The U.S. National Health Care System

PH 150

Ninez A. Ponce, MPP, PhD
Assistant Professor
Department of Health Services,
UCLA School of Public Health
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Outline

(1) Overview of U.S. system compared to other developed countries
(2) Private insurance
(3) Public coverage & the Safety Net
(4) Massachusetts and Medicare Part D
(5) Current policy issues
How does the US “national system” compare to others?
Stylized Overview

Characteristics of U.S. System:

- Big
  - $1.9 trillion in 2004 or $6280 per person
  - 16% of GDP
- Relies on marketplace
  - Competition and cost containment
- Patchwork of insurance coverage
- “Safety net” to cover the patches
Patchwork of Coverage

- **Employer-sponsored private insurance**
  - (if offered, if you are eligible, & if you buy it)

- **Individual private insurance**

- **Medicare:** over 65 or disabled
- **Medicaid:** some (about ½) of poor
- **Military or veterans coverage**
- **Indian Health Services**
- **Uninsured (safety net providers)**
# Coverage from Public Programs

<table>
<thead>
<tr>
<th>Country</th>
<th>% of Population Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>100</td>
</tr>
<tr>
<td>Canada</td>
<td>100</td>
</tr>
<tr>
<td>France</td>
<td>99.5</td>
</tr>
<tr>
<td>Germany</td>
<td>92.2</td>
</tr>
<tr>
<td>Japan</td>
<td>100</td>
</tr>
<tr>
<td>Sweden</td>
<td>74.2</td>
</tr>
<tr>
<td>Switzerland</td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>100</td>
</tr>
<tr>
<td></td>
<td>45.0</td>
</tr>
</tbody>
</table>
### Total Health Care Expenditures, 2001

<table>
<thead>
<tr>
<th></th>
<th>Per Capita Expenditures in U.S. Dollars</th>
<th>Ratio of Expenditures to the United States’ Level</th>
<th>Percentage of Gross Domestic Product Spent on Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>$2350</td>
<td>2.08</td>
<td>8.9%</td>
</tr>
<tr>
<td>Canada</td>
<td>2,792</td>
<td>1.91</td>
<td>9.7</td>
</tr>
<tr>
<td>France</td>
<td>2,561</td>
<td>2.04</td>
<td>9.5</td>
</tr>
<tr>
<td>Germany</td>
<td>2,808</td>
<td>1.74</td>
<td>10.7</td>
</tr>
<tr>
<td>Japan</td>
<td>1,984</td>
<td>2.46</td>
<td>7.6</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2,626</td>
<td>1.86</td>
<td>8.9</td>
</tr>
<tr>
<td>Sweden</td>
<td>2,270</td>
<td>2.15</td>
<td>8.7</td>
</tr>
<tr>
<td>Switzerland</td>
<td>3,248</td>
<td>1.50</td>
<td>10.9</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>1,992</td>
<td>2.45</td>
<td>7.6</td>
</tr>
<tr>
<td>United States</td>
<td>4,887</td>
<td>1.00</td>
<td>13.9</td>
</tr>
</tbody>
</table>
## Utilization of Select Services

<table>
<thead>
<tr>
<th></th>
<th>Acute Care Bed Days per Capita*</th>
<th>Physician Visits per Capita**</th>
<th>Coronary Artery Bypass Operations per 100,000+</th>
<th>Coronary Angioplasty Operations per 100,000++</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>1.0</td>
<td>6.4</td>
<td>83</td>
<td>103</td>
</tr>
<tr>
<td>Canada</td>
<td>1.0</td>
<td>6.4</td>
<td>65</td>
<td>81</td>
</tr>
<tr>
<td>France</td>
<td>1.1</td>
<td>6.5</td>
<td>35</td>
<td>73</td>
</tr>
<tr>
<td>Germany</td>
<td>1.9</td>
<td>6.5</td>
<td>38</td>
<td>166</td>
</tr>
<tr>
<td>Japan</td>
<td>NA</td>
<td>16.0</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Netherlands</td>
<td>0.8</td>
<td>5.9</td>
<td>60</td>
<td>NA</td>
</tr>
<tr>
<td>Sweden</td>
<td>0.8</td>
<td>2.8</td>
<td>54</td>
<td>NA</td>
</tr>
<tr>
<td>Switzerland</td>
<td>1.3</td>
<td>11.0</td>
<td>60</td>
<td>65</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>0.9</td>
<td>5.4</td>
<td>41</td>
<td>51</td>
</tr>
<tr>
<td>United States</td>
<td>0.7</td>
<td>5.8</td>
<td>203</td>
<td>388</td>
</tr>
</tbody>
</table>
## Self-Reporting Waiting Times, 1998

