Real Ways to Drive Down Healthcare Costs

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Free Market Forum

Hillsdale College

October 1, 2010

Outline

- The challenges: high costs, uninsured, deficits
- How public and private insurance contribute to this state of affairs
- Wrong responses: the PPACA (Obamacare) and the demonization and strangulation of private health insurance markets
- A broad, market oriented agenda

  Rational taxation of private health insurance so that consumers willingly have "skin in the game"

  Transforming Medicare so that seniors do, too

  Promoting competitive health insurance markets to make it work as well as possible

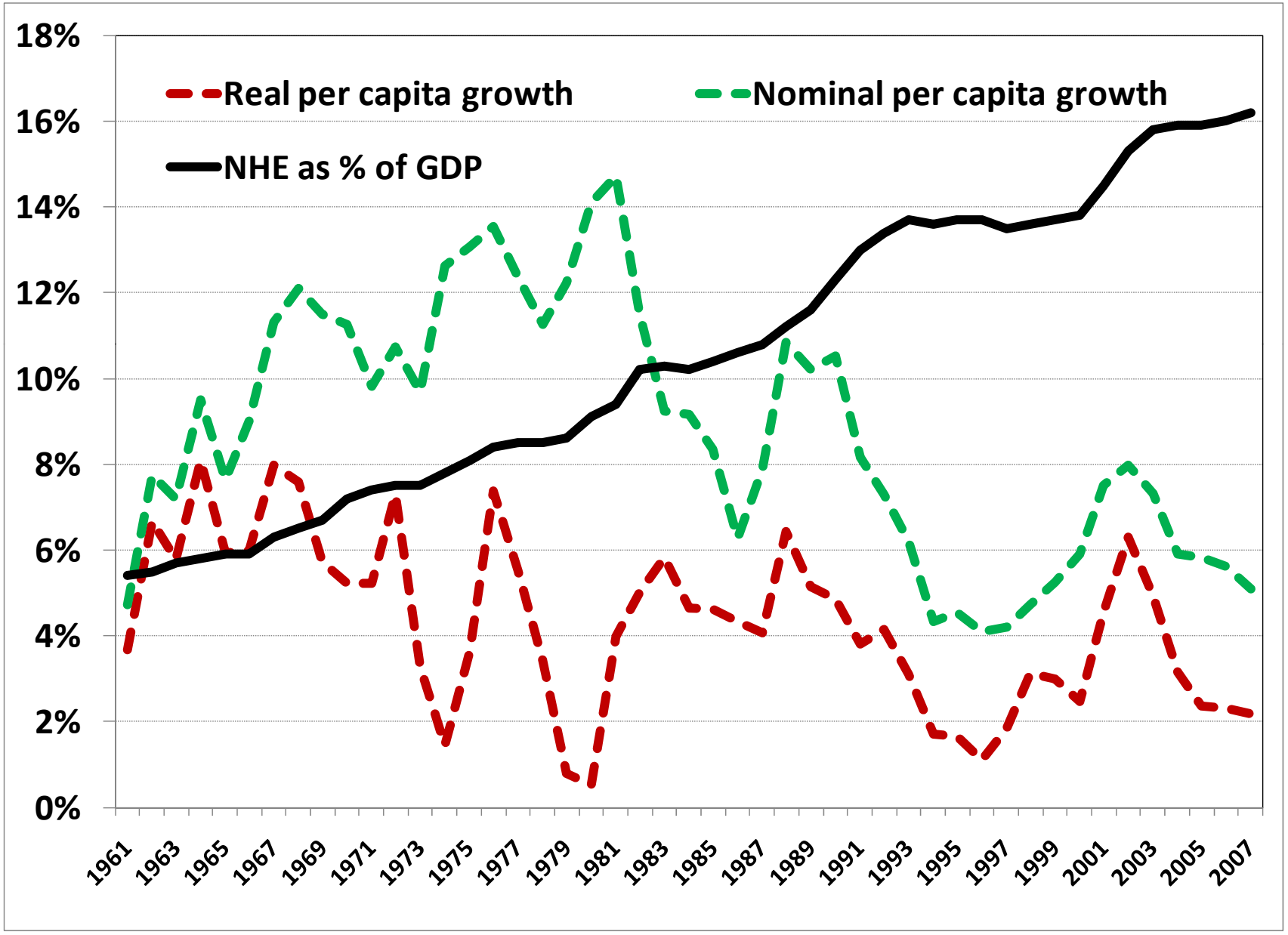
The challenges

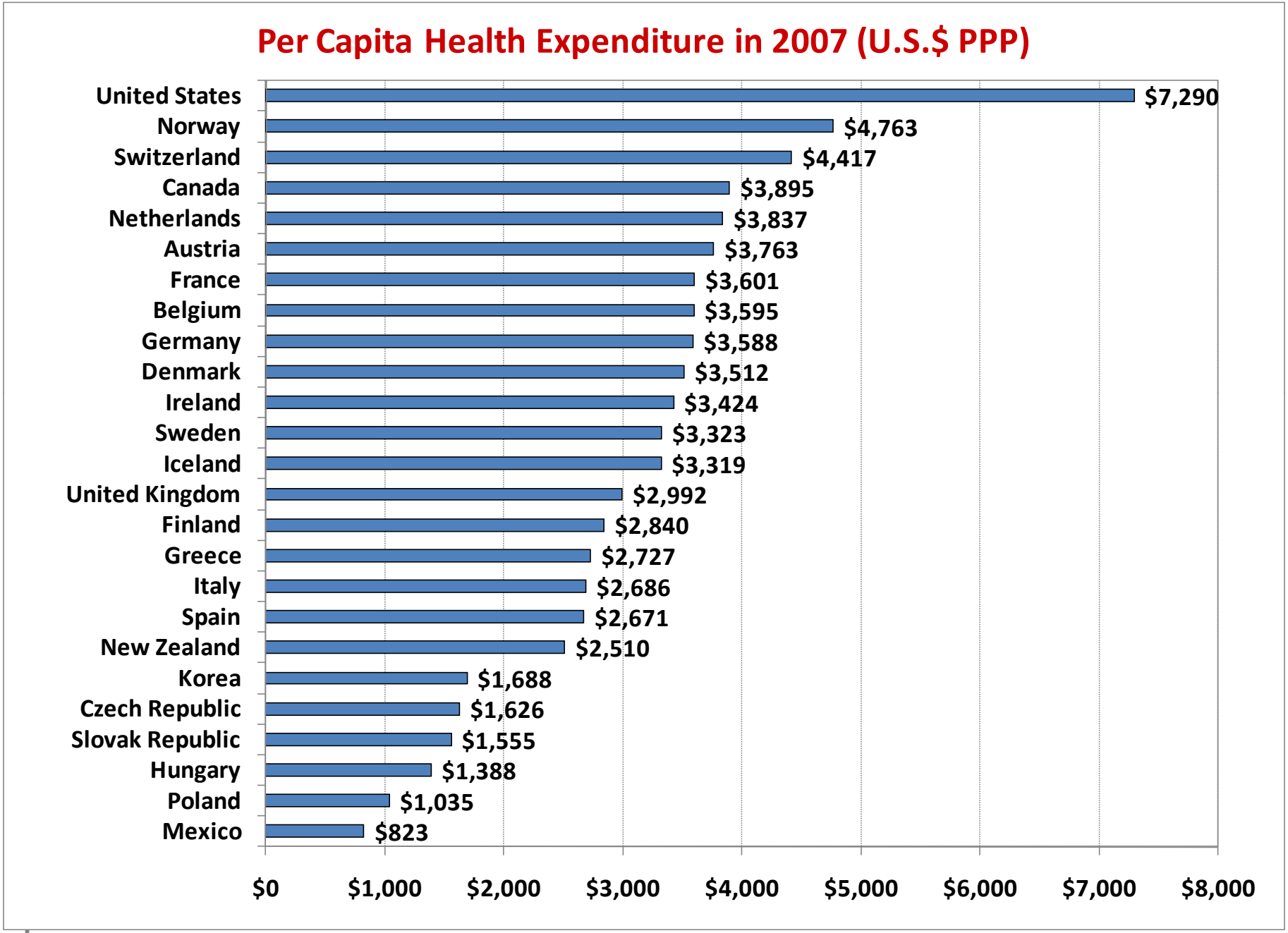
- High healthcare costs
- Rapid growth in costs
- Large numbers of uninsured
- Unsustainable federal healthcare spending
- Change is inevitable – what do a majority of people want?

  More top-down controls with generous “coverage”?

  More choices with more “skin in the game”?

