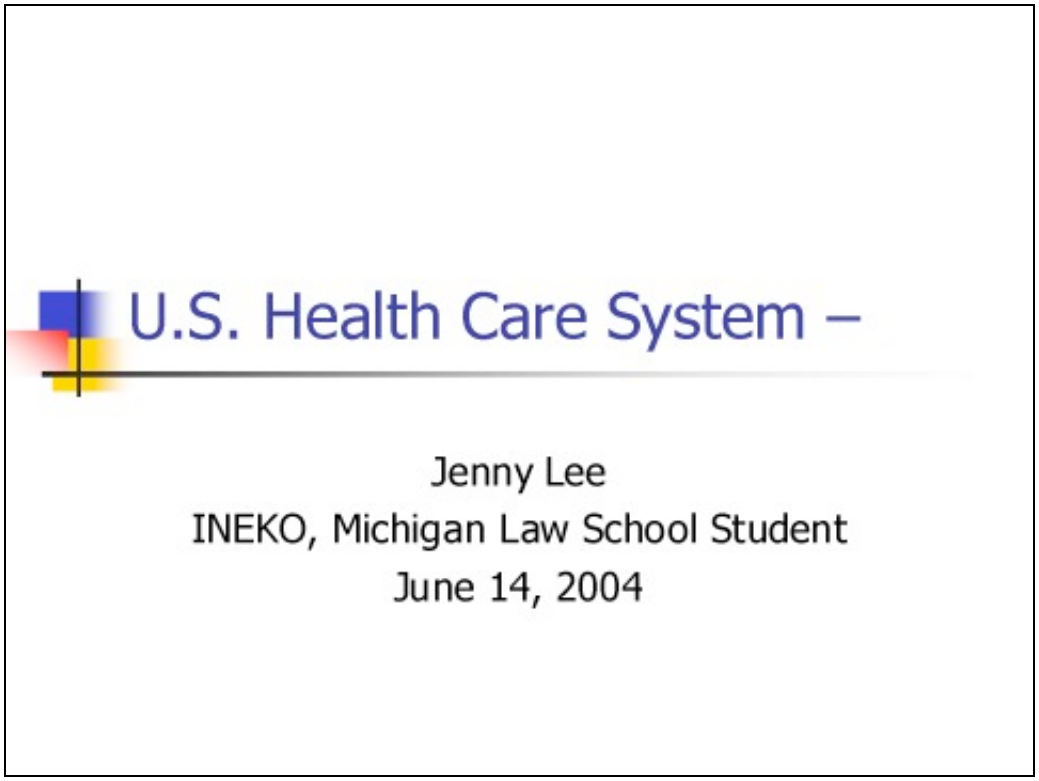
INEKO

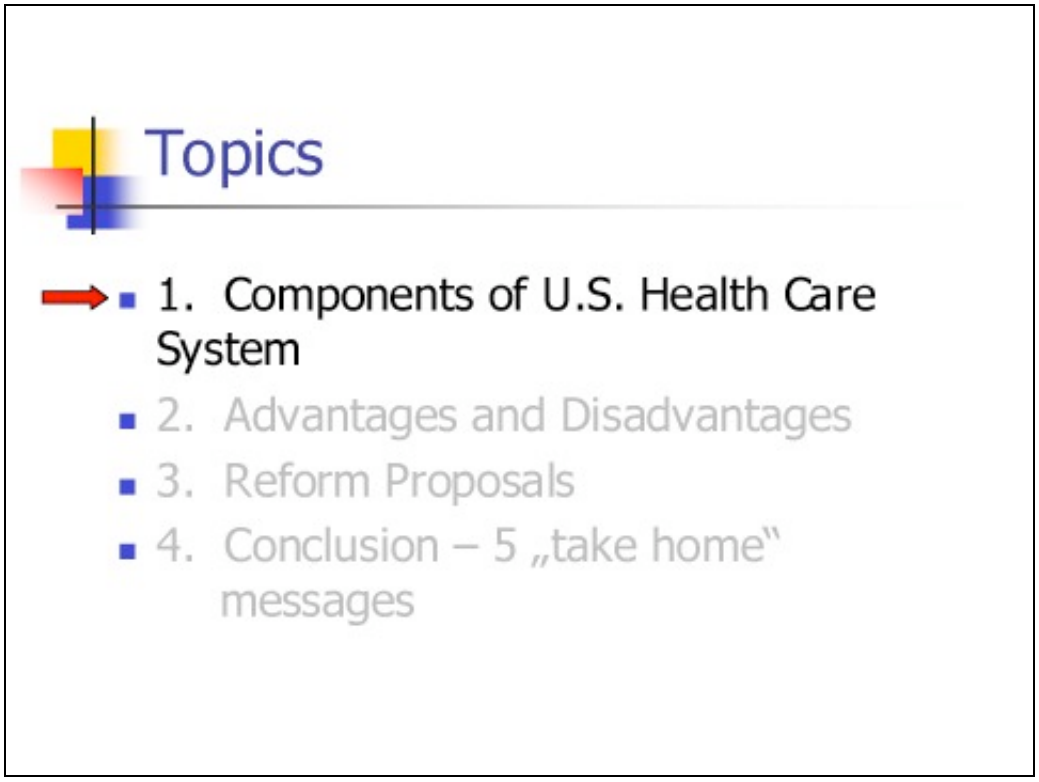
Institute for Economic and Social Reforms

Seminars and Conferences

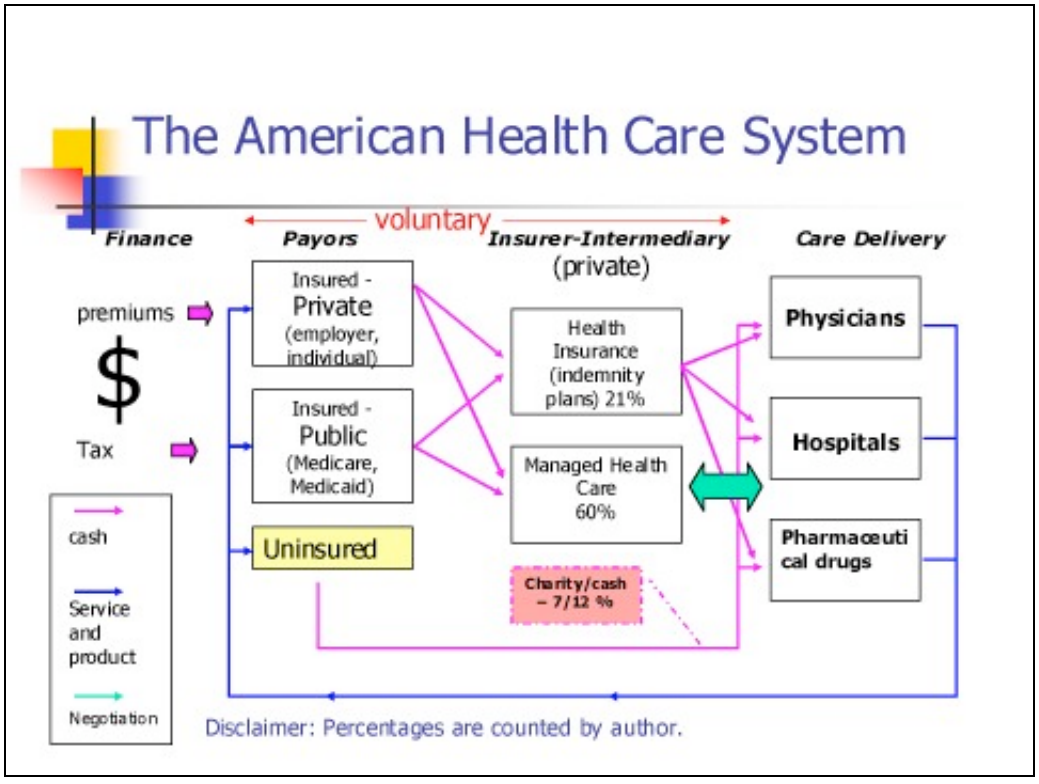
U.S. Health Care System - INEKO presentation



Jenny Lee - Michigan Law School student on her summer internship in INEKO.



The four parts to my presentation are the components of the American health care system, advantages and disadvantages, proposals for reform, and conclusions.



As you can see, it is a complicated and complex system. Cash flows from left to right on this chart with pink arrows. Patients are located in this second column of boxes. And hospitals and providers are here. And medical services flow along the blue arrows.

Some preliminary points are:
1. Voluntary

2. Appreciate how much privatization dominates the system, see insurance companies
3. Uninsured.

Now, I will briefly explain the difference between the private and public sectors in the system. The majority of expenditure is done by a large group of private players. Meaning either the private individual who shops for an insurance policy and buys one, or else the private individual who receives an insurance coverage plan through the employer. This is the top level of boxes. When such an individual is sick, she visits the hospital or doctor and the insurance company then pays the hospital or doctor, or the individual pays a co-payment.

But we can not ignore the public sector. In the United States, the government spends money to provide health care to two segments of American society, the poor, with a program called Medicaid, and the elderly, with a program called Medicare. Like the private players above, the government also gives its business to the insurance companies who give coverage to the poor or elderly beneficiaries of that program. The poor and elderly visit the doctor the same way that an individual does who is in the private sector of health care spending. However, rather than the individual purchasing the plans from the insurance companies, the government provides money to enable that individual to have insurance.

In addition to the private and public sectors which purchase insurance, there are also individual patients who are totally uninsured. I can speak about this experience. So when I visit the doctor, instead of paying for medical services through an insurance company, I pay the costs out of my own pocket. However, in addition to out of pocket costs, the uninsured also receive health services through charities. So in our system, the solidarity exists here with these charities here, as well as the solidarity that the government collects taxes and administers programs for the poor and elderly.

Next, in my view, the most significant major development within the u.s. health care system in the last 20 years took place in the structure of the health insurance companies, which is an entirely privatized industry. An indemnity plan is one type of plan that insurance companies provide. As of 2002, 21% of the expenditure for health care took place through this type of plans.

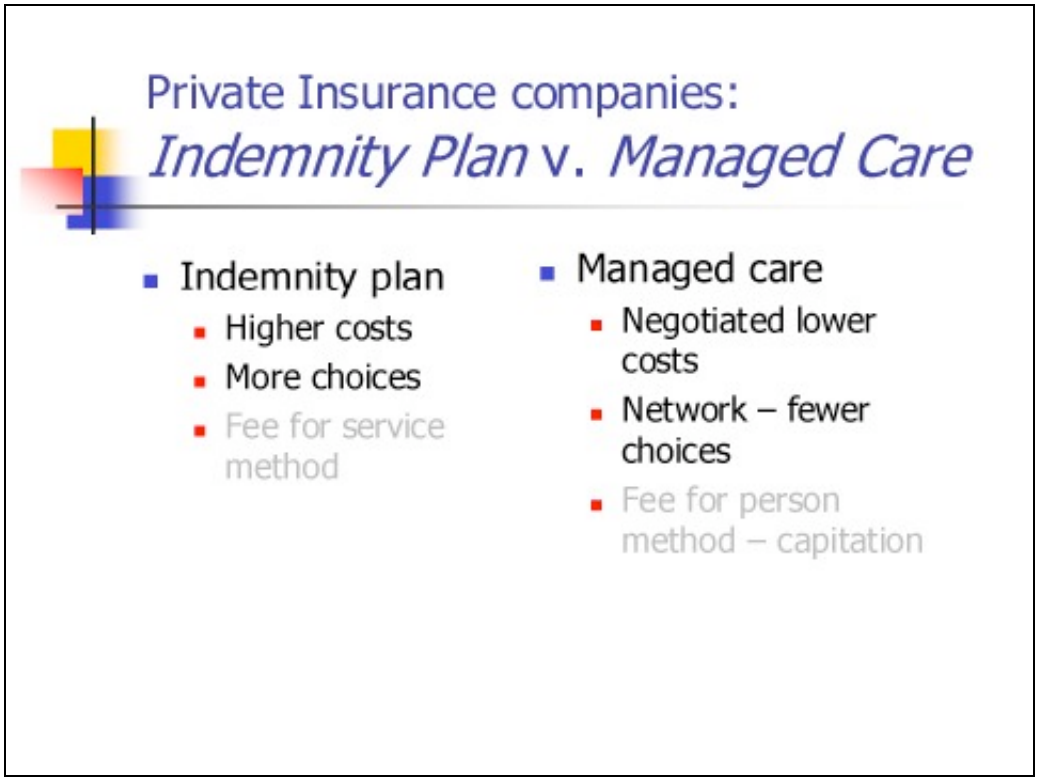
So what is an indemnity plan? An indemnity plan is the traditional health insurance plan. A patient who has purchased this can visit a doctor or hospital, receive treatment, the payment for services is rendered AFTER the services have been delivered. Now, we had a question last week from Eugen about patient rights to choose doctor and hospital. In America, you have the right to choose any doctor and hospital and to have insurance coverage for that choice, if you are under this indemnity type plan.

