NASI Seminar

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

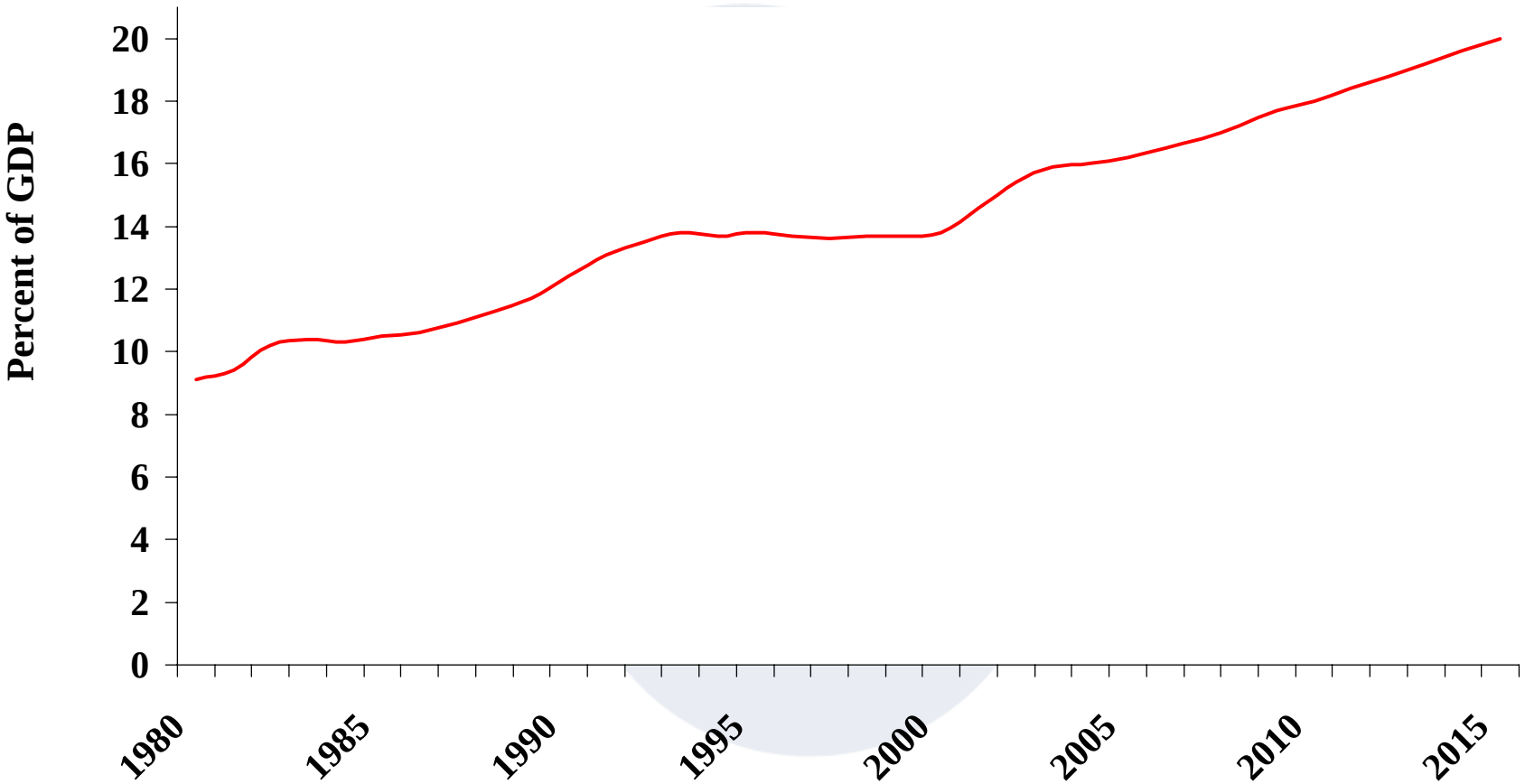
MAKING HEALTH CARE BETTER

ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

OVERVIEW

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

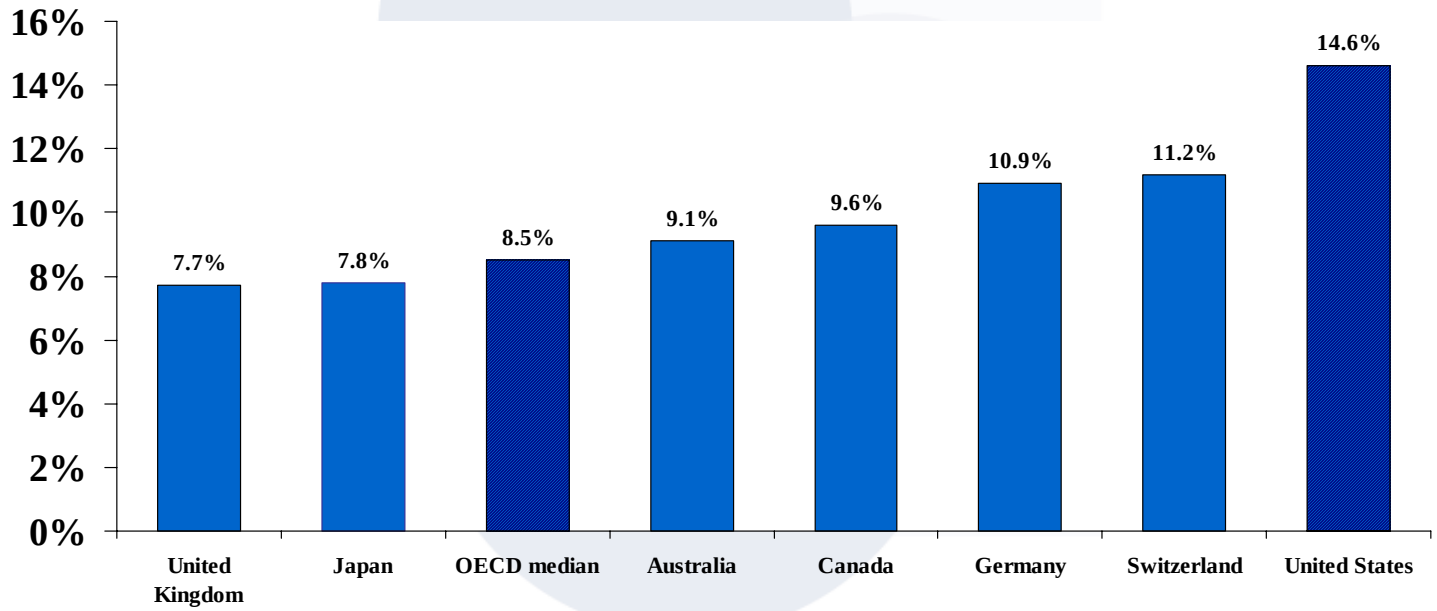
US HEALTH SPENDING AS A PERCENT OF THE GDP, 1980-2015