U.S. health expenditures




Per Capita Health Expenditure in 2007 (U.S.$ PPP)
United States $7,290
Norway $4,763
Switzerland $4,417
Canada $3,895
Netherlands $3,837
Austria $3,763
France $3,601
Belgium $3,595
Germany $3,588
Denmark $3,512
Ireland $3,424
Sweden $3,323
Iceland $3,319
United Kingdom $2,992
Finland $2,840
Greece $2,727
Italy $2,686
Spain $2,671
New Zealand $2,510
Korea $1,688
Czech Republic $1,626
Slovak Republic $1,555
Hungary $1,388
Poland $1,035
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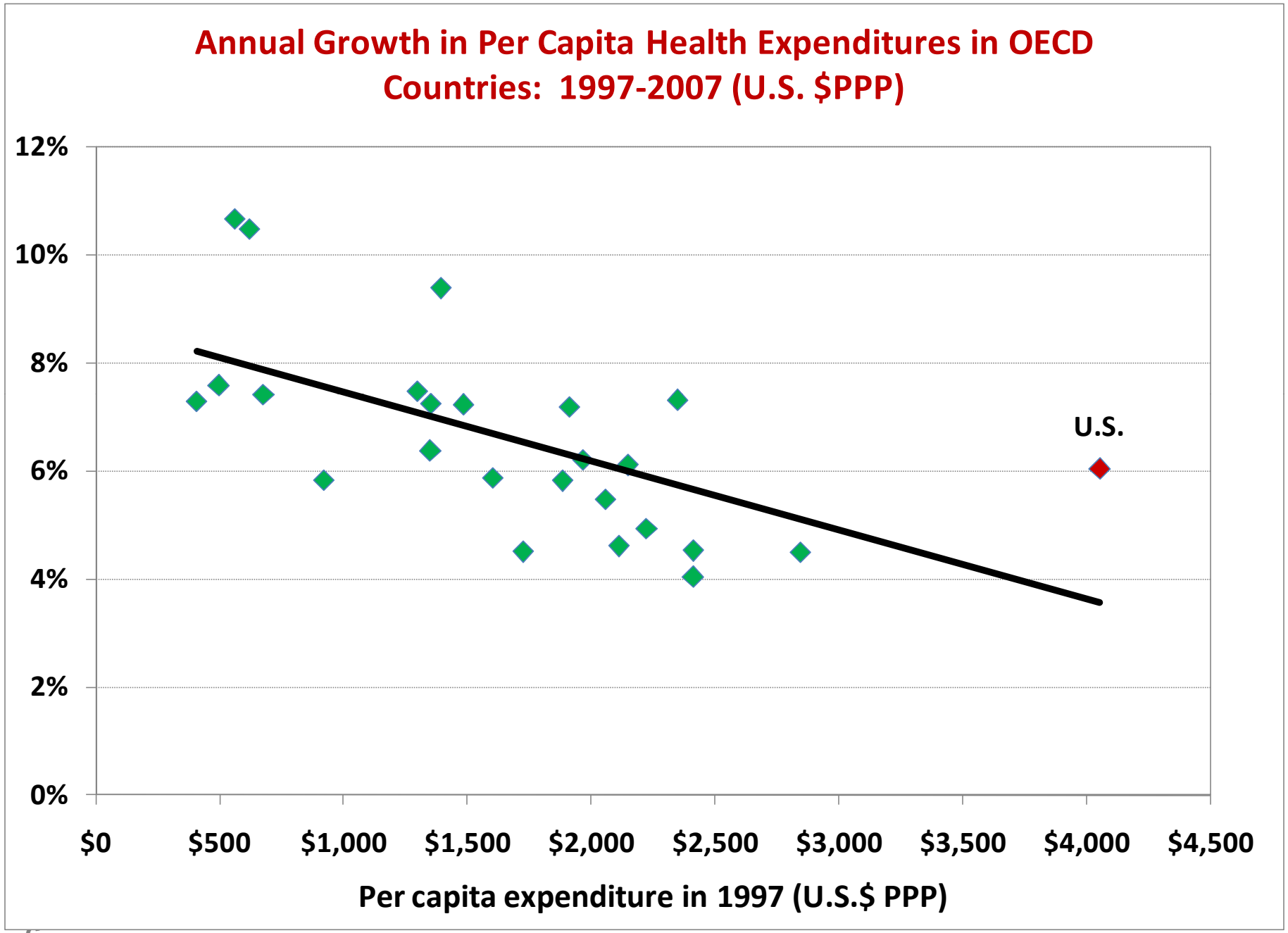
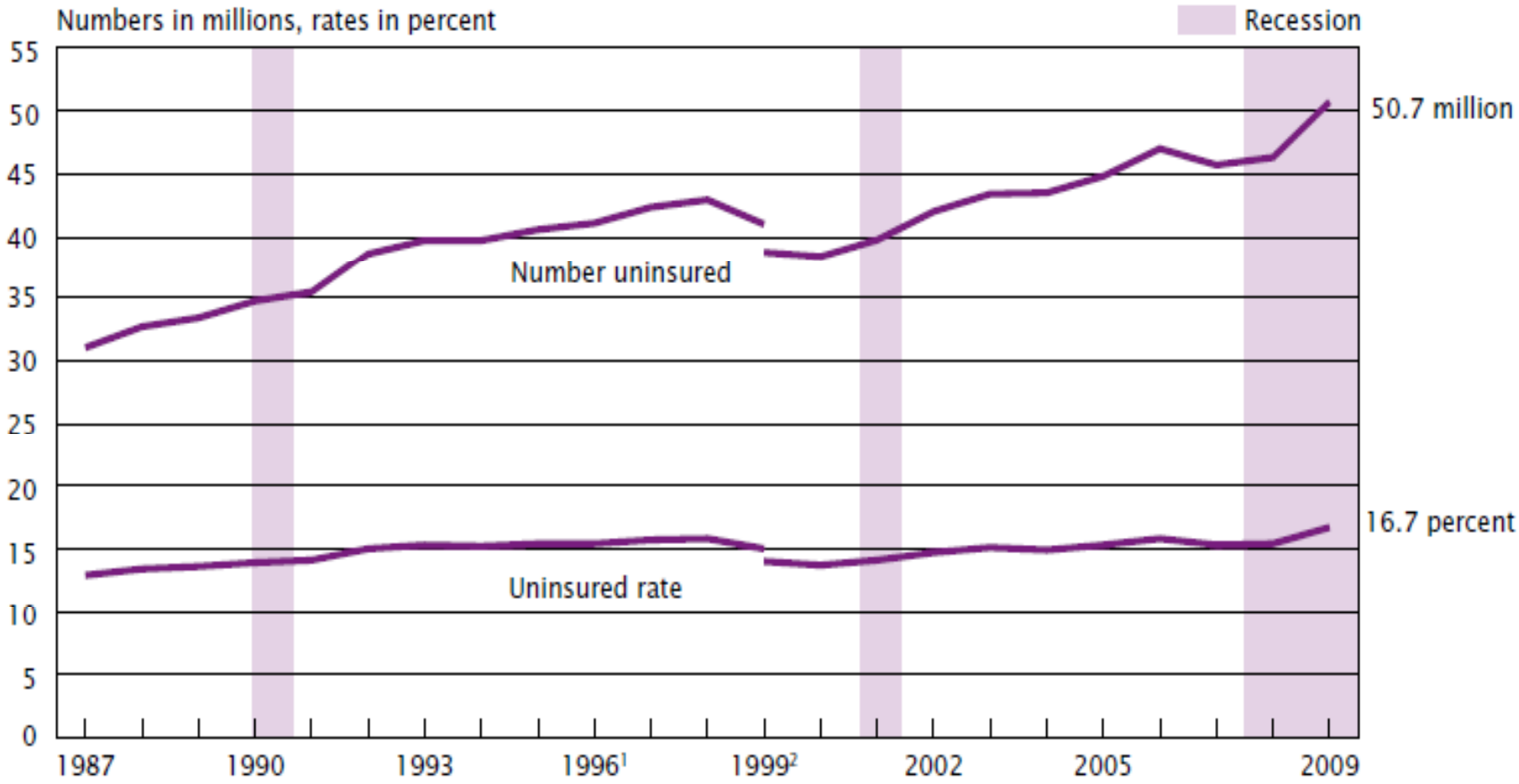

