

US Health Care Overview

Pike Township Grassroots for Change 4/4/09

Objectives

- Provide context and definitions to understand and engage in national and local discussion of health care reform.
- Answer questions of our members and Pike Township residents.

Background

Cast of Characters

The flow of U.S. health care dollars involves...

- Purchasers: Those purchasing health care
- Providers: Those providing health care
- Payers: Those assuming the financial risk of health claims or administering reimbursement for health care claims

Evolution of Health Care Coverage, Part 1

The reimbursement industry today looks very different from what our grandparents experienced.

- Before the 1930s, consumers of health services (purchasers) paid their doctors, hospitals, and medical equipment suppliers (providers) directly. The system worked for those who could afford care or who remained healthy, but illness and injury exposed some people to medical expenses that were well beyond their capacity to pay.
- In the 1930s, purchasers learned they could pay a regular amount to a private “third party”—an insurance company—who would protect them from catastrophic losses. Blue Cross/Blue Shield came into being and the medical insurance industry was born. Purchasers could manage the risks of illness and injury by pooling their dollars with other purchasers. Together, they provided medical insurers (private payers) with enough funds to cover the expenses of the few policyholders who did require expensive care.

Private payers assume the financial risk of health claim losses. They consider this risk worth taking if they can: (1) accurately predict the probability of incurring these losses; (2) get enough subscribers at the right premium to be able to *underwrite* (cover) these losses, and (3) have enough reserves left over to cover future losses and still make a profit.

- The third-party payer system was so well received that in the 1940s and 1950s, employers began to use medical insurance as a bargaining chip in salary negotiations. Employers paid the third-party insurer on behalf of their employees, usually as a trade-off against salary increases.

- In the 1960s, the U.S. government joined in. During President Lyndon Johnson’s “chicken-in-every-pot” era, the federal government began funding and administering health care programs for older citizens and the indigent, using tax dollars to create a funding pool. Medicare and Medicaid were born (public payers). A variety of smaller programs targeted such groups as the rural underserved, veterans, and Native Americans. The main public payers are Medicare, Medicaid, and CHIP.

Medicare is a health insurance program for: (1) people age 65 or older, (2) people under age 65 with certain disabilities, and (3) people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare consists of:

- Part A Hospital Insurance—Paid for through their payroll taxes while working. Helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (but not custodial or long-term care). Also helps cover hospice care and some home health care.
- Part B Medical Insurance—Most people pay a monthly premium. Helps cover doctors' services, outpatient care, and other professional services and medical supplies, if medically necessary.
- Part D Prescription Drug Coverage (new in 2006)—Most people will pay a monthly premium for this coverage. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium.

Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. These may include age, whether a person is pregnant, disabled, blind, or aged; and whether a person is a U.S. citizen or a lawfully admitted immigrant.

- Medicaid programs are funded jointly by the states and the federal government. The federal government’s share is determined annually by a formula that compares a state's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs.
- Medicaid is state administered. Each state sets its own guidelines regarding eligibility and services. For example, the rules for counting income and resources vary from state to state and from group to group.
- Low income is only one test for Medicaid eligibility. Assets and resources (like bank accounts, real property, or other items that can be sold for cash) are also tested against established thresholds.

Children’s Health Insurance Program (CHIP) funds health care for families who don't qualify for Medicaid but still can't afford private insurance.

Evolution of the Health Care Coverage, Part 2

After the 1960s, the costs of medical care rose steadily in a climate where provider fees and medical supplies were generally reimbursed without questioning the actual cost of care.

Health care providers became accustomed to reimbursement, and consumers began to feel entitled to some sort of reimbursement, either from their employer's benefit plan or from a government program. Thus the once-simple medical insurance system evolved into a full-blown reimbursement industry, including both public and private payers.

Because payers assume much of the financial risk for health care expenses, not surprisingly, they get to make many of the rules.

The reimbursement industry has tried all sorts of ways to rein in costs and keep premiums low.

- managed care, sharing the risk with providers
- medical necessity
- pre-existing conditions
- wellness programs
- negotiated deals with preferred providers
- routinely denying coverage to wage a war of attrition
- rescinding coverage

Today, the U.S. reimbursement industry consists of a maze of government payors, commercial insurance companies, Blue Cross Blue Shield organizations, third-party administrators, and self-insured employers. Benefits range from fee-for-service to managed care, with a thousand variations of HMOs, POSs, and PPOs in between. The rules are nonstandard, coverage is fragmented, and acute care still remains the focus of many plans.