CMS National Health Expenditures: "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs,* February 22, 2006 and "National Health Spending In 2004," *Health Affairs* January/February 2006.

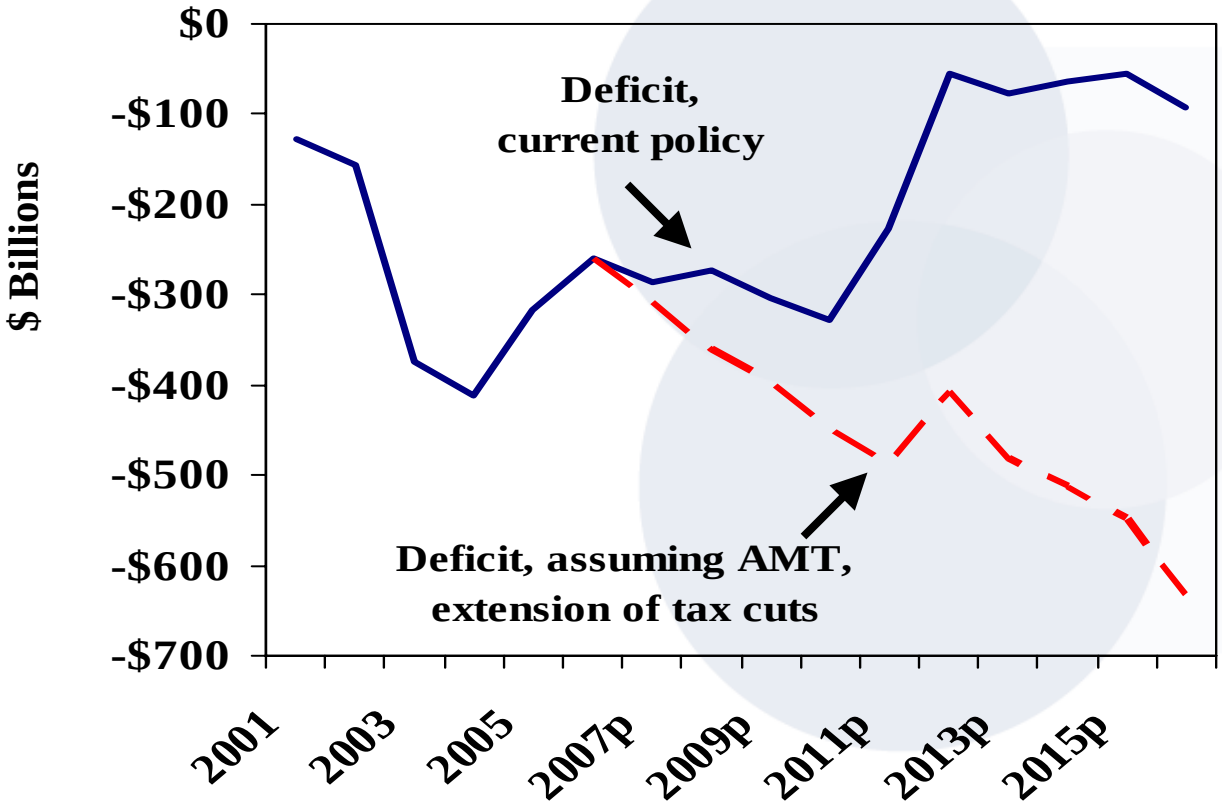
U.S. HEALTH CARE SPENDING MUCH HIGHER THAN OTHER COUNTRIES

Health Spending as a Percent of GDP, 2002



"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.

