

“If You think Health Care is
Expensive Now - Wait ‘til it’s FREE!” *

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The topic is Nat'l Health Care Reform

- or is it Nat'l Health Insurance Reform

- or is it National Health Reform?

- ⦿ This is a moving target that literally changes every day
- ⦿ It may well be different this afternoon when the US Senate recesses today

Whatever we call it, change is on the way and it will affect all of us

- ⦿ For a brief review today, we'll look at:
- ⦿ Overview of health care insurance
- ⦿ Role of federal government in health care
- ⦿ Current status of health insurance
- ⦿ Gov't oversight of health insurance
- ⦿ The "public option" as an alternative
- ⦿ Health care expenses and outcomes
- ⦿ Prospects for health insurance reform

Health Insurance Reform in the US

- Not the first time this issue has arisen
- Pres. Teddy Roosevelt (R) tried in 1908
- Linked with the Flexner Report in 1910
- Revisited in 1937 under “The New Deal”
- Pres. Harry Truman (D) tried again in 1948
- Major expansion in 1965 with passage of Medicare and Medicaid programs (D)
- Growth of HMO’s in 1970’s and 1980’s (R)

Health Insurance Reform in the US

- ⦿ Costs out of control by early 1990's
- ⦿ Reform resurrected 1993 by Clintons (D)
- ⦿ Shot down in 1994 by Congress (R)
- ⦿ On the 2008 campaign radar screen
- ⦿ The mood of the nation has changed
- ⦿ Almost everyone is dissatisfied with the status quo - (even "Harry and Louise")
- ⦿ Goal now is a bill by end of 2009

Health Care Reform derives from a perceived sense of a state of “crisis”

- ⦿ Too much dissatisfaction by all parties – patients, professionals, payors, govt’s
- ⦿ Too much is spent for too little benefit
- ⦿ Disparities in allocation and results
- ⦿ Costs are far outstripping resources
- ⦿ Inequitable distribution of resources
- ⦿ Limited or no access by far too many

Topics that bear on the Current Crisis:

- ① Historical Perspective
- ① Cultural Expectations
- ① Role of Government in Health Care
- ① Free-Market Economic Forces
- ① Employment and Health Care Access

A Brief Historical Overview:

- The Post World War II Era: 1945-1965
- Advent of Medicare and Medicaid: 1965
- Employer-based Insurance 1965-1985
- “Alphabet Soup” Plans 1985-1993
- Failed Reform under Clintons in 1993
- Windfall Insurance profits in 1993- 2006
- The Economic Downturn from 2007

Cultural Expectations:

- Historically, health care access is not a right in the U.S.
- Independence, Freedom of Choice, Personal decisions
- One picks life-style and consequences of own behavior
- Confidentiality and Privacy between individual and health care providers and health care information
- Distrust of Government vs. Trust in Private Sector

Role of Government in Health Care

- ⦿ “Government is the Problem, not the Solution” - RR
- ⦿ Emphasis on population safety (FDA / CDC / USDA)
- ⦿ Minimal role for individual health: (“safety net” only)
- ⦿ “The fewer regulations, the better...”
- ⦿ Industry self-regulation works better than gov’t.

Free-Market Economic Forces

- ① The market place will determine winners and losers and competition will drive efficiency
- ① Unfettered choice is the preferred system
- ① Innovation and market forces will prevail
- ① Ultimately results in a “win-win” for all when each acts in his/her own self-interest

What's happening with “free markets”

- ⦿ Deregulation of banking and mortgages
- ⦿ Lack of oversight and checks/balances
- ⦿ The S&L debacle of the 1980's, then Enron, TYCO, WorldCom, Madoff, Nadel, etc
- ⦿ Demise of airlines, automobiles, steel, insurance, retailers, manufacturing....,
- ⦿ Unfettered fraud and abuse in health care claims: Columbia HCA, Miami DME fraud; prescription drug scams, unregulated HMOs

Employment and Health Care Access

- Traditional mechanism for health care insurance
- Often negotiated through collective bargaining
- Foundation of coverage for most under 65 yrs.
- Unreliable source of coverage in poor economy (e.g., COBRA expansion with federal subsidy)