But the choices are limited if you have a managed care type plan. Why? I will define what a managed care program is first. This means that the managed care corporation, called health maintenance organization or HMO, has gone out into the market, negotiated lower discounted costs with doctors and hospitals and drug companies, and then forms a network of these care providers. Sometimes the HMO has created its own clinic and hires doctors, other times HMO makes contracts with doctors who are in private practice. In either case, an individual who purchases insurance coverage under this program has effectively purchased membership into this group, and can enjoy the lower costs. Each HMO plan is different, but usually, the patient pays nothing when they go to the doctor, or else they pay a small co-payment of 5 or 10 dollars.

However, there are two major rules. First, the individual can only see a doctor that is approved by the HMO. And for some HMOs if you go outside the network, the insurance will cover 0% of the costs. So to answer Eugen's question I must also

discuss this part. For a patient who has this type of health plan, the choices are limited if he wants to have the insurance company pay the bill. There are no government restrictions on choice of doctor of course, but if the individual who is shopping for insurance highly values the benefit of insurance coverage for a broad group of choices, then this type of plan is not good for him. The second rule is that the doctor, who has pre negotiated service prices with the HMO, is then paid by fixed revenue per patient. This means that the patient effectively ***pays in advance for all the treatment*** *he will need by joining this HMO. This is very different from the indemnity plan where the patient simply pays for the medical service as it is administered to him. The result here is that the doctor receives more financial reward for the more patients that he receives, and the reward is not necessarily tied to whether he administers more expensive or presumably difficult treatment.*

By 2002, 60% of health expenditures happened through such HMOs or managed care plans. One major philosophy behind this program is to keep the costs low of health care in general.



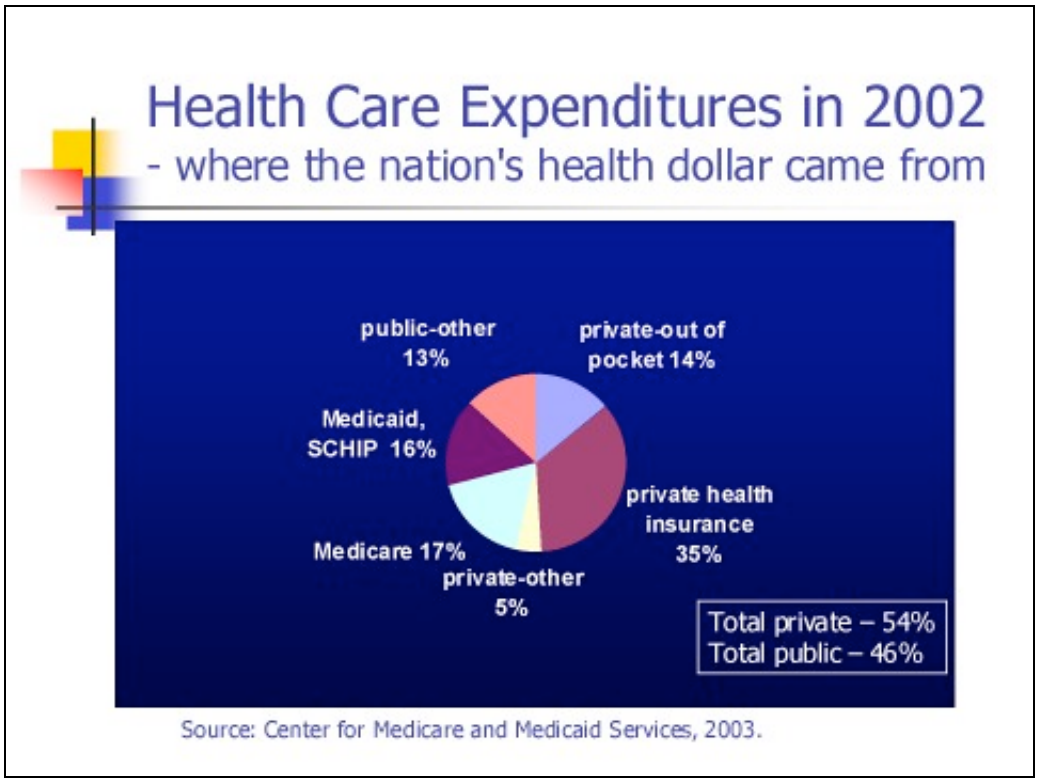
However, the purpose of this slide is to explain what an individual must think when he is choosing a health insurance plan. The indemnity plan is more expensive, but it gives you more freedom of choices. We have the divide between indemnity and managed care in the U.S. Health Care system. But I have also seen it in Slovakia. But not in the health care programs, but rather, in the lunch room. Every day at noon we gather and go to the café in our building. I have noticed that on the left, we have individuals who can purchase what ever food items they want and pay the set prices for those items, and there are no limits on choice. On the right, however, there are individuals who purchased the meal tickets. These people have essentially "pre negotiated" the set food items from which they can choose and these negotiations have happened the day before. As a result, even though this person experiences limited choices, he enjoys lower costs.

If you do need specialists care, an HMO will require that you first get approval from your primary care physician, which can be time-consuming and difficult for someone with cancer. When cancer is your main concern, make sure the plan you are considering provides in-network access to specialists that include cancer

doctors, and experts in cancer pain.

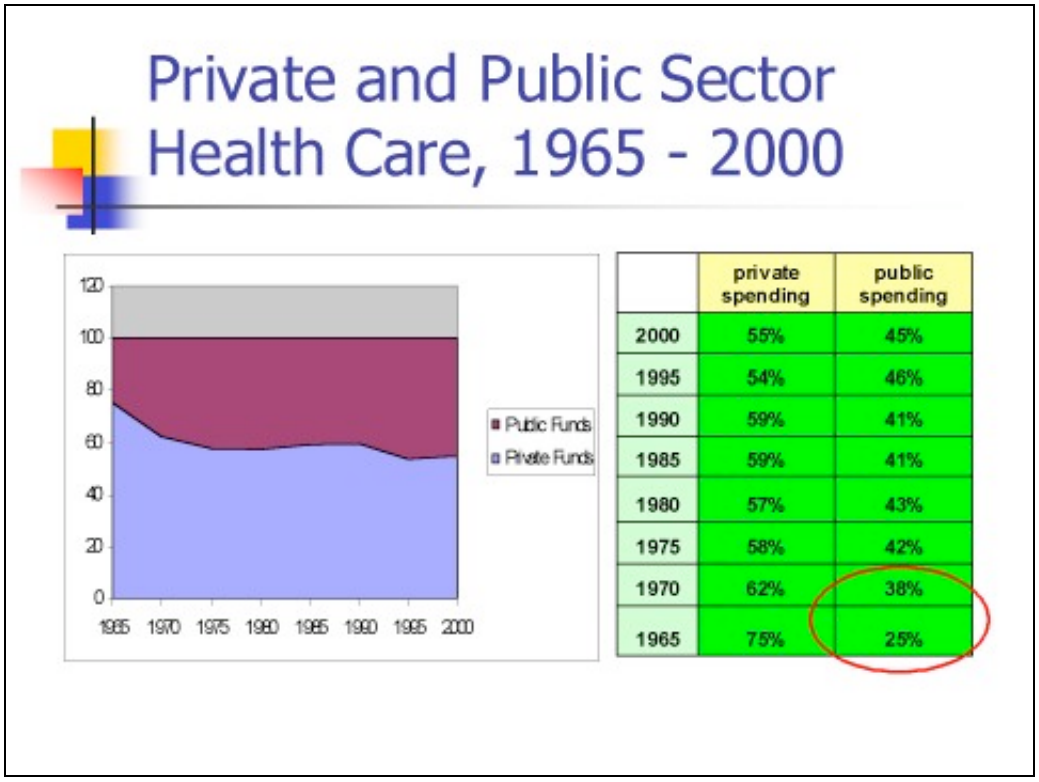
Therefore, I can conclude that both the private and public sector of the u.s. health care system is heavily reliant upon private companies and individuals. So for the market to operate efficiently there must be available information about insurance companies and providers. There are numerous websites where the public can compare health plans and access the information about different insurance companies.

Now, the question we had from Ema last week is whether there is public information available about top 100 hospitals. The answer is that, yes, definitely. One company, named Solucient, publishes a top 100 hospitals list by category of services and is a very reputable rankings list. The second source is published by the US News and World Report, a news magazine. And I will send everyone the internet links for both of those reports today.

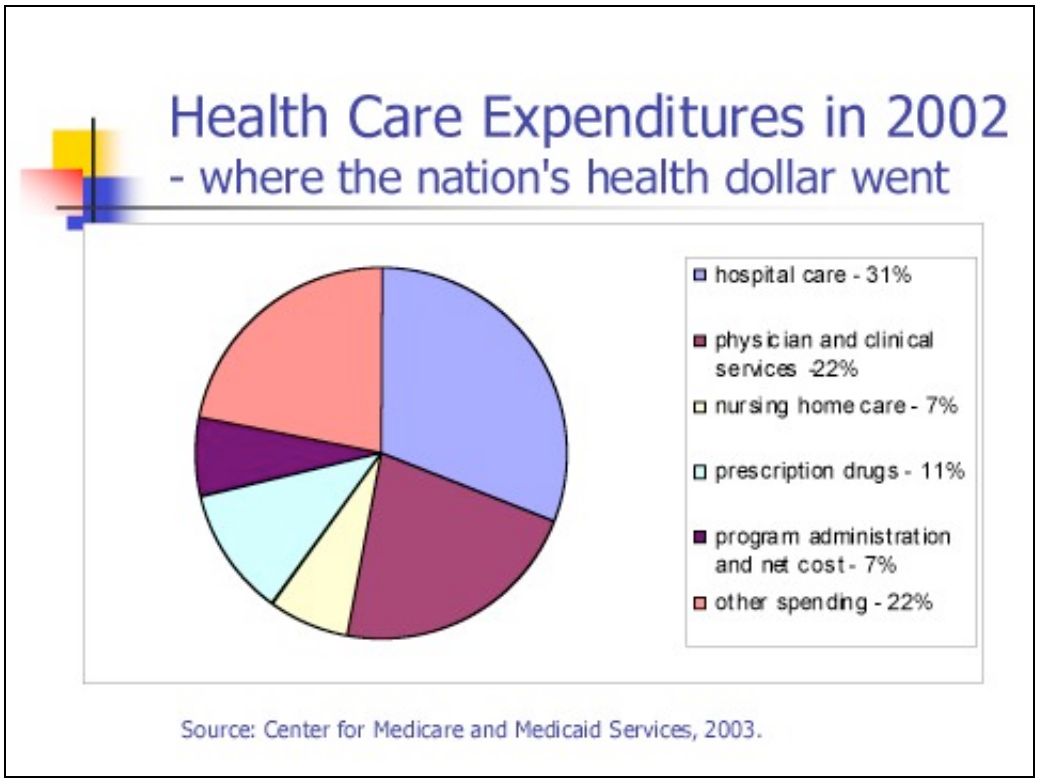


This pie chart shows where the national health dollar came from in 2002. Private health insurance companies spent 35% of the dollar. The other private sector segments were out of pocket payments, and private other, which includes hospital gift shop revenues, parking fees at hospitals, and charity. This adds up to 54% for the private spending.