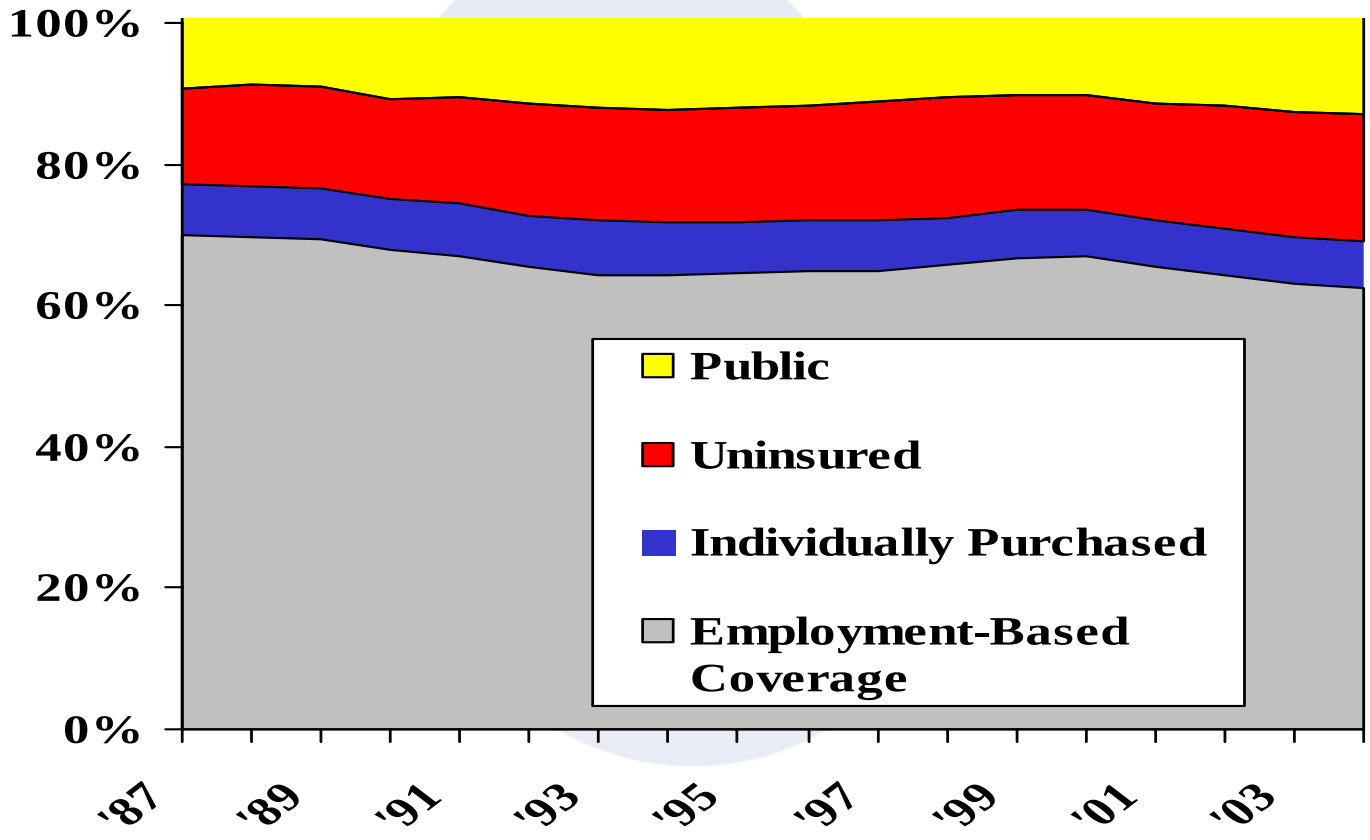
WE HAVE A GROWING FEDERAL DEFICIT (IF TAX CUTS EXTENDED)



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

Congressional Budget Office. "The Budget and Economic Outlook: An Update - Fiscal Years 2007 to 2016," Washington, DC, August 2006