Medicare and Medicaid:

- Enacted under Lyndon Johnson in 1965
- 65+ were under 3% of population in 1965
- Over 24 employees paid in for 1 enrollee
- In 2008, Medicare pop was 12% of total US population and 22% of Florida's total

Medicare/Medicaid & Hospitals - 2007

- Accounts for 56% of Hosp. revenues in 2007: 41% Medicare and 15% Medicaid
- Medicaid is 21% (average) of state budgets
- \$33 Billion shortfall relative to hospital costs
- Average hospital margins: Fell from +6.1% in 2007 to -1.6% in 2008 (Gail Wilensky, HOPE)

Health Care Quality and Outcomes:

- ⦿ Huge variations in health care costs and quality in “small area variation” (J. Wennberg, Dartmouth)
- ⦿ Current system is based on “pay for procedures”
- ⦿ “We get what we decide to pay for...”
- ⦿ Compensation is based on inputs, not outcomes
- ⦿ Leads to high-cost, high-tech care

What do we get for what we spend?

- U.S. spends the most on health care of all nations
- U.S. spent 15.2% of GDP in 2007, second only to the Marshall Islands, (a US territory);
- Cost is expected to be > 19.5% of GDP by 2017
- U.S. spent \$2.26 **T**rillion in 2007 (\$7439 per capita)

What do we get for what we spend?

- At current rate, health care costs are expected to increase 6.7% annually to \$4.6 trillion by 2017.
- In 1996, top 1% of users spent 27% of all h. c. \$\$
- Highest-spending 5% of U.S. pop. accounted for over 50% of all health spending in 2005,

What do we get for what we spend?

- In 2007, the U.S. spent 3% of all health care spending on prevention and 97% on disease management
- Of this 97% for disease management, 75% was spent in the last six months of life
- Of this, 40% was spent in the last 10 days of life

What about Health Care Outcomes?

- Typically, “health” of a society is measured by:
- 1) Infant Mortality Rate = Number of deaths before 1st Birthday / 1000 Live Births
- 2) Life-expectancy (Male/Female/Total)
- 3) Health services utilization rates

So, How does the U.S. stack up?

- U.S. ranks **32nd** in infant mortality **behind** all 48 developed nations plus Macau, Malta, Czech Republic, Slovenia, Singapore, Anguilla, and **Cuba**.
- We are **tied with Croatia** (at 6.4/1000)

So, How does the U.S. stack up?

- U.S. ranks 45th in life expectancy behind all 48 developed nations plus Macau, Singapore, Cayman Islands, Malta, Guam, Jordan, and Bosnia.
- We are tied with Cyprus (at 78 years)

How are we doing overall?

- U.S. ranks **72nd** overall in 2008 in health care access and usage of 195 reporting nations
- Ref: C.I.A. Fact Book and WHO data from U.N.

How are we doing overall?

- US health care access is limited due to lack of coverage, high deductibles, uninsurability (4%), and lack of services in many rural and/or poor areas, plus long waits for care in metro areas.
- The gap widened 20% from 1993 to 2004 esp. among those with low incomes, those with no high school diploma, and non-whites.

What about Individual Outcomes

- Over 100,000 avoidable deaths in US hospitals each year (Institute of Medicine)
- 19% of US hospital admissions in 2007 were re-admissions within 30 days of 1st stay
- Risk of hospital or iatrogenic death rises inversely with size of hospital, readmission rate, and experience with given diagnoses

What about health disparities?

