


Payment for care and cost of care

M6920
November 20, 2001

Paying for anything:

- **pay for it myself**
 - **directly--cash purchases**
 - **indirectly--"free lunch"--airline miles**
- **someone else pays for it for me**
 - **explicitly on my behalf**
 - **for a category to which I belong**
 - **charity**

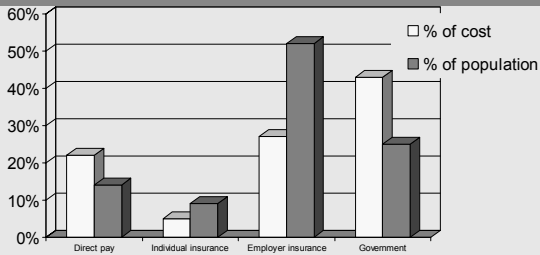
The money comes 3 ways:

- **employers**
 - **governments**
 - **individuals**
- 
- **All are ways of getting money from the resources of households**

Historical snapshot

- **primarily direct payment**
 - in 1960, 49% was direct
 - by 1993, 17.8%
- **as costs rose**
 - cost shifting became common
 - prudent and aggressive purchasers limited these opportunities

Population and payments



Common types of health insurance plans

- **Indemnity or Fee for service (FFS)**
- **Preferred provider organization (PPO)**
- **Point of service (POS)**
- **Health Maintenance Plan (HMO)**

Current experience

- **direct payment by uninsured**
 - insurance unavailable
 - insurance unwanted (voluntarily uninsured?)
 - insurance unaffordable
- **insured but category not covered**
 - pharmaceuticals
 - experimental treatments
 - alternate therapies



Current experience, cont.

- **individual private insurance**
- **employment based insurance**
- **government financing**
 - Medicare
 - Medicaid
 - Military



Current experience, cont.

- **direct support for public hospitals**
 - city/county government
 - state government (MH, TB)
 - federal government (Hanson's disease)
- **special populations**
 - military
 - veterans
 - prisoners



My decisions about paying



Will I purchase insurance?

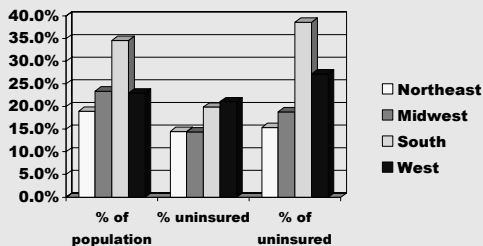
- out of pocket as individual
- through an employer
 - may govern choice of employment
 - 53% of individuals have choice of plan
 - 64% of families have choice of plan
- through a government program
 - determining eligibility
 - determining personal "cost" in enrollment



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Distribution of uninsured

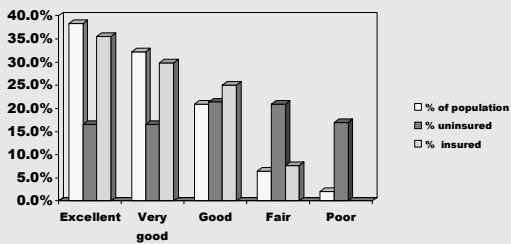


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MEPS, 1999

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Health status and coverage

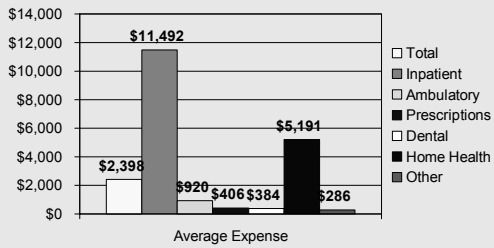


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MEPS, 1999

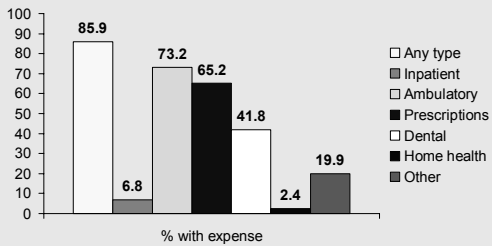
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Average expense per person, 1996*



Columbia University School of Nursing *AHRQ, 1996 MEPS Household Component M6920 Fall, 2001