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



Fronstin, EBRI, November 2005

THE MESSINESS OF US HEALTH CARE FINANCING

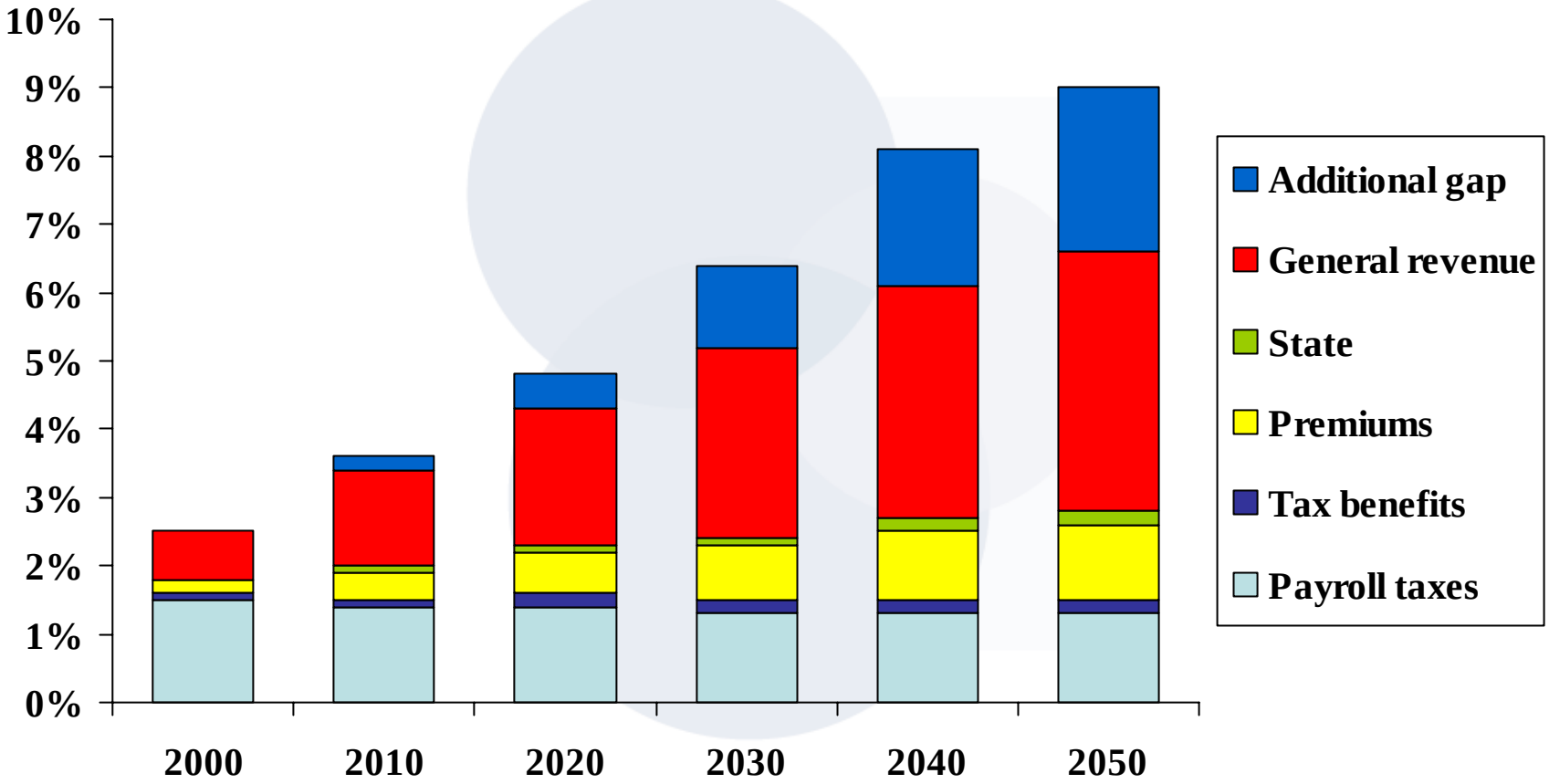
US health care doesn't fit well into neat categories of social welfare transfer financing

- **Medicare**
- **Medicaid**
- **Private insurance**

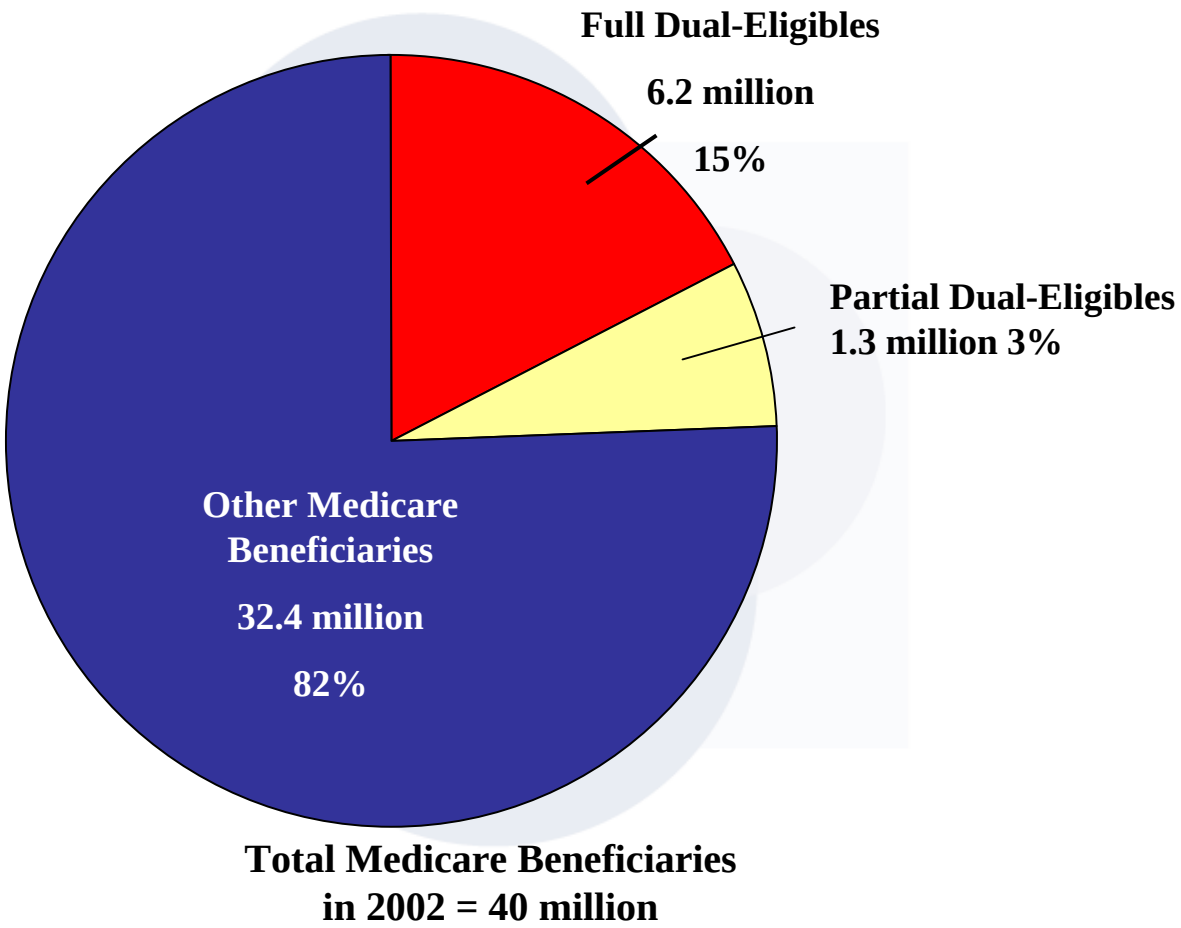
MEDICARE HAS BROAD ENTITLEMENT, PAYROLL TAX AND GENERAL REVENUES, BUT ALSO ...