- Elderly received five times as much in health care spending as children (\$6921 average compared to \$1225) in 2002, due to Medicare
- Lowest access to health care is among Hispanics, esp. poor children under 5 years (fastest growing population in the US)
- In Appalachia, Deep South, and Southern Plains: life-expectancy is over 2 years lower

Medicare Cash In and Cash Out:

- At present, there is no “base” budget for Medicare Part B other than Gen. Revenue
- In 2008 for the first time ever, Medicare expenditures exceeded Medicare revenue
- In 2012, Part B base budgeting is planned
- At current spending, Medicare will become a **\$36 Trillion** unfunded liability by 2031

Unemployment's effects on Medicare:

- ① At current rate of 2.9% payroll tax and rate of pay-outs, Medicare is expected to reach fiscal equilibrium in 2018
- ① From 2018, out-flow will exceed income until estim. Medicare bankruptcy in 2030

The Medicare Payroll Tax:

- In 2000, substantial increase in nursing home Medicare \$ spent compared to acute care \$
- In 2001, a “fix” was implemented to move first 100 days of nursing home care from Part A to Part B Medicare (accounting change only)
- In 2002, added Medicare Part D (the “donut”) – to be revised Jan 1, 2010 (at 50%, not 100%)

Future of Medicare

- From 40 million enrollees now to 78 million by 2031 (> 20% of total pop)
- Could be a \$75 trillion liability by 2050
- Emphasis in future on “value-based” reimbursement that pays for outcome performance instead of procedures

The Economy and Medicare

- Each year of unemployment above 5% means Medicare bankruptcy one yr. sooner (U.S. @7.8% April 2009, now at 9.7%; at least twelve states incl. FL. now over 10%)
- In 2008 for first time ever, Medicare spent more than its revenue from Parts A, B, C, and D -- (leading to re-activation of the Medicare Payment Commission)
- This revenue deficit is expected to continue for at least one year past end of current recession (2012-2013?)

Why Health Cost Reform now?

- Health care is 15% of the overall US economy
- Hospitals are 5% of the overall economy
- Hospitals and h.c. professionals are losing big
- Every 1% of unemployment is 2.5 million more uninsured (= 12.8 million more in past year)

Who is not currently insured?

- In 2007, 48,800,000 (15.7% of pop.)
- 1/3 have family incomes under \$50K
- 10 million are non-citizens (mostly legal)
- 20% can afford it but can't get covered

Recent Politics of Health Care Reform:

- ⦿ Platform of Obama Campaign – a mandate?
- ⦿ Fiscal urgency as well as political momentum
- ⦿ Each month that reform is delayed decreases the likelihood of it happening by 5% from Jan 2009
- ⦿ Hospitals lose 6% per year from Medicare but have had good margins from private payors since 1997 with expansion of Medicare HMO/PPO's

What happened in the “Bush-2” years?

- ⦿ Major expansion of Medicare HMO’s that now cover over 25% of 65+ pop.
- ⦿ Unregulated income for Medicare HMOs with average profit of 13% after taxes
- ⦿ Ratchet-down of physician and hospital reimbursement with “down-coding”
- ⦿ No increase in reimbursement rates
- ⦿ Closure of hundreds of US hospitals

What's happened since Jan. 2009?

- ◎ 1-20: Inauguration statement
- ◎ 2-9: Tom Daschle withdraws name
- ◎ 3-4: White House Summit on H.C.R.
- ◎ 3-9: Stem Cell expansions approved
- ◎ 3-12: Margaret Hamburg named FDA Head

Recent history since March 2009

- 3-20: White House announces \$640B “down payment” (1/2 from AGI > \$250K and 1/2 from new Medicare HMO bidding)
- 3-25: Jean Sebelius nominated for HHS Sec’y
- 3-26: Nancy-Ann Min deParle named head of White House Health Reform team (active in Clinton White House on HCR)

In April and May of 2009:

- A.H.A. announces that 52% of health care in U.S. in 2007 was “uncompensated”
- Congress disapproves \$640B “down-payment”
- Medicare Reform Commission announces pay for performance instead of procedures
- Intended to focus on outcomes, not incomes

What happened in June and July?

- The CBO announced health care costs will exceed \$1 Trillion over next 10 years
- “Big Pharma” announced it will give up \$350 billion in profits over next 10 years
- Hospitals agreed to \$150 billion give-back as part of cost-control efforts

What happened in June and July?