% of population with expense for health care*



Columbia University School of Nursing *AHRQ, 1996 MEPS Household Component M6920 Fall, 2001

federal poverty level for 2001

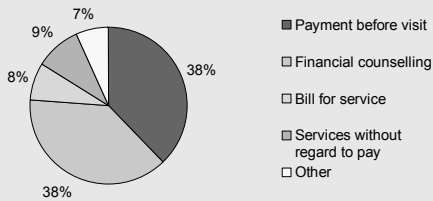
	Lower 48	Alaska	Hawaii
1	8,590	10,730	9,890
2	11,610	14,510	13,360
3	14,630	18,290	16,830
4	17,650	22,070	20,300

Columbia University School of Nursing Source: HHS, 2001 M6920 Fall, 2001

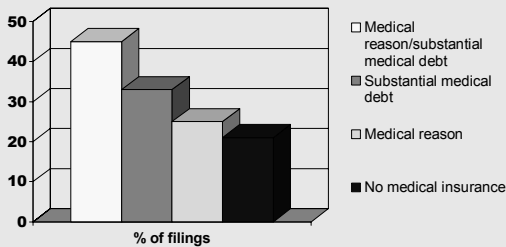
Sliding Fees for Primary Care

	100% FPL	150% FPL	200% FPL	N
HHC	\$19	\$48	\$98	28
Voluntary	\$41	\$62	\$84	81
FQHC	\$29	\$54	\$83	30
Other	\$20	\$36	\$56	16

Payment for Uninsured



Medical cost and bankruptcy



Recent analysis of availability

- amount of coverage in a community related to the labor market
- this confounds the overall, long term finding that smaller firms are less likely to offer

Practical implication

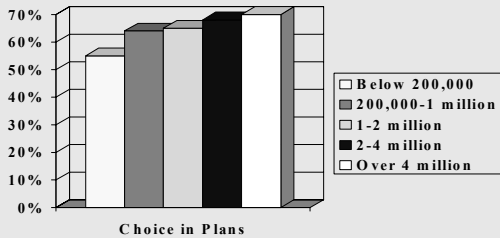
- if companies can hire from a pool that does not expect coverage, they won't offer
- communities with large Hispanic immigrant labor pools tend not to offer coverage

My decisions, cont.



- If uninsured
 - is this problem worth dipping into my pocket?
 - how much care will I buy for any one episode?
- If insured
 - where can I go/how much can I get
 - will I supplement

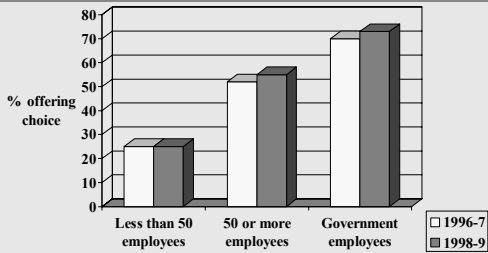
People do have choice of insurance coverage*



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*HSC Community Tracking Study
Household Survey, 1998-1999
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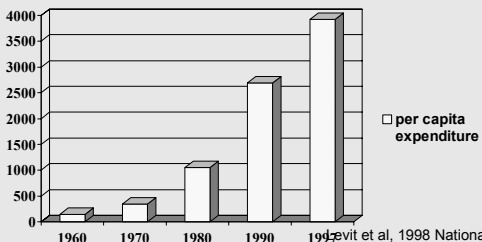
But availability varies*



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*HSC Community Tracking Study
Household Survey, 1998-1999
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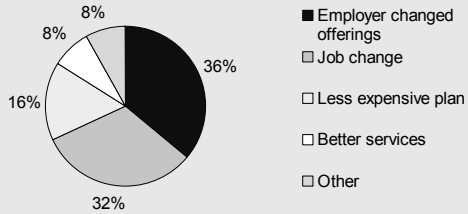
and costs are going up



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Levit et al, 1998 National
Health Expenditures in 1997
Health Affairs 17: (99-110)
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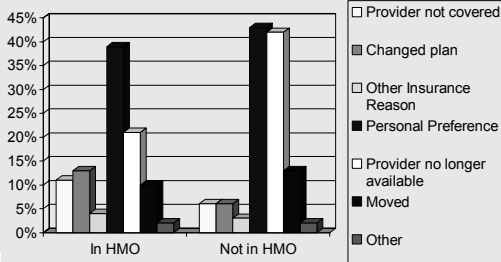
Reasons for changing health plans



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Community Tracking Study
Household Survey, 1996-7
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HMO status makes a difference:



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But we're the good guys! Coalition for Affordable Quality Healthcare

- **24 largest plans**
- **Assert that they:**
 - **work with CDC on antibiotic resistance**
 - **simplify paperwork for credentialing**
 - **improve access and service**
 - **direct access to OB/GYN and pediatrics**
 - **assured ER coverage**
 - **external review of claims**