- 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)



MEDICAID STATUS OF MEDICARE BENEFICIARIES, 2002



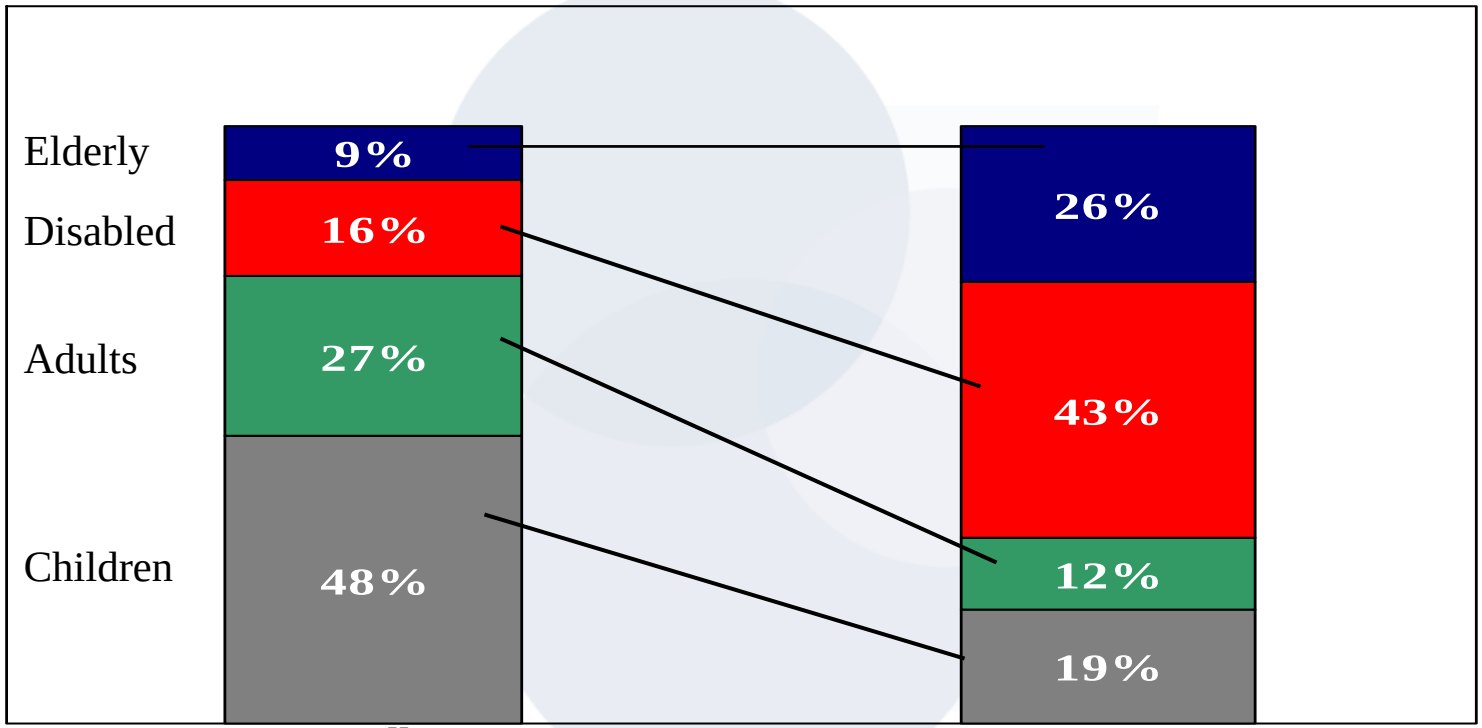
Total Medicare Beneficiaries in 2002 = 40 million

KCMU, "Medicaid: The Basics," December 2005 / KCMU, "Medicaid Primer," July 2005

MEDICAID ALSO HAS MULTIPLE FINANCING SOURCES

- **Federal general revenue**
- **State general revenue, plus…**

MEDICAID IS ALSO MULTIPLE PROGRAMS FOR DIFFERENT GROUPS, 2003



*Total expenditures excludes DSH payments. Source: KCMU, “Medicaid: The Basics,” December 2005 / KCMU, “Medicaid Primer,” July 2005