A study by Harvard Medical School and the Canadian Institute for Health Information determined that some 31% of U.S. health care dollars, or more than \$1,000 per person per year, went to *health care administrative costs*, nearly double the administrative overhead in Canada, on a percentage basis.

In 2000, public payers (Medicare, Medicaid) insured about 22% of the US population. Private payers (insurance companies, HMOs, self-insured employers) insured 65%. The remaining 13% were uninsured.

State of the Nation's Health Care

Fiscal Concern

Among the world's 30 largest industrialized countries, the U.S. has highest per capita expenditure on health care (50% greater than Luxembourg or Switzerland).

- Between 2003 and 2006, U.S. per capita spending grew 17%, from \$5,800 to \$6,800.
- The US spends ~\$650 billion more annually on health care than peer industrialized countries after adjusting for higher national income (wealth).

The GAO values the federal promised benefits as of 2006 at...

- Medicare Part A (hospital insurance): \$11.3 trillion
- Medicare Part B (doctors and outpatient): \$13.1 trillion
- Medicare Part D (prescription drugs): \$7.9 trillion

Insurance Premiums Rising

In 2008, average annual premium for employer-provided family coverage reached \$12,680; \$4,704 for single coverage.

- Premiums are outstripping the rate of inflation or growth in workers' wages. Premiums have doubled since 2000.
- Trying to control their health insurance costs, employers are passing on some of the premium increases to their employees or in some cases dropping employee insurance.

Increasing Uninsured

The United States is the only wealthy, industrialized nation that does not ensure that all citizens have some kind of insurance!

- In 2007, 45.7 million people in the US were without health insurance for at least part of that year. That's 15.3% of the population. An estimated 25% were underinsured.
- Some of the uninsured are healthy so they choose to go without it. Some are unemployed. Some have been rejected by insurance companies and are considered "uninsurable." Most are working-class persons whose employers do not provide group health insurance, and who earn too much money to qualify for local/state insurance programs for the poor but do not earn enough to enroll in an individual health insurance plan.

The economic cost of un-insurance is estimated at between \$65 and \$130 billion annually:

- 18,000 die prematurely.
- Uninsured kids, adults receive fewer, less timely services.
- 8 million uninsured with chronic illnesses receive fewer services, have increased morbidity, worse outcomes.

- 45 million uninsured less likely to receive preventive and screening services.
- 60 million uninsured individuals and their family members have less financial security and increased life stress due to lack of insurance.
- People living in communities with a higher-than-average uninsured rate are at risk for reduced availability of health care services and overtaxed public health resources.
- About 20% of premiums paid by the insured population represents cost-shift by providers to cover costs of caring for uninsured.

Federal Initiatives

The President's 8 Principles for Health Reform

- Reduce rate of growth of health insurance premiums
- Reduce high administrative costs, unnecessary tests and services, waste, inefficiencies
- Aim for universal coverage
- Provide portability of coverage; no preexisting condition restrictions to deny coverage
- Provide choice of health plans and physicians; provide choice of keeping employer-based health plan
- Invest in public health measures to reduce cost drivers, including obesity, sedentary lifestyles and smoking; guarantee access to proven preventive treatments
- Improve patient safety and provide incentives for quality care; support widespread use of health IT (computerized medical records)
- Plan must “pay for itself by reducing the level of cost growth, improving productivity, and dedicating additional sources of revenue.”

Actions to Date

- Reauthorized CHIP: renewed for five years and expands the plan from 7 million children affected to 11 million. Requires mental health parity for states that include mental health/substance abuse services (previously, 3 in 5 states limited coverage). Allows states option of immediately enrolling legal immigrant children. Estimated cost \$73.8 billion over five years; fully funded by 62 cent increase in federal excise tax on tobacco, to \$1.01/pack for cigarettes
- Passed American Recovery and Reinvestment Act (stimulus package): \$59 billion to be spent on health care over next five years—roughly 1 of every 5 stimulus dollars.
 - = \$19 billion will be used to computerize Americans' health records, reducing medical errors, and saving billions in health care costs.
 - = \$87 billion increase in federal share of Medicaid to avert throwing people off Medicaid rolls.
 - = \$21 billion to help unemployed continue health coverage under COBRA.