- ① “The Public Option” gained traction, either as federal government-sponsored program or similar to rural electric cooperatives (Sen. Kent Conrad, N.D.)
- ② Senate Health Committee passed bill on July 15 but not as a bi-partisan effort
- ③ A single-payer program is now dead

Likely elements of “the Reform Plan”

- ⦿ Private insurance and a public option
- ⦿ Portability
- ⦿ No pre-existing exclusions
- ⦿ Free choice of health care providers
- ⦿ Standardized minimum coverage
- ⦿ Reasonable deductibles and co-pays
- ⦿ Supplemental “add-ons” if desired
- ⦿ Government subsidy for low-incomes
- ⦿ “Play or pay” not yet determined

What is “the public option”?

- Details are evolving literally daily
- An alternative to privately-funded health insurance, with range of tiers and services
- Would be offered by federal government as expansion of Medicare and Medicaid
- Free choice of health care resources
- Co-pays and deductibles, with offsets

What's new on “the public option”?

- In fact, we already have it...
- It's called Medicare/Medicaid/V.A. System/Active Military / All of Congress / federal government employees & their dependents
- Covers 27.8% of U.S. population already
- Paid through payroll taxes, co-pays, and direct government grants (that were 45% of total U.S. health care expenditures in 2004)

How might “the public option” work?

- Likely as an employment or non-employment alternative to private insurance (which will likely continue to be tied to employment as the “gatekeeper”)
- By expanding Medicare to 60+ then 59 / 58 / 57 / 56 / 55 year-olds, to cover politically powerful “Boomers”
- Might expand Medicare to the unemployed with federal government subsidies for premiums (as in COBRA)
- Might expand Medicaid to all children < 18 years and to all pregnant women in all states (as in S-CHIP)

How might we get to universal coverage?

- ⊙ Expand on what we already have:
- ⊙ Federal employees and Congress: 5%
- ⊙ Medicaid (including the unemployed) 5%
- ⊙ Veteran's Admin. & CHAMPUS care: 10%
- ⊙ Federal S-CHIP (ChildHealthProgram): 10%
- ⊙ Medicare, (expanded to age 55+): 15%
- ⊙ Employment-provided coverage: 55%
- ⊙ This gets us to universal coverage at: 100%

How will US pay for universal care?

- ⦿ Expand tax on social security benefits of those > 65
- ⦿ Expand payroll tax (but tricky to do in down economy when fewer are employed)
- ⦿ Require competition in HMO Medicare “Advantage” plans (who returned average 13% profit in 2007)
- ⦿ Windfall profits tax on insurance companies
- ⦿ Tax on employer-provided health care benefits

Cost-saving considerations:

- Reimburse through “value-based” care; payments would be results-driven and by competitive bidding
- Institute hospital “global budgeting” and reduce Medicare/Medicaid payments (\$150 billion give-back)
- Reimburse states for achieving goals (with grants) through Medicaid match and incentives
- Focus on health outcomes and cost-containment (largely by “paying for prevention”)

What's the Crystal Ball say?

- Few, if any, are satisfied with present “non-system”
- National mood is ready for past-due reform
- Vested interests are very active -- (Thousands of H.C. lobbyists now spend \$1.4 million PER DAY)
- Incremental change is our history of reform overall
- Public Pressure will meet Political Will in Fall of 2009
- Real reform won't happen without cost containment

Prospects for “Universal” Health Care Reform in 2009

- ◉ Good chance of passage if part of a budget reconciliation bill (needs only 51 Senate votes)
- ◉ Politically stronger if passed as a stand-alone bill (would need 60 Senate votes – which Democrats now have with Minnesota Sen. Al Franken and Arlen Specter, plus 2 Repubs. & VT independent)
- ◉ To date, 69 sponsors for the **2 House** bills (Dingell-Conyers health reform initiative) + **2 Senate** bills

“When all is said and done...”

- Fall 2009 will be a very interesting time in the Congress when it returns from summer recess (to act on 2 Senate and 2 House bills, as of Friday, August 7, 2009)
- As with Medicare/Medicaid in the 60's and “DRG's” in the 1970's, this wave of health care reform will be far-reaching
- The changes will affect all of us for generations
- This is about **Trillions** and not just “decimal dust”