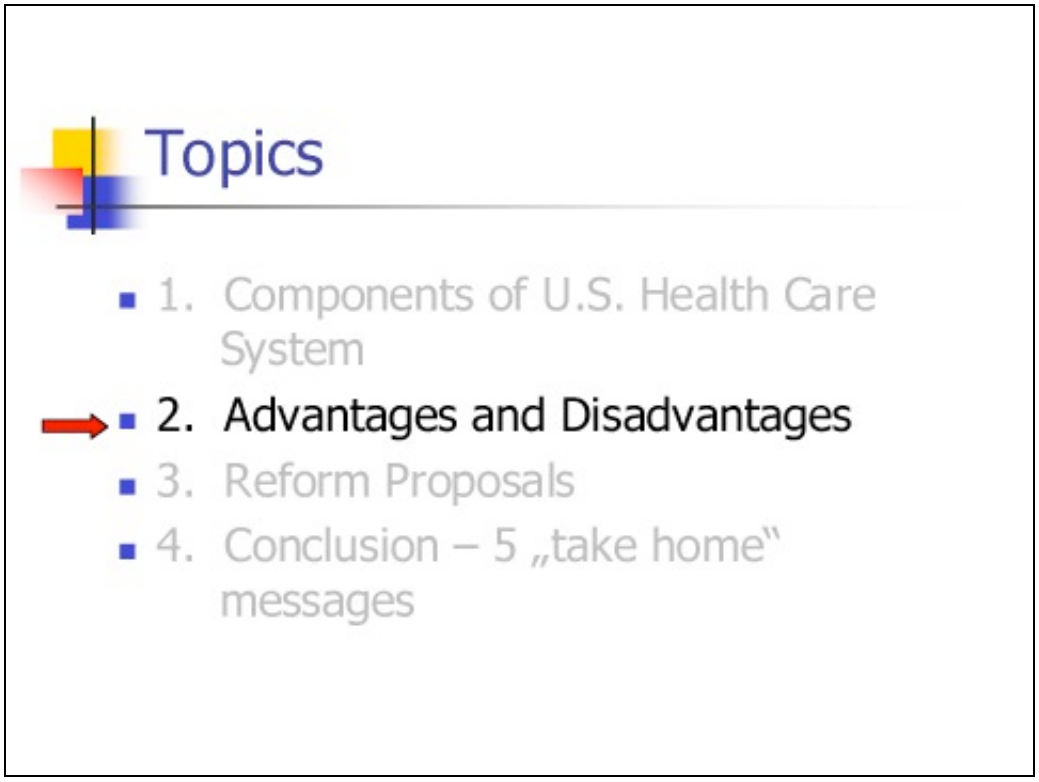
As for the remaining 46% in public spending, this is how it is broken down. Most importantly, there was Medicare, the government provided health care for the elderly. This program was the SINGLE largest purchaser of health care in 2002. Then we have Medicaid and an insurance program for children. And finally, there is 13% of public other which includes workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.



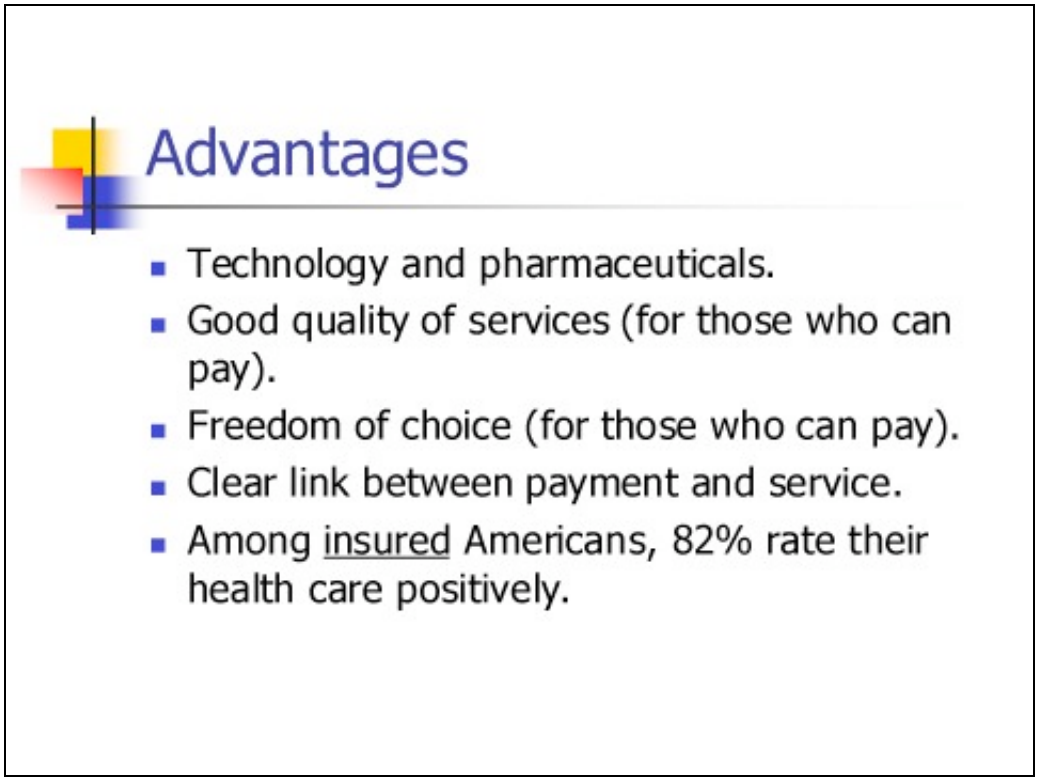
This next graph and chart shows the trend. As you can see here, between 1965-1970, the U.S. experienced a huge expansion of public sector spending as a percentage of the whole. This could also be an explanation for why the health care spending as a total has also increased dramatically since the 1960s.



Almost 1/3 of the spending went towards hospital services. Coming in 2nd was both physician services and other spending, which were both at 22%. Then we had prescription drugs at 11%, nursing home care at 7%, and then program administration at 7%.

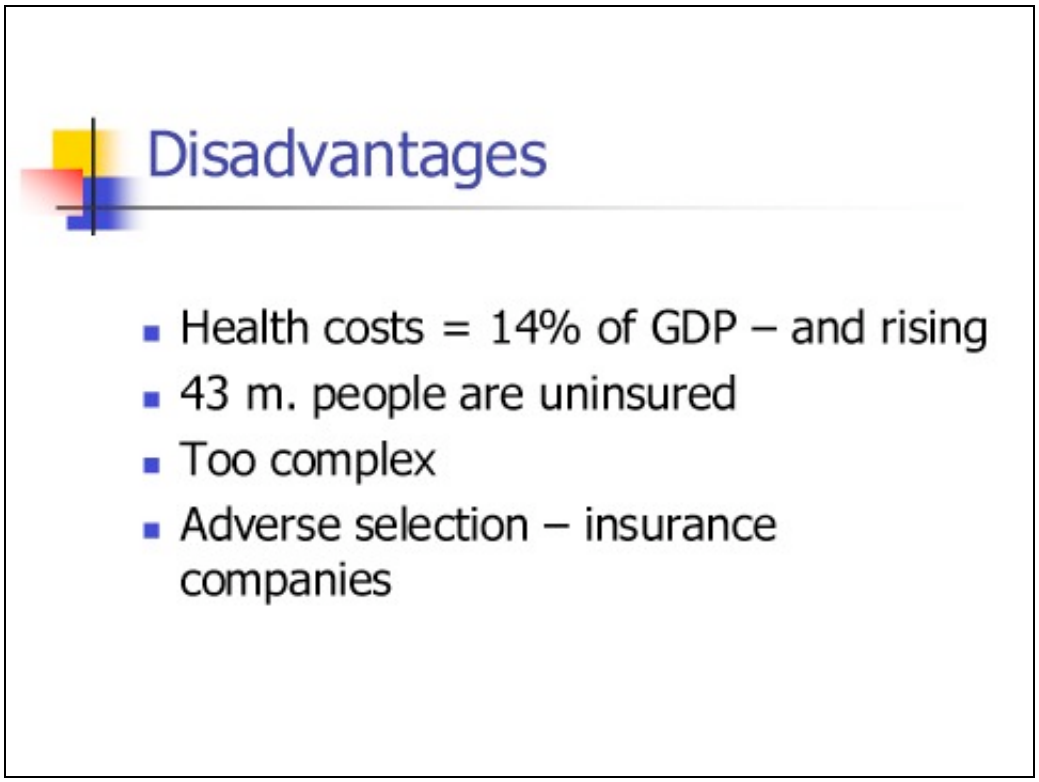


Now I will analyze the advantages and disadvantages.



As for the advantages, first, the u.s. has super technology and a very high quality of pharmaceuticals. Secondly, in terms of service, the OECD recently released a survey of 35 countries, and according to those findings, the U.S. scores best in the world for patient participation in treatment decisions, promptness of service, and respect for patients. Thirdly, the market is filled with various types of health care plans, indemnity vs. managed care, basic coverage versus major coverage, and the system is characterized by incredible freedom to choose. In fact, you can even choose to be uninsured as I have done. Fourthly, I see an advantage in the

fact that if an individual wants to pay more for better care, he is able to depend on the fact that he will actually receive better treatment. Fifthly, people are satisfied. For people who are in the insured group, 82% rate their care positively.

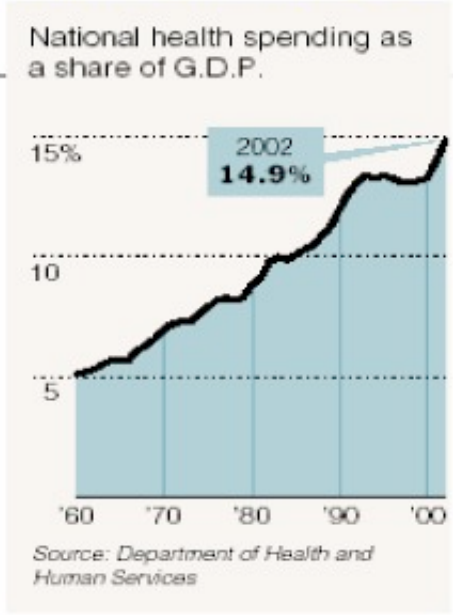


And as you can see, we have many disadvantages as well. First, the cost of health care in the united states amounted to 14.9% of GDP in 2002. Secondly, people are uninsured, and this is a problem for reasons that we will discuss. The third point is that the system is very complex. For example, even in the very specific and narrow segment of health care expenditures, Medicare, there is a very enormous list of rules, exceptions, and conditions that must be met to participate in this program. This is just one example. But the complexity also impacts the success of reformers who must understand the system in order to improve it. Finally, the system promotes adverse selection. This means that the insurance companies purposely target those who are healthy as consumers, because the sick will incur larger medical bills. This is a major disadvantage because to the extent that you believe the purpose of health care is to heal the sick, the system is structured with cost incentives for companies to keep quality and quantity of health care from those who need it most.