PRIVATE HEALTH INSURANCE

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

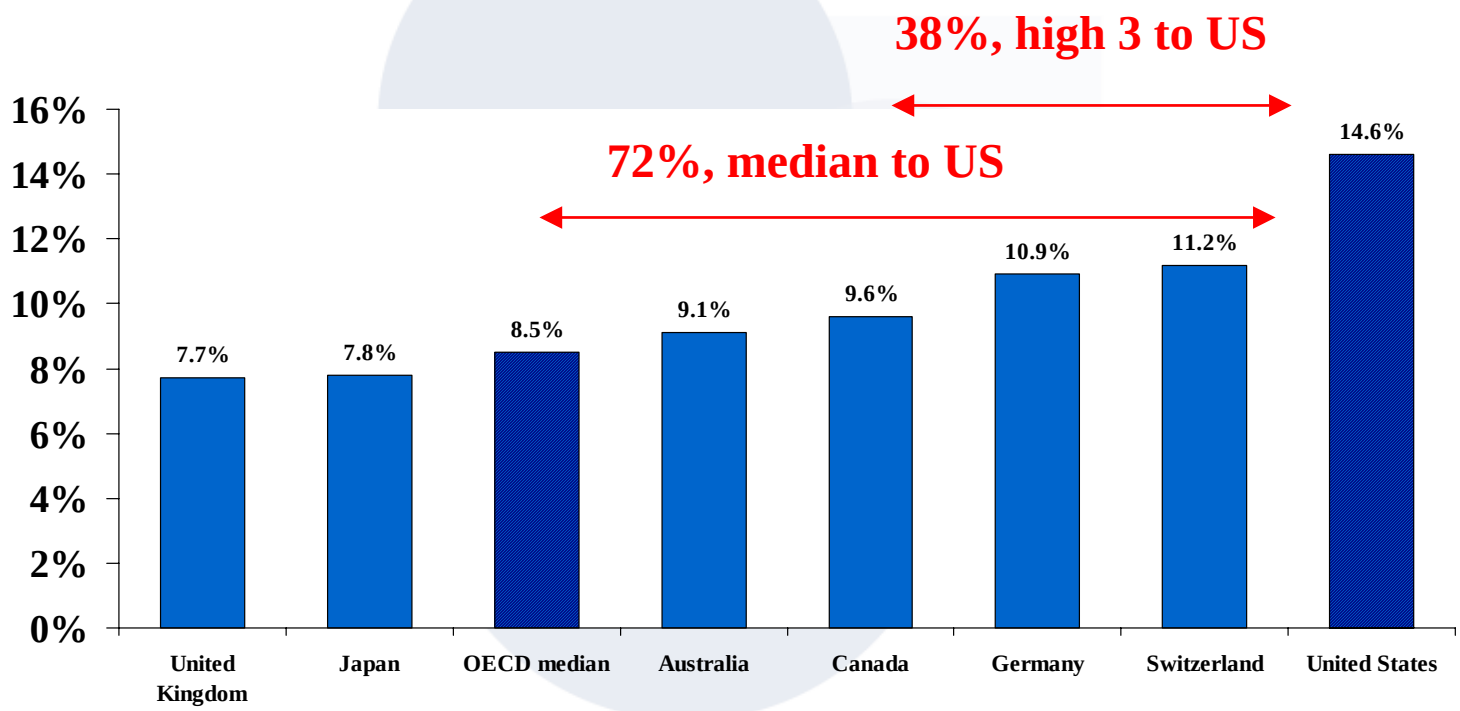
- **$658 billion in private health insurance premiums in 2004 (5.6% of GDP)**
  - **$452 b from private/public employers (3.8% GDP)**
  - **$206 b from employees (1.8% GDP)**
- **Even there, a $106 billion tax subsidy (tax expenditure) – which is 1% GDP**