<table>
<thead>
<tr>
<th>Waiting times for non-emergency surgery for themselves or a family member:</th>
<th>Australia</th>
<th>Canada</th>
<th>United Kingdom</th>
<th>United States</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
<td>16</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Less than one month</td>
<td>46</td>
<td>28</td>
<td>23</td>
<td>60</td>
</tr>
<tr>
<td>1-3.9 months</td>
<td>32</td>
<td>43</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>4 months or more</td>
<td>17</td>
<td>12</td>
<td>33</td>
<td>1</td>
</tr>
</tbody>
</table>

## Life Expectancy and Infant Mortality Rates, 1998*

<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy at Birth (years)</th>
<th>Infant Deaths per 1,000 Live Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>78.7</td>
<td>5.0</td>
</tr>
<tr>
<td>Canada</td>
<td>78.6</td>
<td>5.5</td>
</tr>
<tr>
<td>France</td>
<td>78.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Germany</td>
<td>77.5</td>
<td>4.7</td>
</tr>
<tr>
<td>Japan</td>
<td>80.6</td>
<td>3.6</td>
</tr>
<tr>
<td>Netherlands</td>
<td>78.0</td>
<td>5.2</td>
</tr>
<tr>
<td>Sweden</td>
<td>79.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Switzerland</td>
<td>79.5</td>
<td>4.6</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>77.3</td>
<td>5.8</td>
</tr>
<tr>
<td>United States</td>
<td>76.7</td>
<td>7.2</td>
</tr>
</tbody>
</table>

* Data for Canada are for 1997.
RELATIONSHIP BETWEEN NATIONAL WEALTH AND HEALTH EXPENDITURES

Overview of the US health care system

Between 2001 and 2011, health spending is projected to grow 2.5 percent per year faster than GDP, so that by 2011 it will constitute 17 percent of GDP.

Other Spending 24%
Nursing Home Care 7%
Prescription Drugs 9%
Program Administration and Net Cost 6%
Nursing Home Care 7%
Physician and Clinical Services 22%
Hospital Care 32%
Total Health Spending = $1.3 Trillion

Note: Other spending includes dentist services, other professional services, home health, durable medical products, over-the-counter medicines and sundries, public health, research and construction.
In recent years, the hospital share of total spending has decreased while the prescription drug share has increased.
The financing of prescription drug expenditures has rapidly shifted from consumer out-of-pocket spending to private health insurance.

Note: Data are Calendar Year.

Over the decade, out-of-pocket payments declined while private insurance payments increased.
The Nation’s Health Dollar, CY 2000

Medicare, Medicaid, and SCHIP account for one-third of national health spending.

Total National Health Spending = $1.3 Trillion

1 Other public includes programs such as workers’ compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and State and local hospital subsidies and school health.
2 Other private includes industrial in-plant, privately funded construction, and non-patient revenues, including philanthropy.

Note: Numbers shown may not sum due to rounding.

Private Insurance

(1) Development
(2) Current statistics
(3) Employer-based coverage
Development of Private Insurance

- Story begins around 1930 in U.S., although earlier in countries such as Germany

- First example: 21-day hospital benefit for $6/year (Baylor University, Dallas, 1929)
  - Hospitals then banded together to give choice of facility; gave them $$ even if beds in Great Depression even when beds were empty, which led to the formation of “Blue Cross”
A.M.A. was worried that insurance could lead to “socialized medicine,” so “Blue Shield” plans didn’t form till 1940s
- 10 tenets of coverage (MDs have complete control over care, free choice of MD, etc.)