Key Players for Reform

These are names you are likely to hear as changes in U.S. health care are debated:

- *Senator Max Baucus*, Chairman Senate Finance Committee. Baucus issued a white paper in November that states positions on key health policy issues and may represent grounds for a new bipartisan consensus. See Savvy Citizen Health Care site for link.
(<http://finance.senate.gov/healthreform2009/home.html>)

- *Senator Edward Kennedy*, Chairman on the Health, Education, Labor and Pensions Committee. Kennedy is working to lay the groundwork for a breakthrough on health care reform this year. His staff has held more than a dozen meetings with key advocacy and interest groups that are sure to influence the debate. Kennedy has stated, "We need proposals that hold the promise of providing every American with quality health coverage - making sure that it is a right and not a privilege."
- *Kathleen Sebelius*, secretary-designate of the U.S. Department of Health and Human Services. HSS oversees Medicare, Medicaid, CHIP. Sebelius, governor of Kansas, is a former insurance commissioner.
- *Nancy-Ann DeParle*, director of the White House Office of Health Reform. DeParle has worked on health care on both the state and federal level. She is a veteran of reform efforts in the 1990s. <http://www.capwiz.com/sjhs/issues/alert/?alertid=12913281>

President's Proposed "Health Reform Reserve Fund"

- \$634 billion over 10 years (2010-2019).
- About ½ (\$318 billion) to come from additional income tax increases on upper-income taxpayers (\$200,000 singles, \$250,000 individuals).
- About ½ (\$316 billion) to come from health care savings, including \$175 billion in competitive bidding to reach payment/prices for Medicare Advantage plans.
- \$38 billion in reduced Medicare payments to hospitals.
- Meaningful revenues to fund coverage expansions (including tax hikes) do not begin to crop up until 2011 and 2012.

Legislative Initiatives

S.4 Comprehensive Health Reform Act of 2009—Introduced January 6, 2009. Calls for Congress to enact, and the President to sign, legislation to guarantee health coverage, improve health care quality and disease prevention, and reduce health care costs for all Americans and the health care system. 19 co-sponsors.

H.R. 676 Medicare for All Bill (Single Payer)—Rep. John Conyers is leading the fight for Single Payer Health Care with [H.R. 676, the "Medicare For All" Bill](#). Democrats.com is joining the [Leadership Conference for Guaranteed Health Care](#) (LCGHC) to support H.R. 676.

Practical Matters

State of the State

- About 16% of the population of Indiana is enrolled in Medicaid: 59% of children, 18% adults, 8% elderly, and 15% disabled.
<http://www.statehealthfacts.org/profileind.jsp?rgn=16&cat=4&ind=199>
- In Marion County, the number of people enrolled in Medicaid was 162,327 in 2007. Almost 96,000 of those were children. <http://www.in.gov/fssa/files/omppMarion.pdf>
- In the three years from 2005 to 2007, the average number of uninsured was 12.3%, or 766,000 individuals.

Hoosier Healthwise (Medicaid)

Hoosier Healthwise is Indiana's health care program for children, pregnant women, and low-income families. Several benefit packages are available, with varying monthly premiums.

Hoosier Healthwise is working to

- (1) ensure that more young children receive well-child doctor visits,
- (2) support early healthcare for pregnant women,
- (3) help the most vulnerable Medicaid recipients improve their health and manage chronic conditions such as heart disease, diabetes and asthma.
- (4) help seniors and people with disabilities become active members of their communities instead of living in an institution.
- (5) help thousands of low-income seniors buy the prescription drugs they need to stay healthy.

Details at www.in.gov/fssa/ompp/2545.

The stimulus package will add \$1.4 billion to Indiana fund for Medicaid (by formula). Distribution is overseen by the budget office and Family and Social Services Administration.

Healthy Indiana Plan (HIP)

The Healthy Indiana Plan provides health insurance for uninsured adult Hoosiers between 19-64 whose household income is between 22 and 200% of the federal poverty level (FPL), if they are not eligible for Medicaid.

The federal poverty level (FPL) is adjusted to the number of persons in a family. (For a single person, the FPL is income below \$10,000. For a family of four, it's under \$21,200.)

Eligible participants must be uninsured for at least 6 months and cannot be eligible for employer-sponsored health insurance. HIP offers:

(1) a basic commercial benefits package once annual medical costs exceed \$1,100.

(2) A “Power Account” valued at \$1,100 per adult to pay for initial medical costs. Contributions to the account are made by the State and each participant (based on a sliding scale). No participant will pay more than 5% of his/her gross family income into the Power Account, although many will pay less.

(3) Coverage for preventive services up to \$500 a year at no cost to participants. After the \$500 is met, preventative services are covered, but the Power Account must be used if necessary.