LOOKING AT US VARIATIONS

- With other countries
- Within US

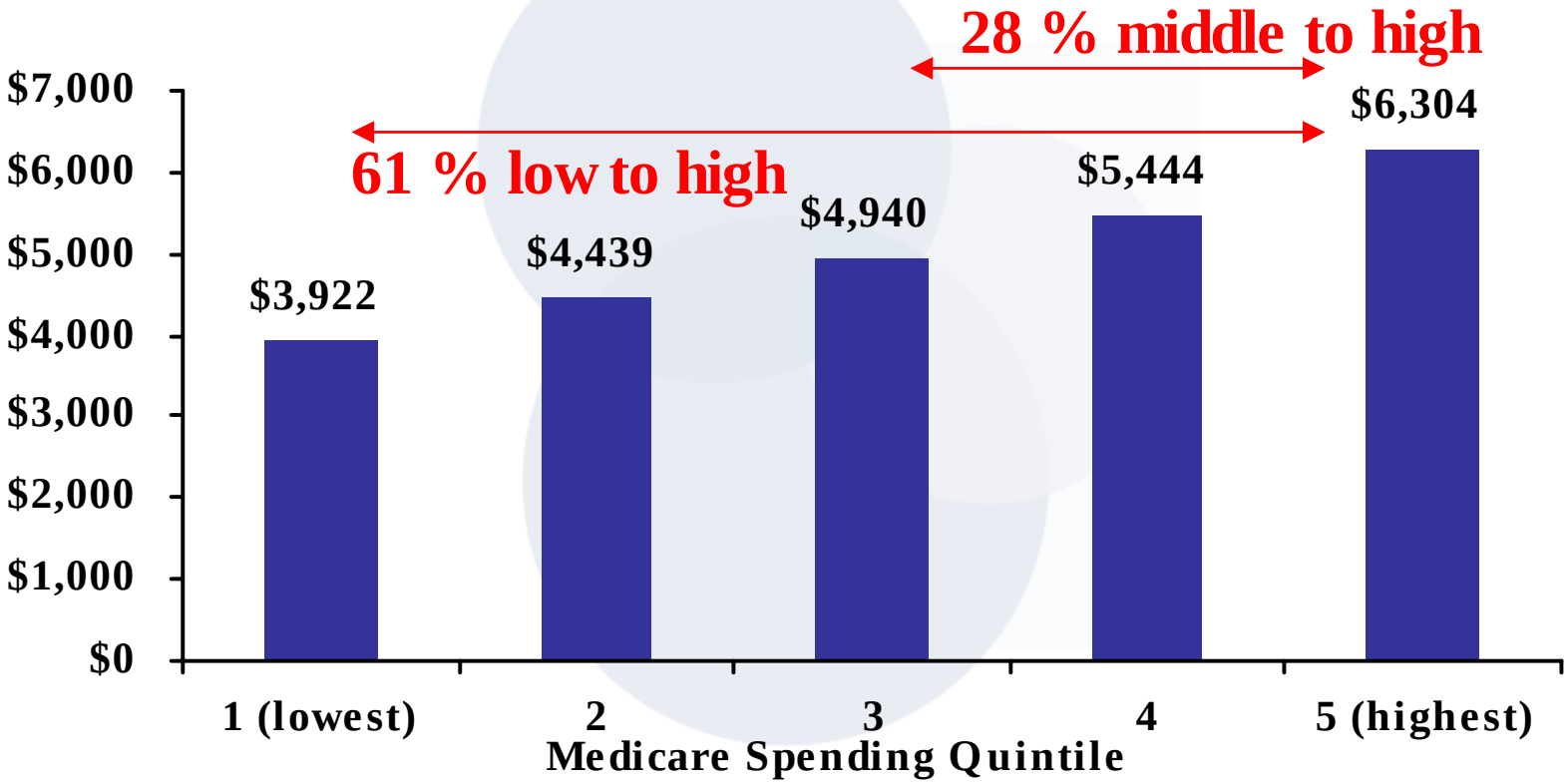
U.S. HEALTH CARE SPENDING MUCH HIGHER THAN OTHER COUNTRIES

Health Spending as a Percent of GDP, 2002



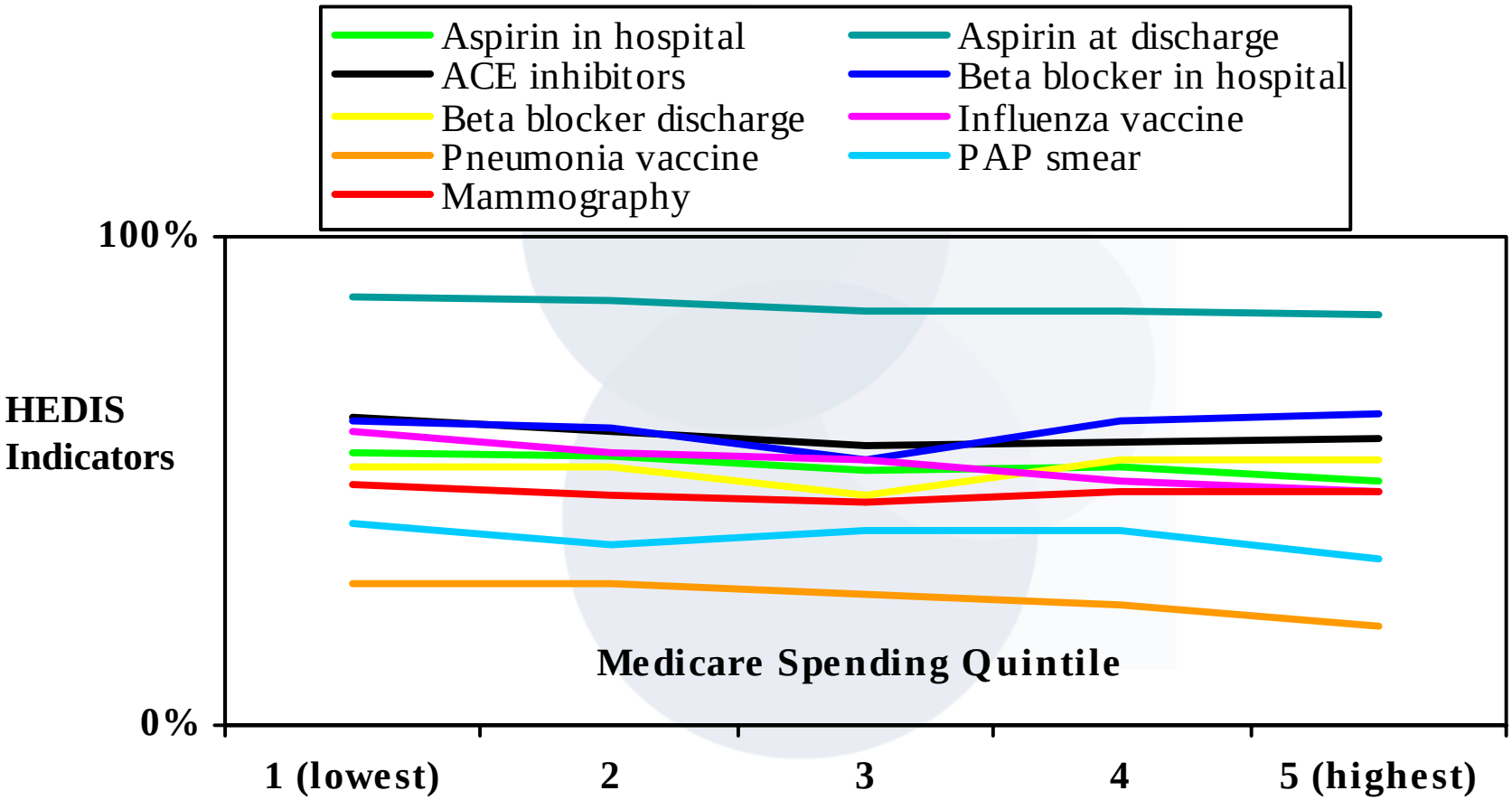
"U.S. Health Spending Habits Grab International Attention," *Health Affairs* July/August 2005 Note: Most recent data show that NHE as percent of GDP in the U.S. in 2002 were 15.4% not the 14.6% given in the graph.