Rising Costs

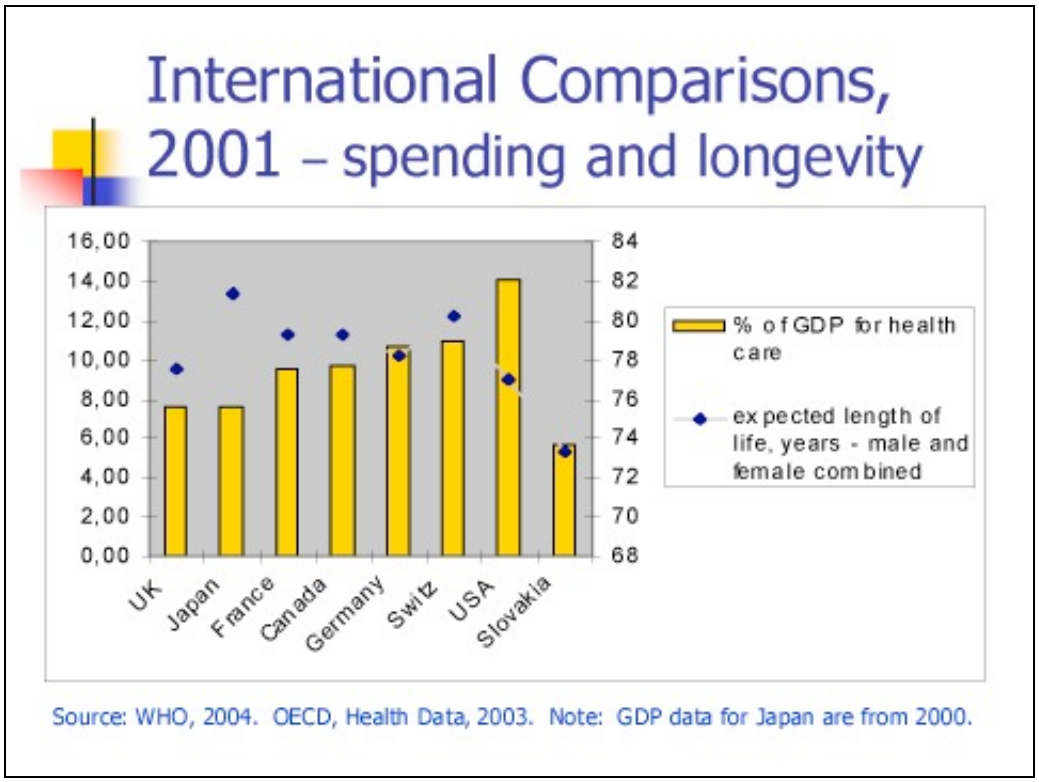
What has been the trend for the cost of health care in the last 40 years?

National Health spending as a share of GDP

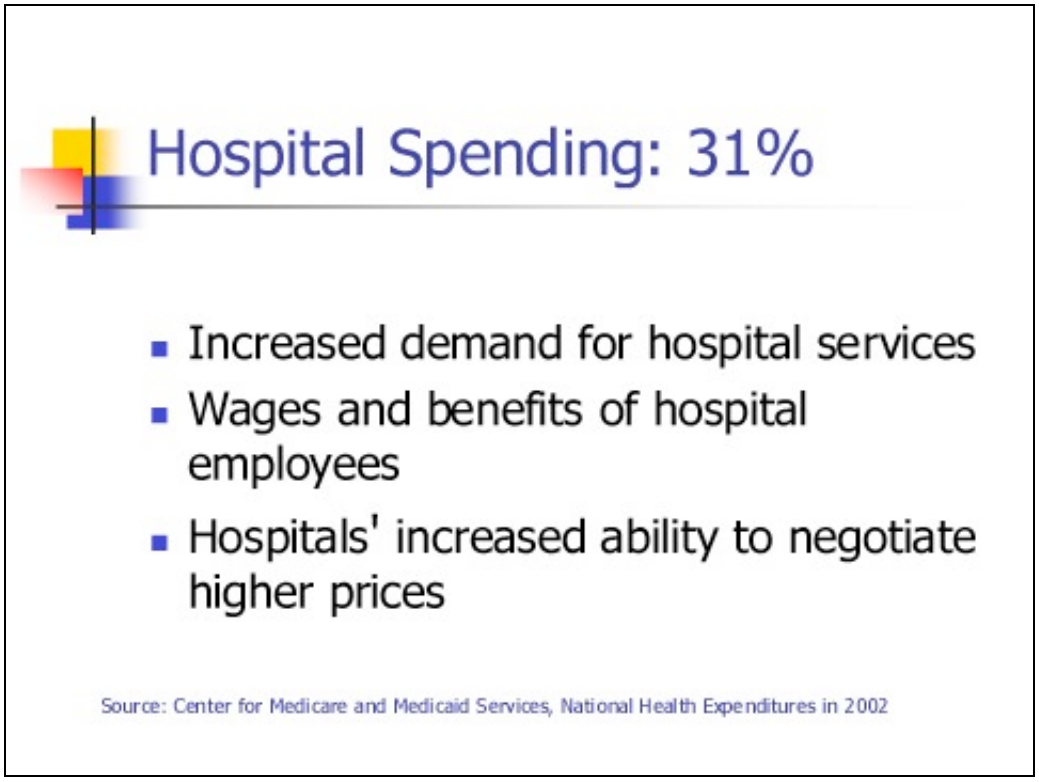


As you can see here, the percentage of GDP that was health care was only 5% in 1960. There was a steep increase until 1992 when the costs stopped increasing for about 8 years in the 90s. Policy makers suggest that this was because at this time the managed health care policies succeeded in containing cost. However, in 2000, there was another spike, and this is due to the increase hospital spending and pharmaceutical drug spending increase we have had between 2000 and 2002.

As for the future projected number, the percentage of GDP will probably continue rising because now American faces the problem of the aging population.



As you can see, I selected France, Germany, Switzerland, Canada, Slovakia, Britain and Japan to analyze their health care spending as a percentage of GDP and the expected number of years that a person will live, accounting for the total population, including both men and women. I compared this with U.S. data. As you can see, in 2002, the American is expected to live until age 77, much lower than the other countries picture on this chart, with the exception of Slovakia. Regarding the health care expenditure as a % of GDP all countries have a percentage between 9.5 and 10.9 percent, and the U.S. has 14.1% in 2001. The contradiction is that even though the U.S. spends the largest share of its GDP on health care, Americans are not living longer.



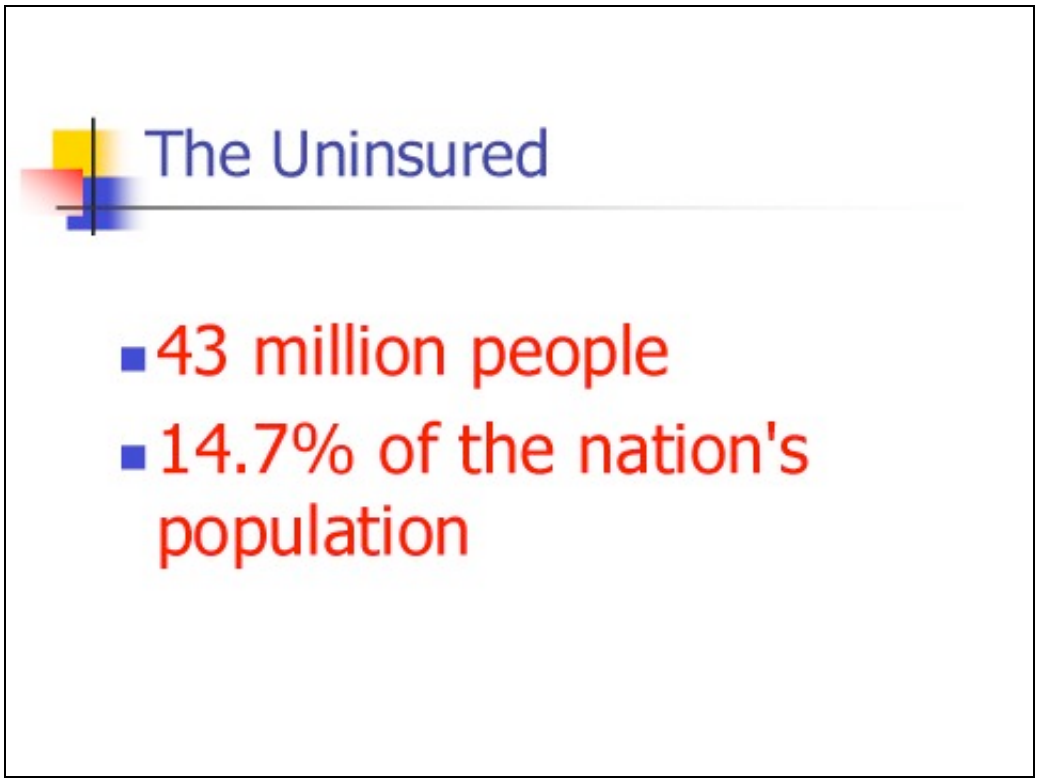
Well, in 2002, the largest piece of the pie for national health expenditure was hospital spending. These are the reasons why hospital spending is increasing.

Increased demand is reflected in both the increase in the number of hospital admissions and also the increase in the number of days spent at the hospital for each stay. The second reason is wages and benefits of hospital employees have increased. And finally, hospitals have improved the ability to negotiate higher prices with HMOs and health care providers.

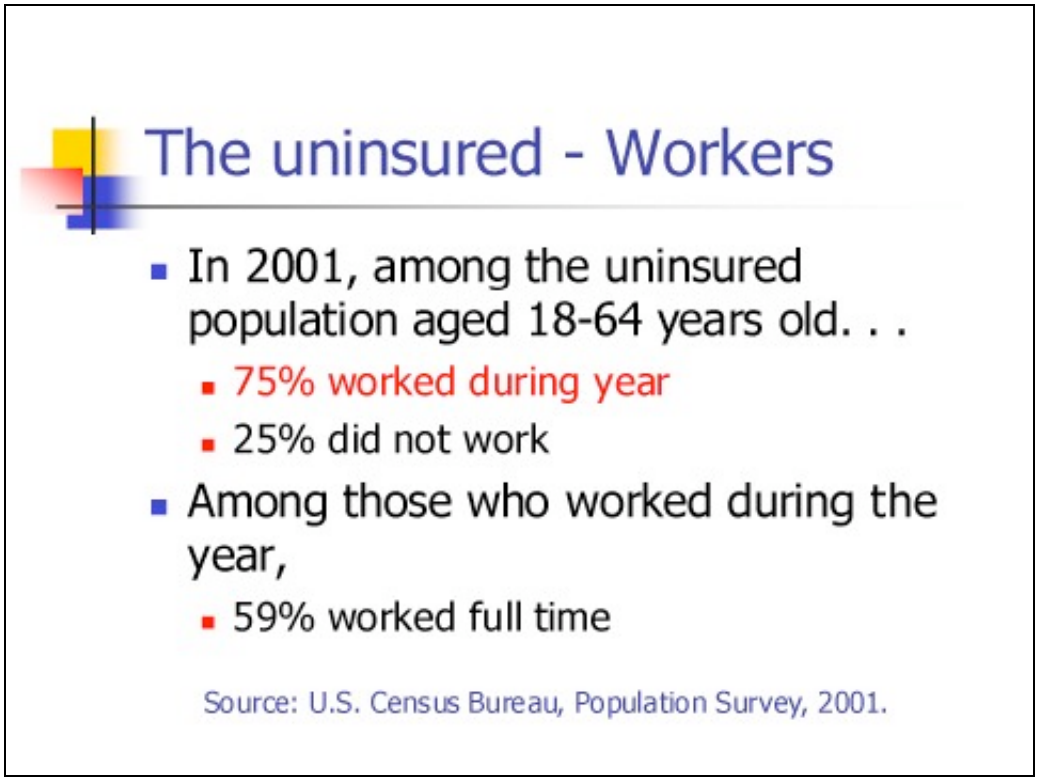
Administrative costs. Administrative costs exist for hospitals, government, as well.