Annual Growth in Per Capita Health Expenditures in OECD Countries: 1997-2007 (U.S. $PPP)
12%
10%
8%
6%
4%
2%
0%
U.S.
$0
$500
$1,000
$1,500
$2,000
$2,500
$3,000
$3,500
$4,000
$4,500
Per capita expenditure in 1997 (U.S.$ PPP)

We spend a lot – insurance costs a lot – and . . .

Figure 7.
Number Uninsured and Uninsured Rate: 1987 to 2009



Who are these 50 million?

- They generally have access to acute care (emergency) without regard to ability to pay (many are billed)
- We don’t know how much health and longevity is affected
- Characteristics (approximate)

  10 million non-citizens (46% rate, at least half unauthorized)

  15 million or more eligible for free Medicaid coverage

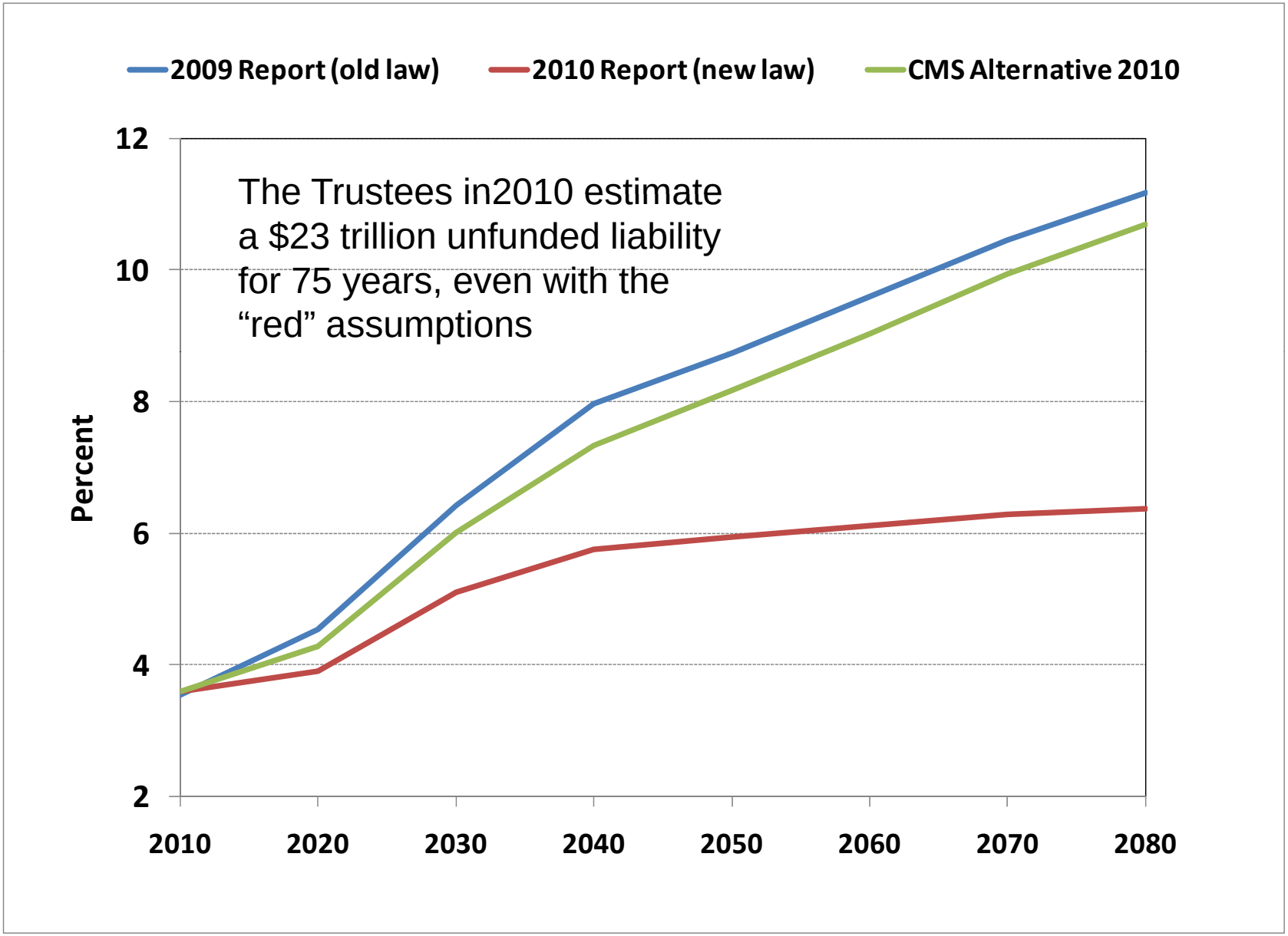
  10 million or more eligible for work-related coverage