(4) Co-pays are required for emergency services only. However, the co-pay will be returned if the service was deemed a true emergency by prudent layperson standard.

Details at www.hip.in.gov or 1-877-GET-HIP9 (1-877-438-4479).

Continuation Health Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives workers who lose their jobs, and thus their health benefits, the right to purchase group health coverage provided by the plan under certain circumstances.

If the employer continues to offer a group health plan, the employee and his/her family can retain their group health coverage for up to 18 months by paying group rates. A second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

The COBRA premium may be higher than what the individual was paying while employed but generally the cost is lower than that for private, individual health insurance coverage.

Note: COBRA generally does not apply to plans sponsored by employers with fewer than 20 employees.

Stimulus News

- The good news is, for people who have become unemployed since September 1, 2008, the stimulus money will pay 65% of their COBRA premium; they will pay only 35%. This premium reduction applies to periods of health coverage beginning on or after February 17, 2009, and lasts for up to nine months.
- Also good news, if they became unemployed and did not get on COBRA, they can go back and talk to their previous employers now and get on COBRA.
- Under ordinary circumstances the employee and his/her family each have 60 days to elect the COBRA coverage, otherwise they lose all rights to COBRA benefits.
- But with the stimulus package, individuals involuntarily terminated from September 1, 2008 through February 16, 2009 who did not elect COBRA when it was first offered OR who did elect COBRA, but are no longer enrolled (for example because they were unable to continue paying the premium) have a new election opportunity.

- This election period begins on February 17, 2009 and ends 60 days after the plan provides the required notice. This special election period does not extend the period of COBRA continuation coverage beyond the original maximum period (generally 18 months from the employee's involuntary termination).

Details at <http://www.dol.gov/ebsa/cobra.html>

Obama's Health Care Agenda

On health care reform, the American people are too often offered two extremes -- government-run health care with higher taxes or letting the insurance companies operate without rules. President Obama and Vice President Biden believe both of these extremes are wrong, and that's why they've proposed a plan that strengthens employer coverage, makes insurance companies accountable and ensures patient choice of doctor and care without government interference.

The Obama-Biden plan provides affordable, accessible health care for all Americans, builds on the existing health care system, and uses existing providers, doctors, and plans. Under the Obama-Biden plan, patients will be able to make health care decisions with their doctors, instead of being blocked by insurance company bureaucrats.

Under the plan, if you like your current health insurance, nothing changes, except your costs will go down by as much as \$2,500 per year. If you don't have health insurance, you will have a choice of new, affordable health insurance options.

Make Health Insurance Work for People and Businesses -- Not Just Insurance and Drug Companies.

- Require insurance companies to cover pre-existing conditions so all Americans regardless of their health status or history can get comprehensive benefits at fair and stable premiums.
- Create a new Small Business Health Tax Credit to help small businesses provide affordable health insurance to their employees.
- Lower costs for businesses by covering a portion of the catastrophic health costs they pay in return for lower premiums for employees.
- Prevent insurers from overcharging doctors for their malpractice insurance and invest in proven strategies to reduce preventable medical errors.
- Make employer contributions more fair by requiring large employers that do not offer coverage or make a meaningful contribution to the cost of quality health coverage for their employees to contribute a percentage of payroll toward the costs of their employees' health care.
- Establish a National Health Insurance Exchange with a range of private insurance options as well as a new public plan based on benefits available to members of Congress that will allow individuals and small businesses to buy affordable health coverage.
- Ensure everyone who needs it will receive a tax credit for their premiums.

Reduce Costs and Save a Typical American Family up to \$2,500 as reforms phase in:

- Lower drug costs by allowing the importation of safe medicines from other developed countries, increasing the use of generic drugs in public programs, and taking on drug companies that block cheaper generic medicines from the market.
- Require hospitals to collect and report health care cost and quality data.
- Reduce the costs of catastrophic illnesses for employers and their employees.
- Reform the insurance market to increase competition by taking on anticompetitive activity that drives up prices without improving quality of care.

The Obama-Biden plan will promote public health. It will require coverage of preventive services, including cancer screenings, and increase state and local preparedness for terrorist attacks and natural disasters.

A Commitment to Fiscal Responsibility: Barack Obama will pay for his \$50 - \$65 billion health care reform effort by rolling back the Bush tax cuts for Americans earning more than \$250,000 per year and retaining the estate tax at its 2009 level.

Source: http://www.whitehouse.gov/agenda/health_care/