However, here I have highlighted only one example of administrative costs, those of insurance companies. This point truly highlights the privatized nature of the u.s. health care companies because we have increased marketing costs, in the form of advertising and market analysis as corporations compete for the patient business. Also, we have patient tracking. This means that insurance companies, especially managed care companies, have set aside resources to monitor the health costs for each customer of the HMO, because the revenue provided to doctors and hospitals is calculated on a per person basis. So for example, some doctors who receive this competitive service from the insurance company, and the information allows the doctor to remain aware at all times of how much this patient contributes to the doctors overall revenue stream.

Finally, insurance companies are big business, and CEOs salaries are enormous. And of course in order to stay in business, the insurance companies must have profits which are included in the cost of health care.

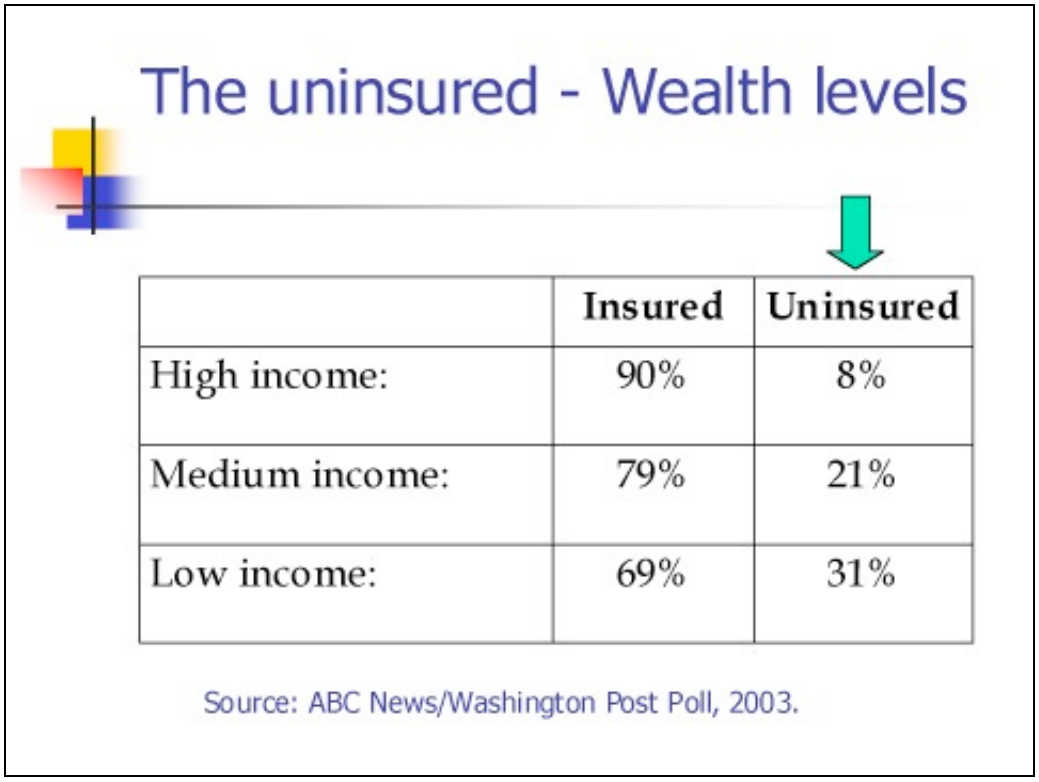


43 m. people, 14.7 % of the national population.



This slide destroys that myth. In 2001, among those who were uninsured who were old enough to work, 75% of them did work. Furthermore, among those who worked, 59% worked full time as opposed to part time.

Although the Medicaid program is a safety net for a minimum level of poor ness. People who work who are above that level, and do not enjoy the benefits from the national Medicaid program, and in terms of health coverage, they fall through the cracks.



This slide shows that if you look at the group of those with a high income, there is

only a small percentage of that group who is uninsured.

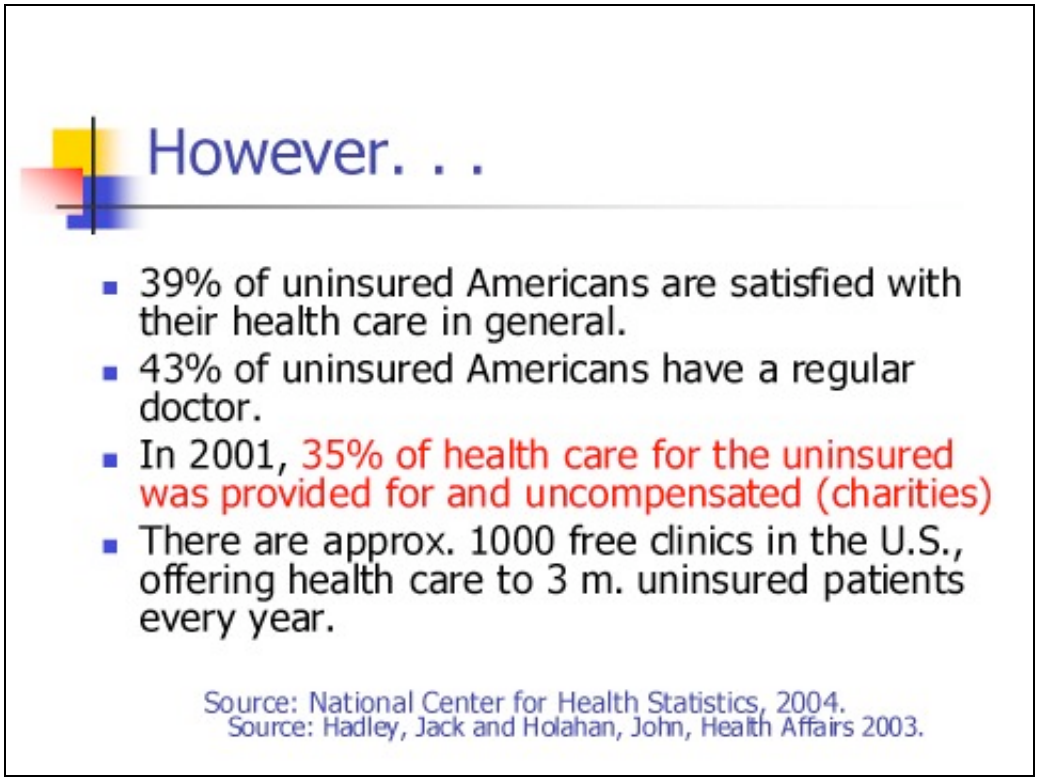
However, if we go to a lower income, which is less than 30K USD per year, according to my numbers here, than there is a greater chunk of them who are uninsured.

Well, the most significant consequence of being uninsured is that the uninsured individual has to THINK about cost before deciding to go to the doctor or hospital. Contrast this with the person who is uninsured, cost is an important subject to think about when shopping FOR an insurance plan, but not at the moment when you are sick or the minute you drive to the hospital. I think for the uninsured, the health bill is a more immediate and tangible expense. Many results may follow. If you are uninsured, and you can afford it, then you will go to the doctor. If you are uninsured and you can not, then you delay treatment or forego treatment altogether. Then, the result is they may experience worse health.

I learned that in a city in Slovakia one person died recently because of not having health treatment that could have saved his life. And I also learned that there was a great public shock and outcry. I can tell you that, in the United States, the Institute of Health released last year the number that 18000 Americans die each year because of medical problems that they could have treated but did not because they did not have health coverage. In fact, 40% of uninsured Americans said they had an unmet medical need in the last year. This means that they skipped a medical test, treatment or follow up, or failed to see a specialist.

Also, for those who are uninsured, even those who DO go to the hospital may receive poorer care because they must consider cost when choosing treatment options.

Finally, of course, there is emotional and financial distress and suffering. Not only for the individual who is sick, but also for his family.

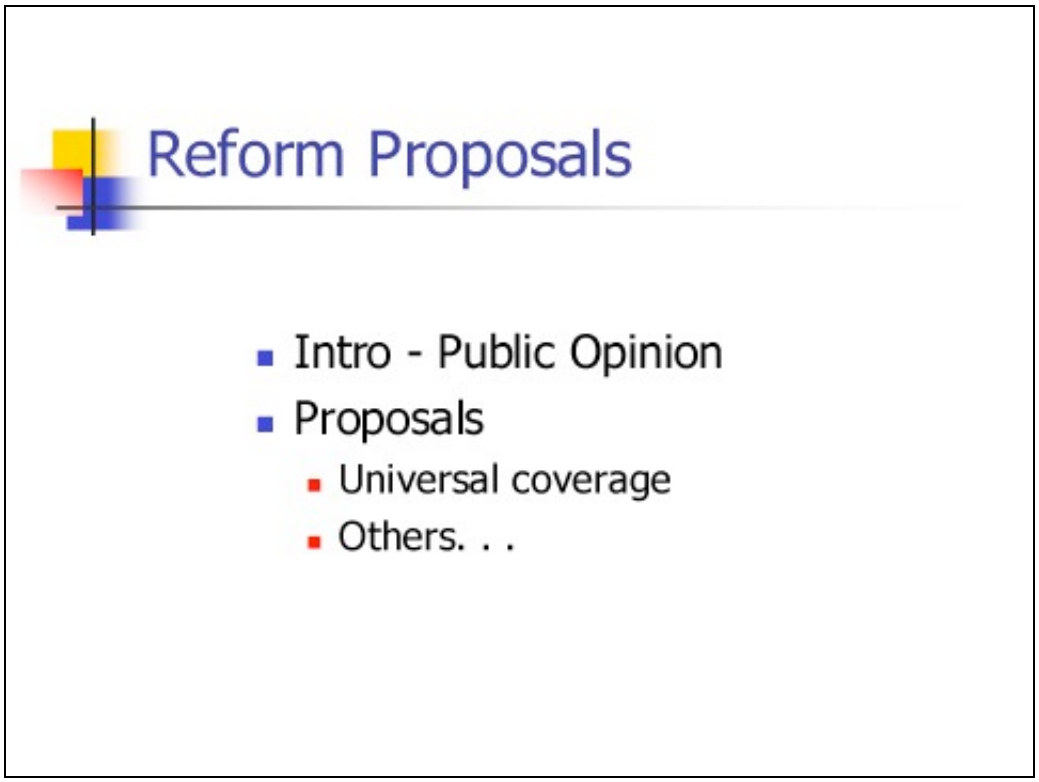


39% of uninsured Americans are generally satisfied with their health care. And 43% of uninsured Americans have a regular doctor.