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Regressive vs. progressive payments

- if cost is a flat fee, it will disproportionately hit the poor
 - This is acceptable for consumer goods with no public benefit--if people really want it, they'll find the \$\$ or earn more
 - It ignores the "public good" aspect of health

Income transfer

- if cost is sliding fee of some kind, income transfer is involved
- if the ratio remains the same across income levels, it is proportional
- if the ratio of fee to income increases at higher level, it is progressive

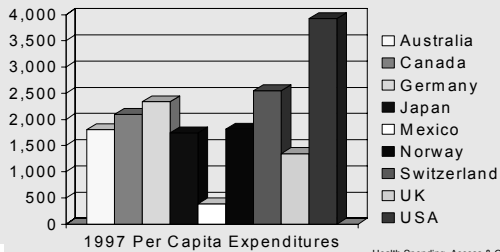
Controlling Costs:

- reducing overall investment or limiting % of GDP
- limiting growth
- limiting expenditures in some one sector

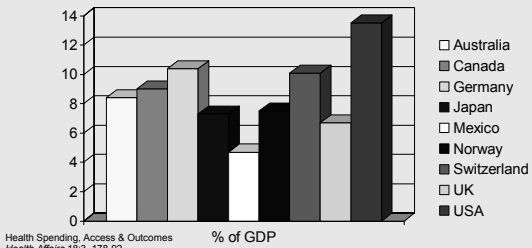
All cost control hurts someone. . .

- limiting employer costs → increase co-payments
- limiting hospitalization → layoff nurses & other employees (
- limiting profits → reduced growth in retirement funds

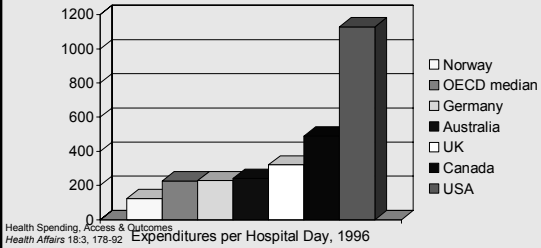
Why we are concerned



Another perspective



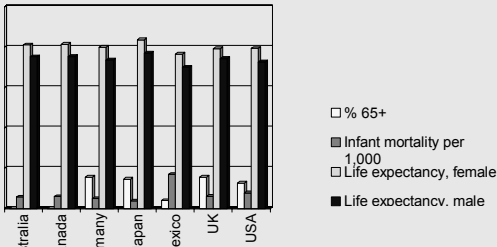
And yet another. . .



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And what we get. . .



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US Expenditures

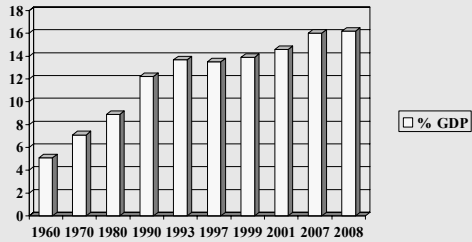
Health Affairs

Source of funds	1980	1990	1998	2001 (est)
National Expenditure	247.3	699.4	1,088.2	1,403.6
Private \$	142.5	416.2	586.0	774.9
Private Insurance	69.8	239.6	346.7	474.2
Out of pocket	60.3	145.0	189.1	236.5
Public funds	104.8	283.2	502.2	628.7
Medicare	37.5	111.5	211.3	257.4
Medicaid	14.5	42.7	95.0	122.7
Other Fed'l	19.9	41.0	56.8	67.6
State and local	32.8	88.0	139.2	181.0

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Health Expenditure as % of GDP



US trends

Health Affairs

Category	1960	1970	1980	1990	1998
National Total (Billions)	26.9	73.2	247.3	699.4	1,149.1
Services and Supplies	25.2	67.9	235.6	674.8	1,113.7
Hospital care	9.3	28.0	102.7	256.4	382.8
Home Health Care (free-standing)	0.1	0.2	2.4	13.1	29.3
Prescription drugs	2.7	5.5	12.0	37.7	90.6
Nursing home care (free-standing)	0.8	4.2	17.6	50.9	87.8
Administration	1.2	2.7	11.9	40.5	57.7
Gov't PH Activities	0.4	1.3	6.7	19.6	36.6