WWII stimulated development; with labor shortage and wage controls, health insurance became attractive fringe benefit, and courts later ruled it not taxable income
Medicare & Medicaid in mid-1960s
- Compromise between liberals who wanted social insurance, and providers who didn’t want excess government interference

Compromise: 3-pronged approach put together by Congressman Wilbur Mills:
- Part A of Medicare, hospital insurance, is like social insurance, financed from payroll taxes
- Part B, physician coverage, voluntary and partly paid by beneficiaries and partly from general revenues - but with generous reimbursement rules
- Medicaid was not made an entitlement program, but a rather welfare-like program for poor people.
Health Insurance Coverage, US and CA, Ages 0-64, 2005

United States | California

- **Uninsured**
  - United States: 18%
  - California: 21%

- **Privately Purchased**
  - United States: 5%
  - California: 7%

- **Medicaid/Other Public**
  - United States: 16%
  - California: 18%

- **Employer-Based**
  - United States: 61%
  - California: 53%

Source: KFF 2006
Statistics: The Uninsured (CPS 2005)

Percentage of population under age 65:
- total population: 18% (46 million people)
- age 18-24: ~29%
- Black: 15% (pop. share 13%)
- Latino: 30% (pop. share 14%)
- <200% FPG: 65%

(about $40k pretax income for family of 4)

(note that median family income in 2005 is $56K)

- Workers ~35 million
The “Safety net”

- Intact? Endangered? Imaginary?
- IOM: Definition:
  - “Those providers that organize and deliver a significant level of health care and other health-related services to the uninsured, Medicaid and other vulnerable populations.”
  - “core safety-net providers”-
    - Legal mandate of “open door” policy
    - Serves a substantial share of uninsured, Medicaid and other vulnerable populations
      - No set threshold, but deemed detrimental to community if these providers disappear
$500 cash upfront for an appointment—patient’s perspective

"I make minimum wage, Dude—no way I have that kind of money lying around. What am I supposed to do?"

His low-income job offered no health insurance but paid him just enough to disqualify him for Medicaid coverage.

*JAMA.* 2006;296:1701-1702
At times, and especially early in my career, I have been proud of carrying that burden, of being part of a safety net for the neediest. At other times, and more so lately, I wonder if my very participation in this system plays a darker role—a complicit role—of enabling the disparity of care to persist, of helping to provide false reassurance that we actually have a safety net that provides adequate care to all in need.

*JAMA.* 2006;296:1701-1702
Recent “sweeping” reforms
The Massachusetts model: An artful balance
(Turnbull; Health Affairs 2006)

Background
- Massachusetts health reform legislation
  - Goal = provide coverage to nearly all residents
    - 12% uninsured
  - Employs both proven and innovative policy strategies
    - Medicaid expansions
    - Subsidies for low-income
    - Individual mandate
    - State purchasing pool
    - Others
The Massachusetts model: An artful balance
(Turnbull; Health Affairs 2006)

Discussion
- Triumphs
  - Sweeping reform vs. incremental change
  - Solution involving government, employers, and individuals
The Massachusetts model: An artful balance
(Turnbull; Health Affairs 2006)

Discussion, cont’d

- Challenges
  - Need for ongoing public support, especially in light of changes still to come including the individual mandate (July 2007)
  - Individual affordability
  - State’s economic state over time
  - Addressing address for undocumented, 300%-500% FPG
  - Adequate funding of the safety-net
  - Cost containment
Medicare Part D: Market-Driven, Plus Oversight

1. Voluntary enrollment
   As of June 2006, Nearly 23 Million of 43 million Medicare Beneficiaries Have Enrolled in Part D

2. Federal government does not set prices, premiums, or formularies

3. Federal government and plans share financial risk

4. Plans compete for enrollees, within regions, based on premiums, OOP, benefit design, reputation

5. Beneficiary protections
   - Low-income subsidy
   - Formulary protections
**Medicare Part D Standard Benefit Design**

<table>
<thead>
<tr>
<th>Plan’s Coverage</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary Cost-Share</td>
<td>$5,100</td>
<td>$5,451¹</td>
</tr>
<tr>
<td>Plan’s Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catastrophic Coverage</td>
<td>$265</td>
<td>$265</td>
</tr>
<tr>
<td>No Coverage (&quot;donut hole&quot;)</td>
<td>$2,250</td>
<td>$2,400</td>
</tr>
<tr>
<td>Partial Coverage</td>
<td>$250</td>
<td>$265</td>
</tr>
</tbody>
</table>

¹Equivalent to $3,850 in out-of-pocket spending: $3,850 = $265 (deductible) + $534 (25% cost-sharing on $2,135) + $3,051 (100% cost-sharing in the “gap”).

Current Policy Issues

(1) Access/equity
- About 46 million uninsured
- Getting access to care in HMOs
- Disparities in access and treatment

(2) Rising costs
- Higher premiums, higher cost sharing
- Especially pharmaceuticals
- Movement away from tightly managed care

(3) Quality
- Does competition improve or deter quality?
- Do HMOs provide as good quality of care?
- Consumer-driven health care