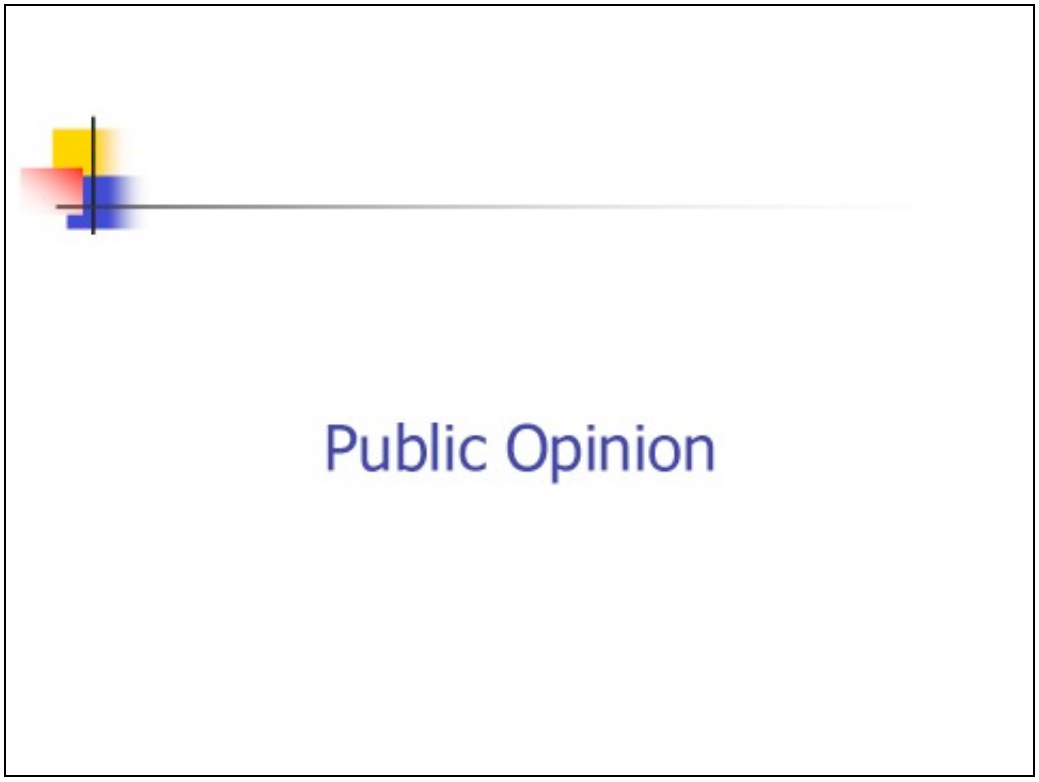
So the next question is, of all these uninsured Americans who are more or less satisfied, WHERE is their health care coming from?

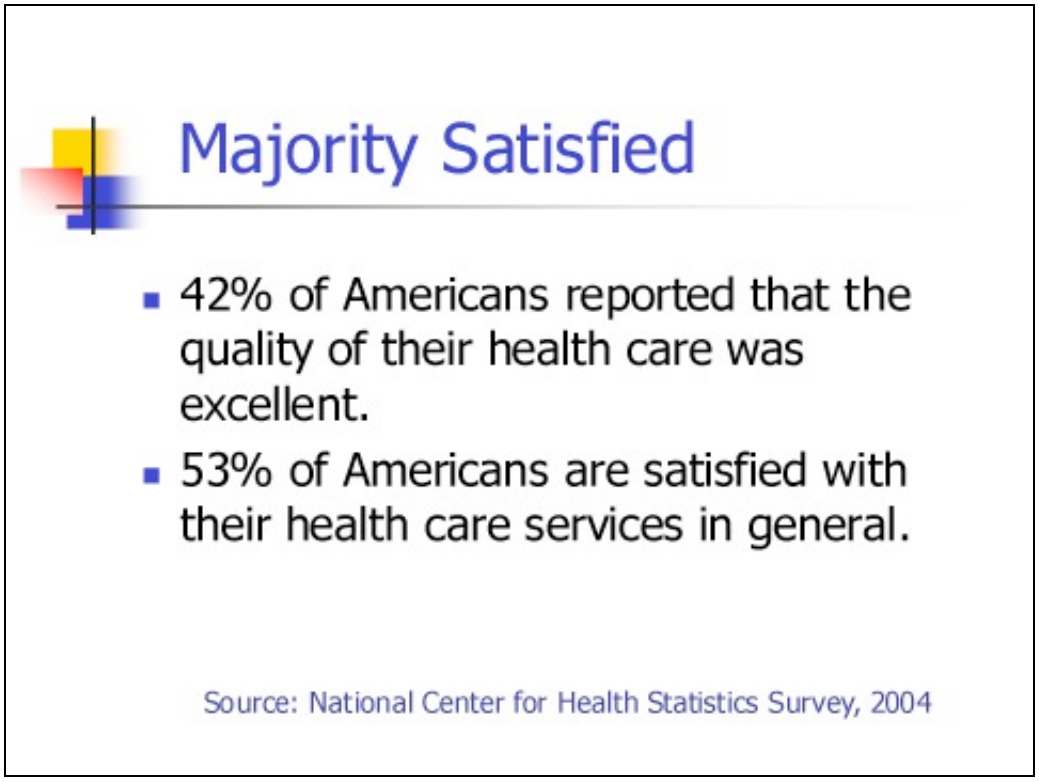
Well, in 2001, about 35% of it was provided for by uncompensated services, through charities. Furthermore, 3 m. uninsured patients were treated by 1000 free clinics in the United States.

The last analysis of this presentation involves reform proposals.

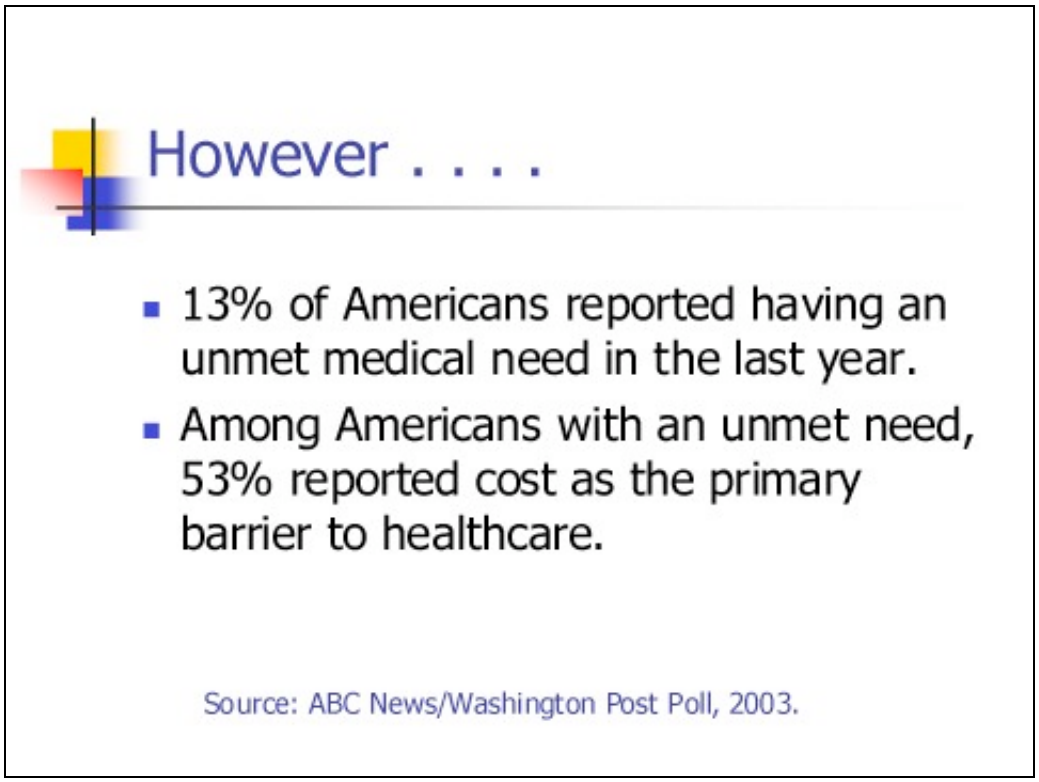


We will talk about public opinion first, and then dive into the actual proposals.

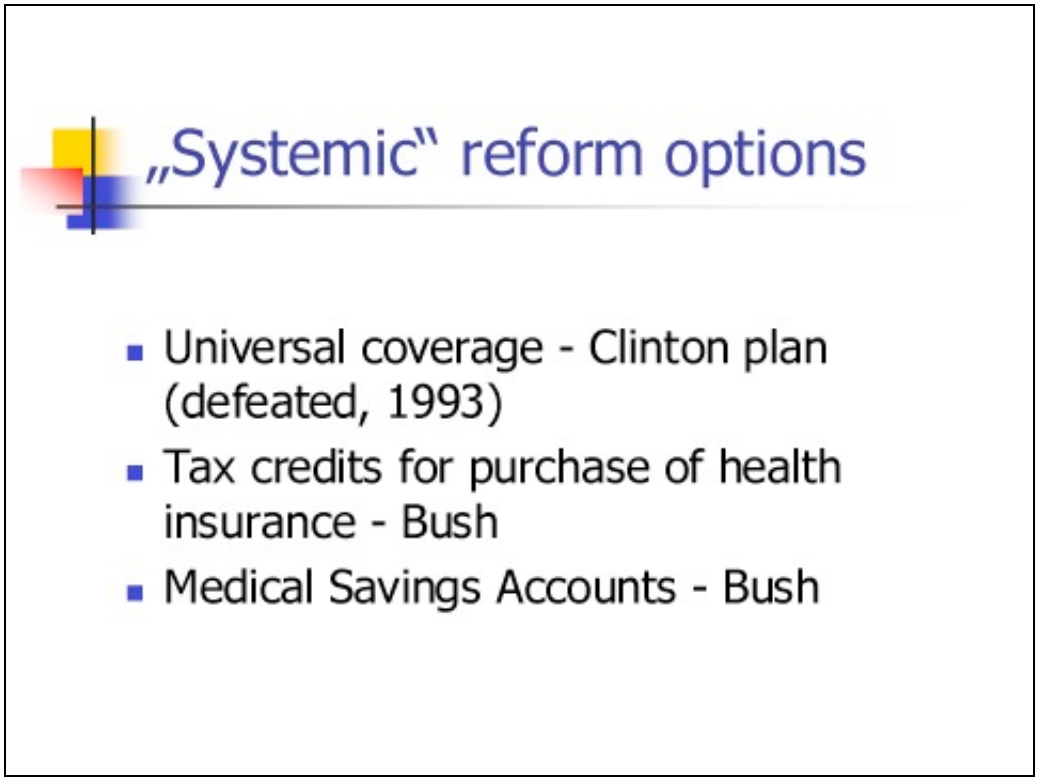




The majority was satisfied. These are opinions taken from a Survey in 2004. 42% of Americans reported that the quality of their health care was excellent. 53% were satisfied generally.



13% of Americans reported having an unmet medical need. Why? Because cost is the prohibitive factor 53% of the time that there is an unmet need.



I will briefly highlight each of these 3 reform options.

