING SOURCES

- Federal general revenue
- State general revenue, plus...
MEDICAID IS ALSO MULTIPLE PROGRAMS FOR DIFFERENT GROUPS, 2003

- Elderly: 9%
- Disabled: 16%
- Adults: 27%
- Children: 48%

Total enrollees = 52.4 million

- Expenditures:
  - Elderly: 26%
  - Disabled: 43%
  - Adults: 12%
  - Children: 19%

Total expenditures = $252 billion

In 2004, US spent $1.9 trillion on health care: 16 percent of GDP

- $658 billion in private health insurance premiums in 2004 (5.6% of GDP)
  - $452 b from private/public employers (3.8% GDP)
  - $206 b from employees (1.8% GDP)
- Even there, a $106 billion tax subsidy (tax expenditure) – which is 1% GDP
LOOKING AT US VARIATIONS

- With other countries
- Within US
U.S. HEALTH CARE SPENDING MUCH HIGHER THAN OTHER COUNTRIES

Health Spending as a Percent of GDP, 2002

United Kingdom: 7.7%
Japan: 7.8%
OECD median: 8.5%
Australia: 9.1%
Canada: 9.6%
Germany: 10.9%
Switzerland: 11.2%
United States: 14.6%

72%, median to US
38%, high 3 to US

“U.S. Health Spending Habits Grab International Attention,” Health Affairs July/August 2005  Note: Most recent data show that NHE as percent of GDP in the U.S. in 2002 were 15.4% not the 14.6% given in the graph.
AND WITHIN US, MEDICARE SPENDING VARIES SIGNIFICANTLY

WITHIN US, HIGHER SPENDING NOT ASSOCIATED WITH BETTER QUALITY

HIGHER SPENDING NOT ASSOCIATED WITH BETTER QUALITY - STATEWIDE

Data on the statewide level show there is a negative relationship between cost and quality.

$2,000/capita difference: @ 30 percent

Baicker and Chandra, Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality Of Care, Health Affairs Web Exclusive, April 7, 2004
ONE KEY ISSUE IN US: SUPPLY-INDUCED DEMAND

- Studies indicate that the composition of the health care workforce explained 42 percent of the difference among states in Medicare spending.

- Higher spending regions have:
  - More physicians overall
  - Fewer general practitioners, more specialists

- States with more general practitioners had higher quality, lower cost.

Baicker and Chandra, “Medicare Spending, The Physician Workforce, And Beneficiaries’ Quality Of Care,” *Health Affairs* Web Exclusive, April 7, 2004
ISSUES, PART I

- Is health care an issue for US because it limits GDP growth, is it a value issue, or something else?
- How do we think about the mixed financing of US public and private programs in this analysis?
- Is there truly no equity/efficiency tradeoff?
- Should we be concerned about Medicare?
  - Cutler et.al: money has provided value
  - But:
    - $36,300 per YOLG overall in 1990s
    - $145,000 per YOLG for >65
ISSUES, PART II

- How address health coverage, public/private market issues?
- How address cost variation w/ other nations?
- How address quality/cost variation w/in US?
- What about Medicaid?
EXPANDING COVERAGE, GETTING VALUE FOR SPENDING

- How do we address health coverage expansions?
  - Publicly: is single payor “the” answer?
  - With revised private plus public combination?
  - Medicaid expansion? How do tax credits fit?

- How finance what we choose given new data?

- Do we care about international cost comparison?
  - Higher income/unit prices in US – is this inevitable? How deal with it?
  - Higher administrative costs: Multiple private, and public, payors must demonstrate value …
HOW DO WE ADDRESS COST/QUALITY VARIATION WITHIN THE COUNTRY?

- What do we do about substantial volume differences around country – which appear to be driven by delivery system structure and incentives?
- Can we “norm” the higher cost, lower quality Medicare regions to US median or better? (or to Switzerland?)
- Presume same variations in private non-public programs: how do we address that?
WHAT ABOUT MEDICAID?

- Implication is that broad-based, non-means tested programs preferable
- That is fine, but let’s not have this study be used to further attacks on Medicaid...
  - For better or worse, Medicaid critically important today
  - How do we either maintain, improve its financing and payments?
    - pending that better, broader approach
    - or as ongoing alternative in the absence of broad-based action
THANK YOU

For more information contact:
Jack Ebeler (Jebeler@achp.org)
202-785-2247
www.achp.org