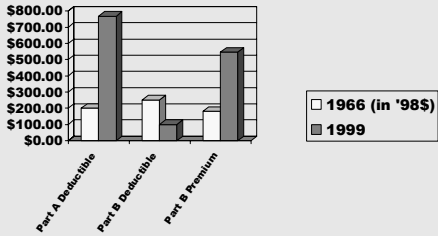


Cost of insurance management

- **Employer group plans: 10-15%**
- **Individual private plans: 30-50%**
- **Medicare: <2%**



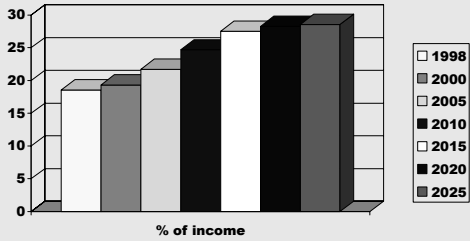
Payments by Medicare Beneficiaries



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Commonwealth Fund, from HCFA
& US House of Rep. *Green Book*, 2000
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Out-of-pocket spending by elderly

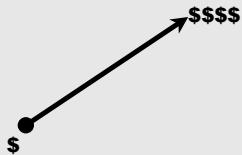


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M.Moon, *Growth in Medicare Spending*,
Commonwealth Fund, May, 1999
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Prescription drugs

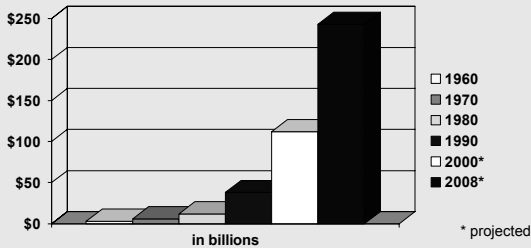
- The industry expects 15% revenue growth 2000-2005
- Growth due to
 - More prescriptions
 - Mix of prescriptions
 - Price
- HMO prescriptions/member/year
 - Non-Medicare: 5.8/Medicare: 17.4



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National spending for prescription drugs

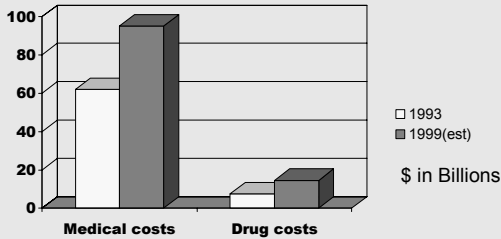


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KFF Medicare Program, March 2000

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Blues cost increases



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Drug spending growth

top 10 drugs/growth		top 10 launches	
○ Prilosec	34	○ Viagra	57.8*
○ Prozac	20	○ Arthrotec	15
○ Zocor	55	○ Singulair	11.5
○ Claritin	40	○ Plavix	9.8
○ Pavachol	15	○ Meridia	9.0
○ Zyrtec	68	○ Evista	8.3
○ Allegra		○ Allegra-D	7.5
○ Zyban	18	○ Trovan	7.5
○ Evista	>1000	○ Zomig	6.2
○ Propecia	>1000	○ Propecia	6.1

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*\$million/month
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Direct to Consumer ads

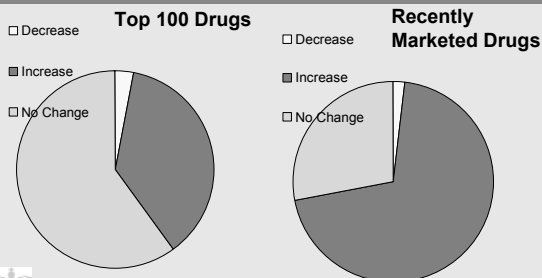
- **Antihistamines (22%/ \$287 M)**
- **Cholesterol Reducers (9%/ \$113M)**
- **Hair loss (7%/ \$92M)**
- **Inhaled steroids (6%/\$84M)**
- **Smoking Cessation (6%/\$81M)**
- **All Others (50%/ \$644M)**

And more subtle ads: NY Times, April 18, 2000

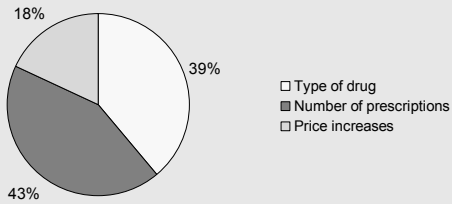
- **“An Open Letter to Healthcare Providers Nationwide” from 33 MDs, 2 nurses and 1 pharmacist**
- **Must not be content with elevated systolic or diastolic blood pressure**
- **No mention of diet or exercise**
- **This message supported by Bristol-Meyers-Squibb Co. as part of its commitment to extending and enhancing the lives of patients**