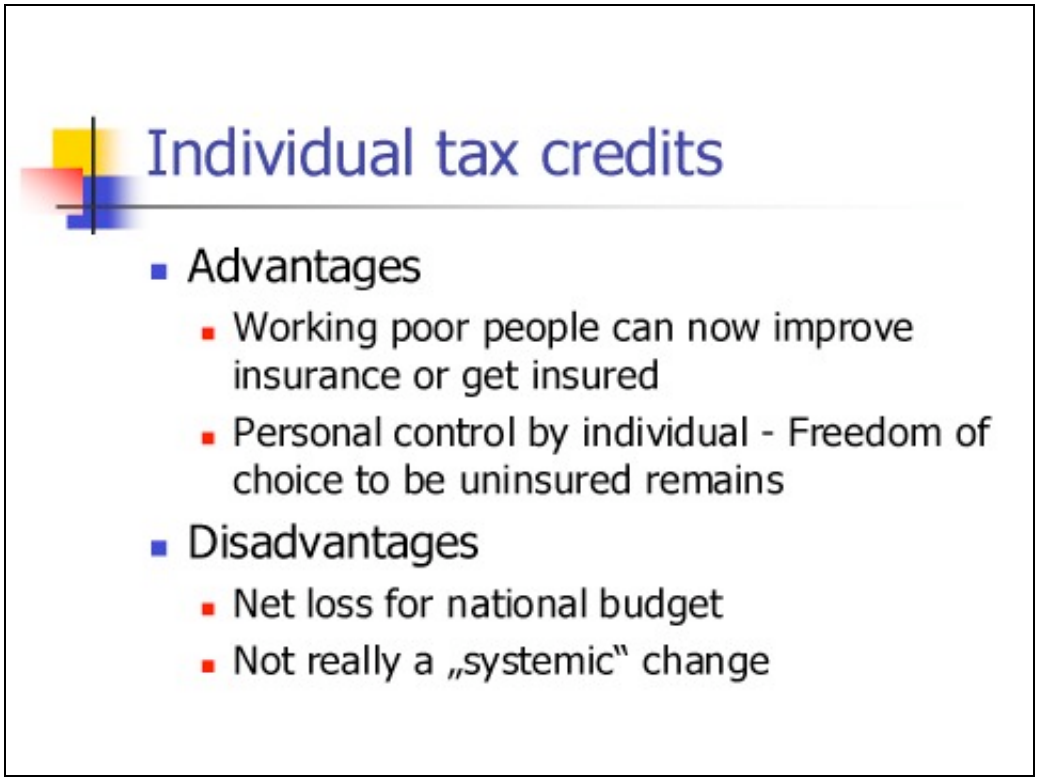
***First**, America actually did propose to implement a universal coverage system. In 1993, Hillary Clinton was the head of this task force. This failed. However, there is still support among policy makers today to implement a universal coverage system.*

***Next**, the Bush tax credits. Bush actually included an 89 b. cushion in his budget in 2001 reserved for this tax credit program for the uninsured individual, whereby the government gives tax credit money, between 1000 and 2000 per person who*

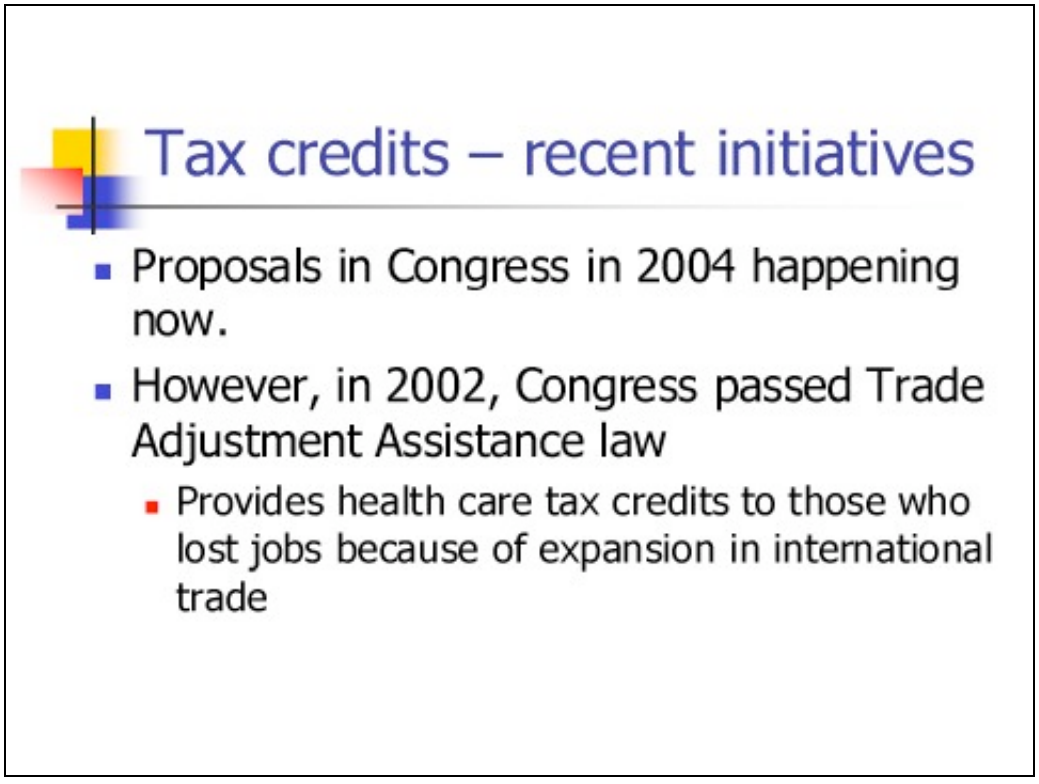
is uninsured. But Congress has not yet been able to implement a broad system to give such tax credits yet to all the poor and uninsured.

***Finally**, savings accounts, which is also supported by Bush, whereby individuals could set aside their own money to use for medical purposes.*

The advantages for this reform option is that, first, we achieve solidarity for the poor and uninsured. We reduce adverse selection. Meaning, that the incentive by private companies to choose to serve only the healthy will be somewhat eliminated so adverse selection is reduced. Thirdly, the admin costs are reduced. The downfalls are of course, more government bureaucracy. And this is highly politically unfeasible. As far as the powerful political interests of the CEO s of the health care services industry who are represented in Congress, they provide strong resistance to universal health coverage because such a proposal would eliminate their businesses. Also, there would be a weaker link between benefit and payment, as well as reduced market competition.

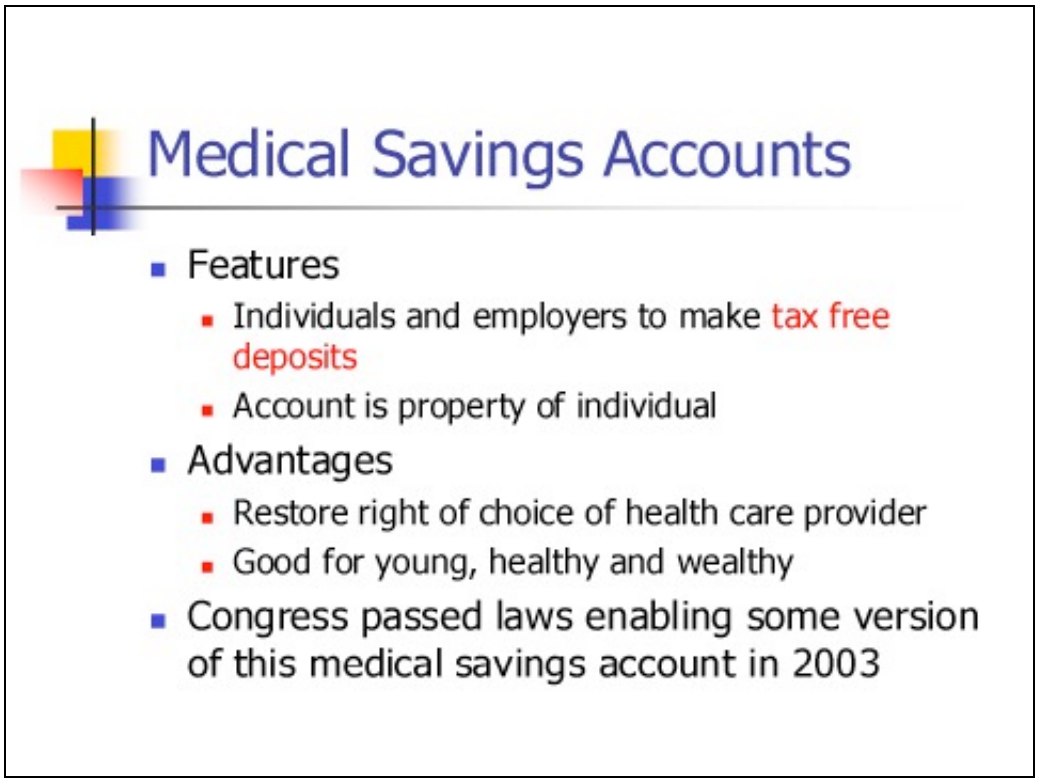


As for this second reform option, individual tax credits, the major advantages are that by increasing the individuals spending power by giving tax credits, the poor can now either improve their insurance coverage or else get insurance. As compared to the universal coverage option, this proposal has the advantage of retaining freedom of choice, even the freedom to choose to remain uninsured. As for disadvantages, this is a net loss for the national budget, and also, it is not really a systemic change. We do not eliminate structural actors and mechanisms here; we simply keep all the existing players, and just give patients more money to spend.



Presently there is a proposed bill in the House for tax credit for individuals. And in the Senate there is a bill for tax credits for micro businesses along with Hillary Clinton.

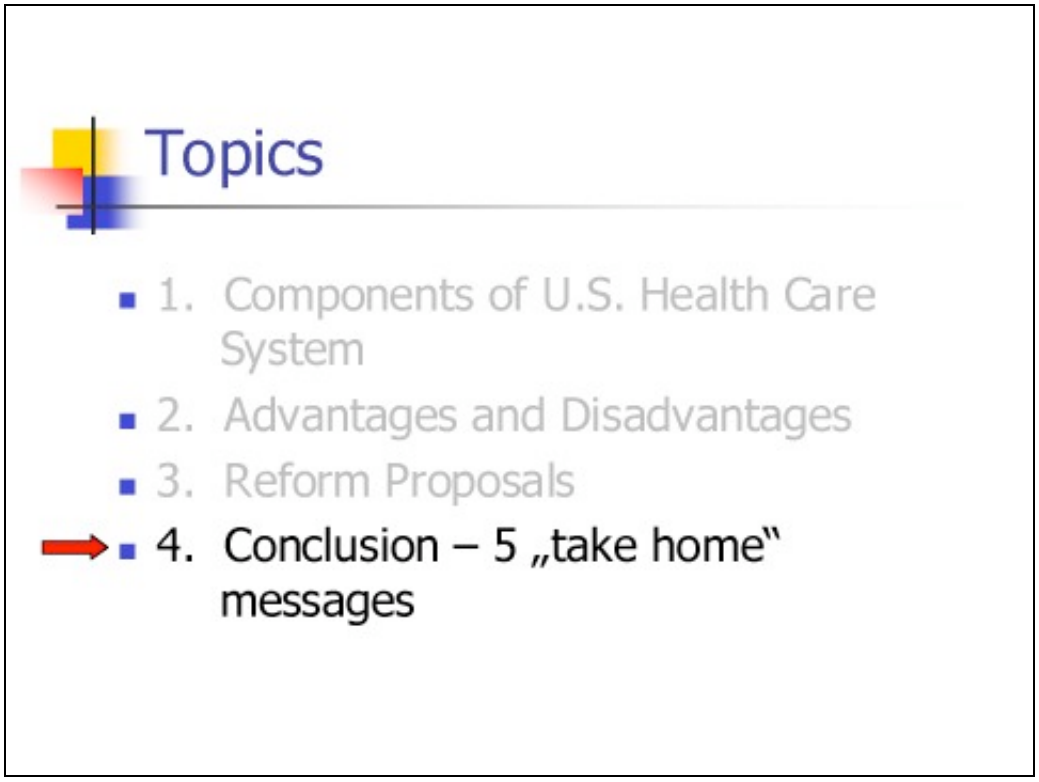
However, one piece of successful legislation involves tax credits that was passed in 2002. I know economists here will appreciate this one. In 2002, Congress passed Trade Adjustment Assistance law, which provides health care tax credits to those who lost jobs because of expansion in international trade.