AND WITHIN US, MEDICARE SPENDING VARIES SIGNIFICANTLY



Fisher, et al., "The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care." *Annals of Internal Medicine,* 2003:138(4)

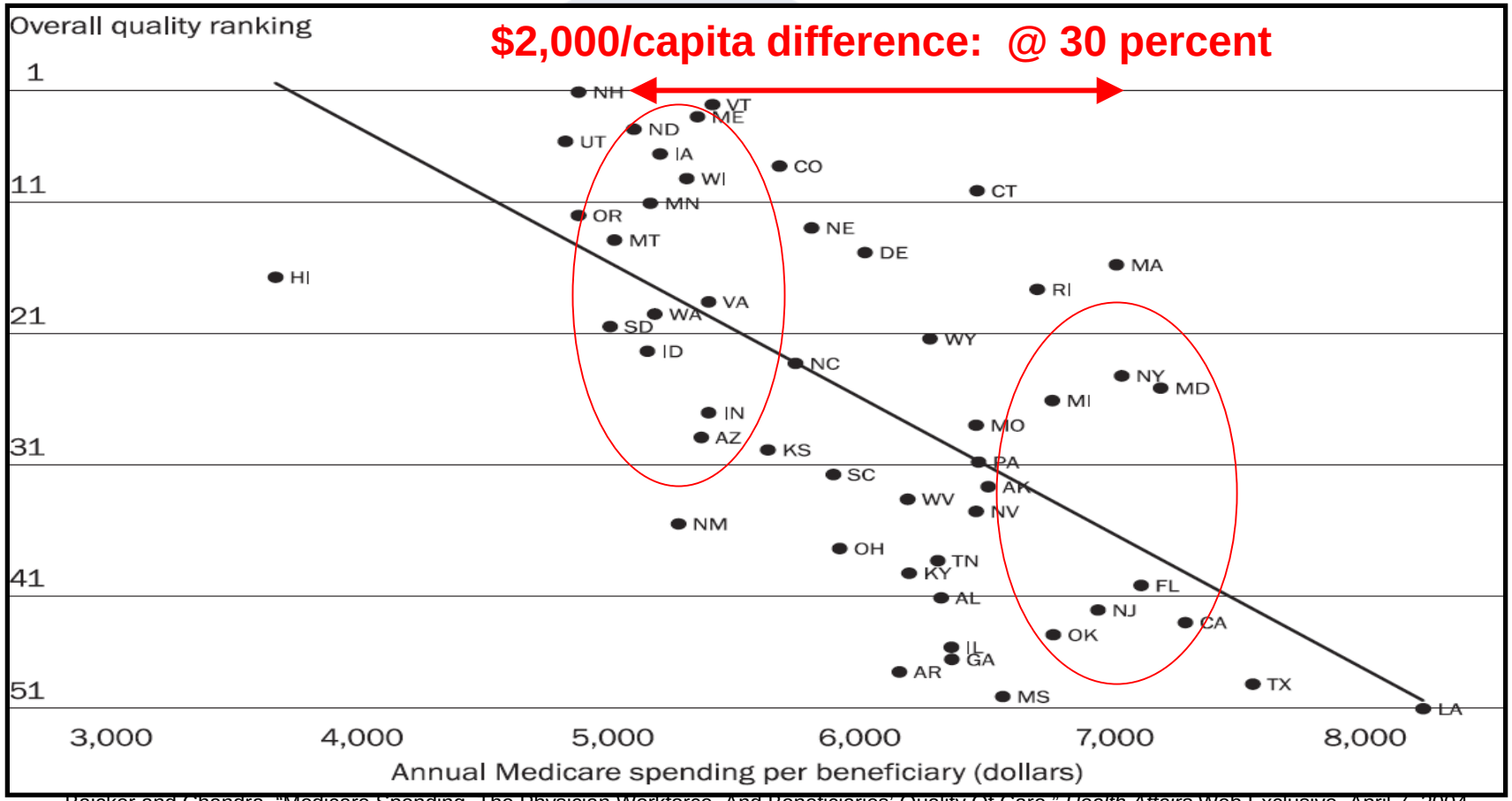
WITHIN US, HIGHER SPENDING NOT ASSOCIATED WITH BETTER QUALITY



Fisher, et al., "The implications of regional variations in Medicare spending. Part 1: The content, quality, and accessibility of care." *Annals of Internal Medicine,* 2003:138(4)

HIGHER SPENDING NOT ASSOCIATED WITH BETTER QUALITY - STATEWIDE

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



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