Drug price increases

University of Maryland
Center on Drugs & Public Policy



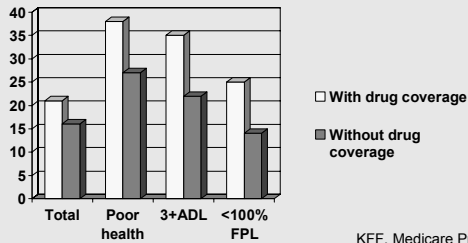
Source of increase in drug costs



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Kaiser Family Foundation
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Number of Rx/year, Medicare, 1996

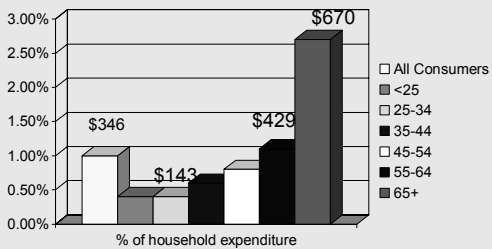


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KFF, Medicare Program
March 2000

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Consumer Expenditures



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Focus on Unit Cost

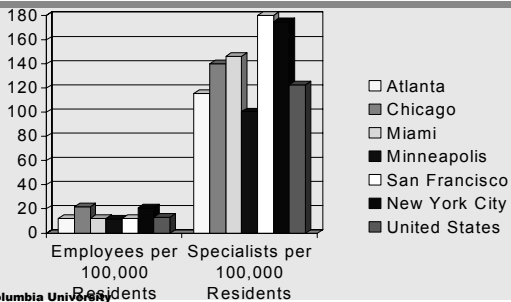
- **Cost to producer**
 - materials x labor x profit
- **Control the cost per unit**
 - make it more cheaply
 - reduce margin
- **Cost to purchaser**
 - price x volume
- **Control your costs**
 - buy less or another product

The Roemer dilemma

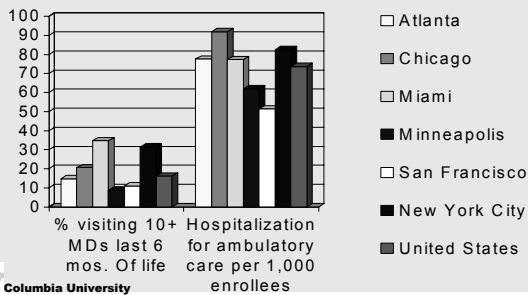
- **'A built bed is a filled bed'**
- **Lower occupancy does not automatically save money**



Why costs are high: 1996 hospital employees



Why costs are high: Medicare patients, 1995-6



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How we have dealt with cost in health

- **Shift from community rating to experience rating**
- **Controlling the number of units**
 - competition or planning
- **Changing to different units**
 - many raise rather than lower costs

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Controlling the price per unit

- **competition**
 - drugs/the role of patents
 - consumer role different than in TV market
- **certificate of need**
- **wage or price controls & fee regulation**

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Change in payments

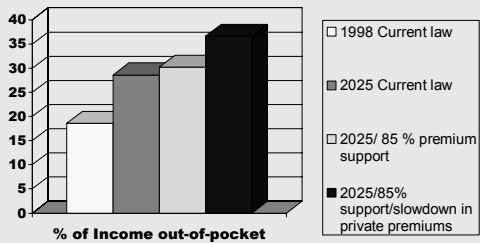
- **Prospective payment shifts perspective as components go from being . .**
- **revenue generating to . .**
- **cost generating**

A coming change in coverage. . .

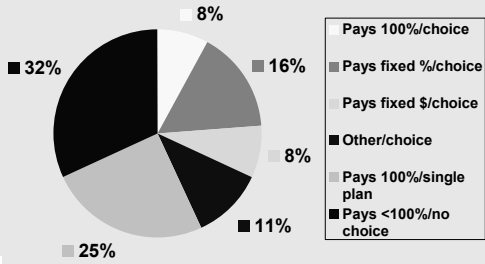
- **From defined benefits to**
- **defined contributions**



Impact of change to premium support approach



Contribution policies



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RWJF Employer Health Insurance Survey
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So how are we doing in the U.S.?

- **Cost?**
 - % of GDP, per capita spending
- **Access?**
 - % insured vs. uninsured
 - Availability of primary care services
- **Quality?**
 - Satisfaction with care?
 - Infant mortality?
 - Life span?

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