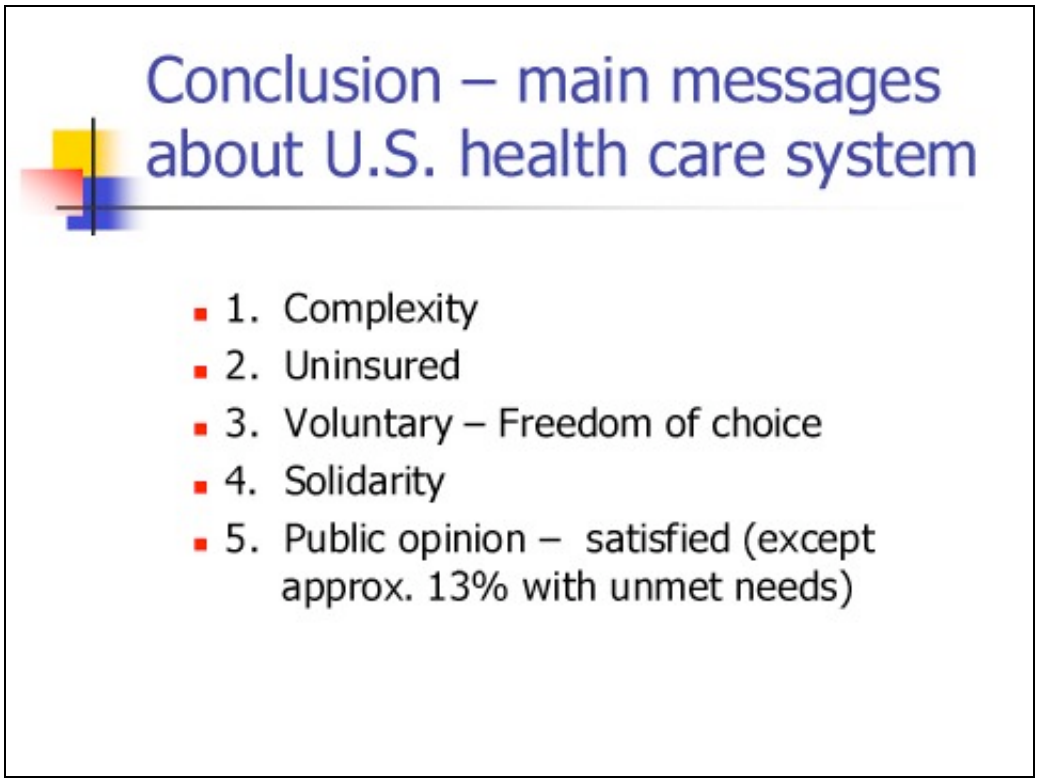


As for medical savings accounts, the third reform option. It is very important to realize that this is TOTALLY different from insurance. Whereas insurance involves an individual purchasing the ability to have someone else manage health risks. A savings account is nothing more than an account to make tax free payments into, to put money away for future health costs. In the past, there were restrictions on such health savings accounts, and this reform push is to eliminate restrictions.

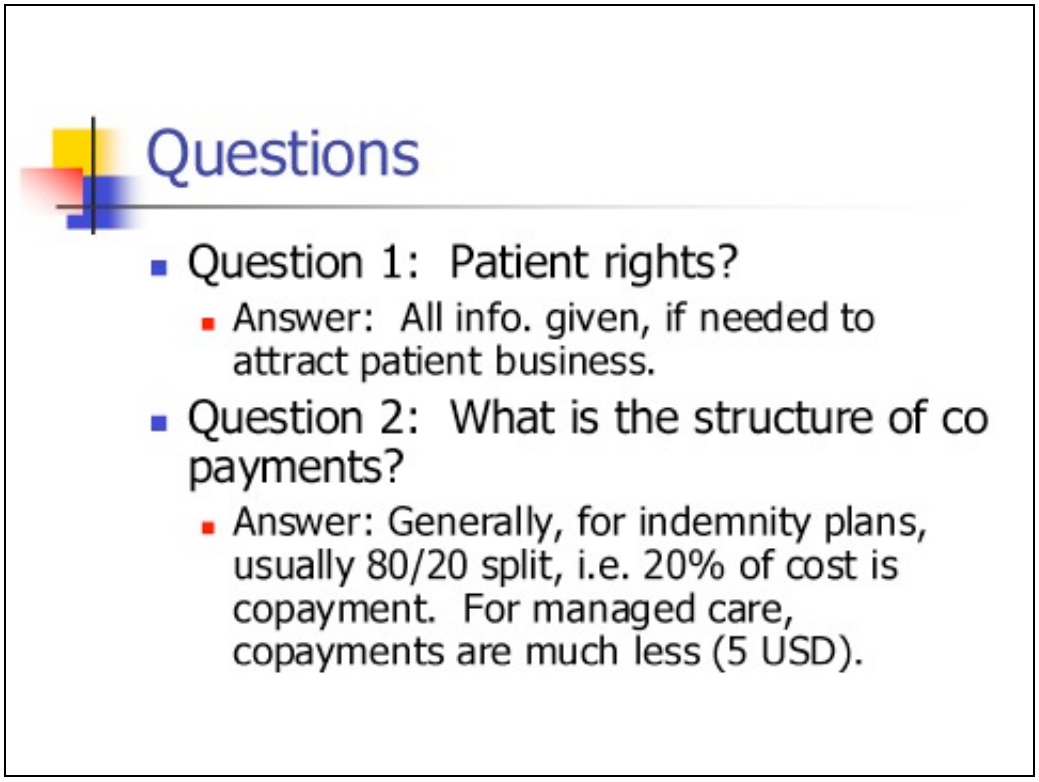
The advantage is that it allows individuals freedom to choose whatever they want to do with their own money, and it is tax free. And also, this especially benefits those who are young, healthy and wealthy.

A limited version of the medical savings account idea was included as part of the Medicare reform package passed by Congress in November 2003.





• Complexity - for both individuals and for policy reformers
• Uninsured - this is a major message because the right to health care is not a fundamental human right. It is not in our Constitution as such, in fact it is not even mentioned in the Constitution. And to have 18000 Americans die each year because of lack of coverage is a problem. Yet on the other hand, a large proportion of the uninsured said they were satisfied.
• Voluntary - Freedom of choice
• Solidarity
• Public opinion - satisfied (except approx. 13% with unmet needs)



Now there are some questions i received last week to discuss now, and after that, of course, I would open it up to additional questions.

Question 1: What are the patient rights, such as rights to have diagnosis information and information concerning the success of treatments?

*Answer: All info. given to attract patient business. **T**his means that the doctor is a business man and the patient is a consumer. So in order to satisfy the consumer, the doctor will give all the information required to secure the patients business.*

Question 2: What is the structure of co payments?

*Answer: For indemnity plans, usually 80/20 split. For managed care, co-payments are much less. **But this is a very general answer and it concerns doctor visits**. The structure of co payment depends on the actual health plan, for example, some co-payments amounts change each year for inpatient and outpatient treatment. For a hospital care and nursing home care, there may be a daily charge as a co-payment. And for medications, there is usually a co-payment for prescription drugs, and there is a structure of set charges for each different type of medication.*

Additional questions (collected after the presentation):

1. What is the trend in share of the uninsured over the decades in the US, is it going up? What was it before introducing Medicare and Medicaid?

Answer:
Before the introduction of Medicare and Medicaid in 1965, around 33% of the total US population was uninsured. In the 1970s, the percentage of uninsured of total population fell to 12% after introducing Medicare and Medicaid.

2. What was the reason for the expansion in public spending as a percentage of total spending between 1990 and 1995? What happened under Clinton?

Answer:
Medicare and Medicaid spending increased in that period as well. As for the Clinton administration between 1993-2000, yes, he did do the following: Clinton spent 16 b. USD to expand coverage for children, but this was in 1997. In 1997 the US also modernized and expanded the Medicare Trust Fund.

3. How many people use HMO's and indemnity plans? You gave us percentages on the spending, but this may be different from the share of the population.

Answer:
In, 2000, according to a report by InerStudy, which is described in the Research in Healthcare Financial Management, 2002, there were 213 m. insured people enrolled in some version of the HMO. Based on the total U.S. population in 282 m in 2002 and also the assumption that 15% of people were uninsured in 2002, I calculate the following:

76% of total population had HMO programs
9% of total population had indemnity programs
15% were uininsured

Also,

89% of insured population had HMO programs
11% of insured population had indemnity programs

4. Do people who are really sick and/or old use HMOs, or is it mostly for the young?

Answer:
It has been argued that HMOs have practices by which they keep the sick from enrolling in their programs or else discourage the sick from staying in their programs.

HMOs are popular among the young and healthy, but have been criticized by those who need more serious medical care.

5. How many people are covered by the 2002 Trade Assistance Act?

Answer:
In order to qualify to receive health care tax credits under this law, the individual must be in one of the following groups: 1. certified by the Department of Labor as having lost their jobs because of foreign competition. 2. workers aged 50 yrs or older who lost their jobs because of foreign competition and then took another line of work at lower pay and 3. other retirees who receive benefits from a separate pensioners program, PBGC. The amount of people in the first group is estimate to be 135000 workers and their dependents. Same for the third group. As for the second group, the number of people is estimated to be much less.

See the following links for more information:
http://www.statecoverage.net/pdf/issuebrief303trade.pdf
http://www.doleta.gov/tradeact/directives/107PL210.pdf

Note: In order to be eligible for this tax assistance, you must already have health coverage, so it is NOT really an initiative to cure the problem for the uninsured.

6. Are there organizations that monitor the quality of hospitals, doctors and/or insurance companies? And if so, are such organizations public or private?

Answer:
There seems not to be any central governmental organization that monitors the quality of hospitals and providers. However, we do have state laws as well as state offices, e.g., California, that have the goal of regulating the managed care industry. For instance, in California, the Department of Managed Care publishes "report cards" for HMOs and also maintains an online consumer complaint system.

Also, in the U.S. there is a private company called Healthgrades, Inc. that produces health care providers ratings and advisory services. You can purchase reports on specific doctors and view lists of top hospitals. The hospital list is not very comprehensive in my opinion but the report on doctors seems very comprehensive.

As for insurance companies, a company by the name of eHealthInsurance Services, Inc. does provide an insurance broker service that allows consumers to choose from insurance companies. Not only does eHealthInsurance aim to simplify the process of applying for health insurance, it makes it far easier for individuals and small businesses to compare a variety of health plans and to choose the one that suits them best, both in terms of coverage and cost.