  11 million in households with incomes > $75,000

  20 million in households with incomes > $50,000

  21 million aged 18-34

Projected Medicare spending as percent of GDP



How public and private insurance contribute

- Too much insurance for many of those who have it

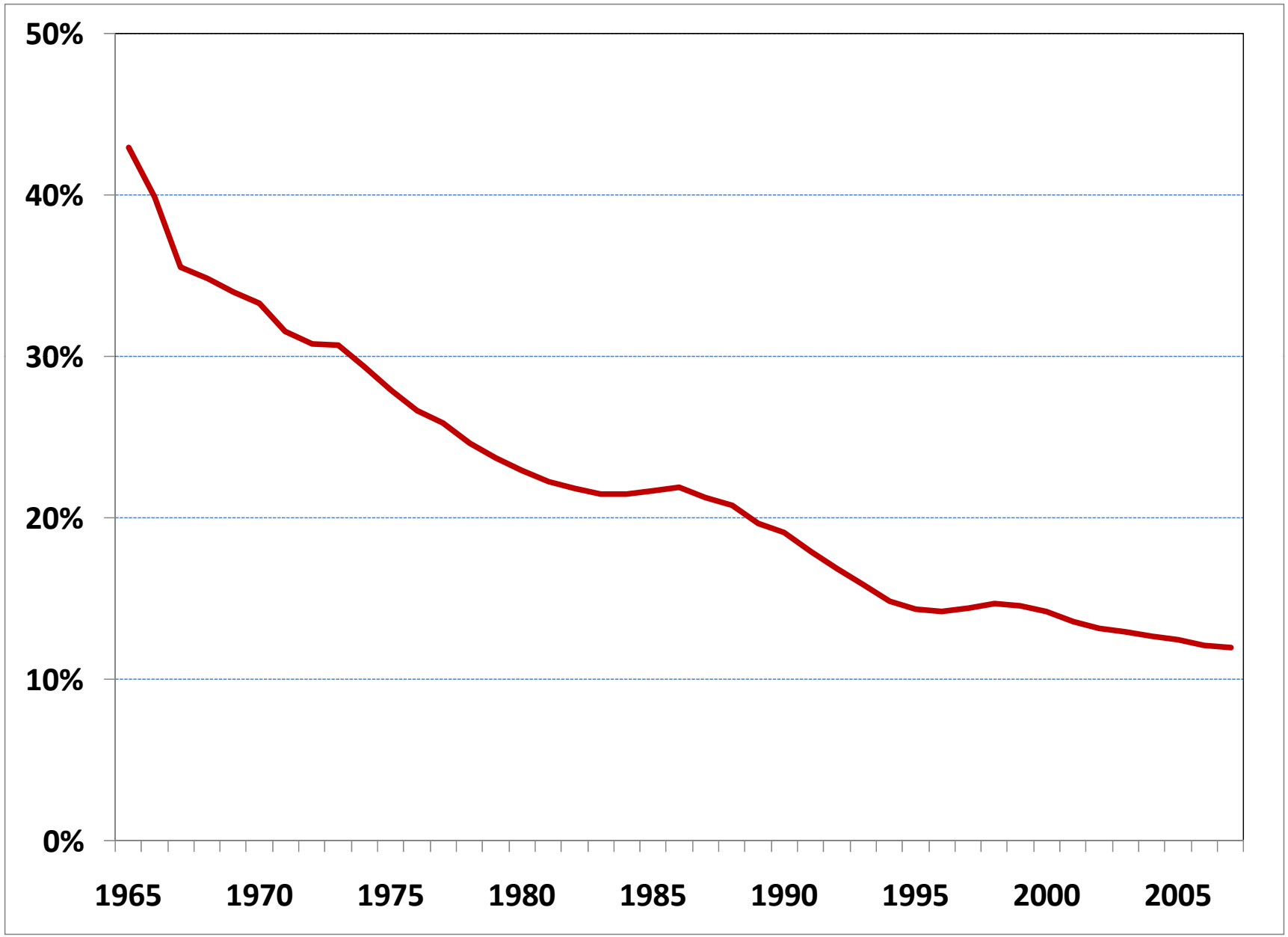
  Too much utilization of expensive, low-valued care

  Inadequate incentives for strong managed care / delivery system reforms

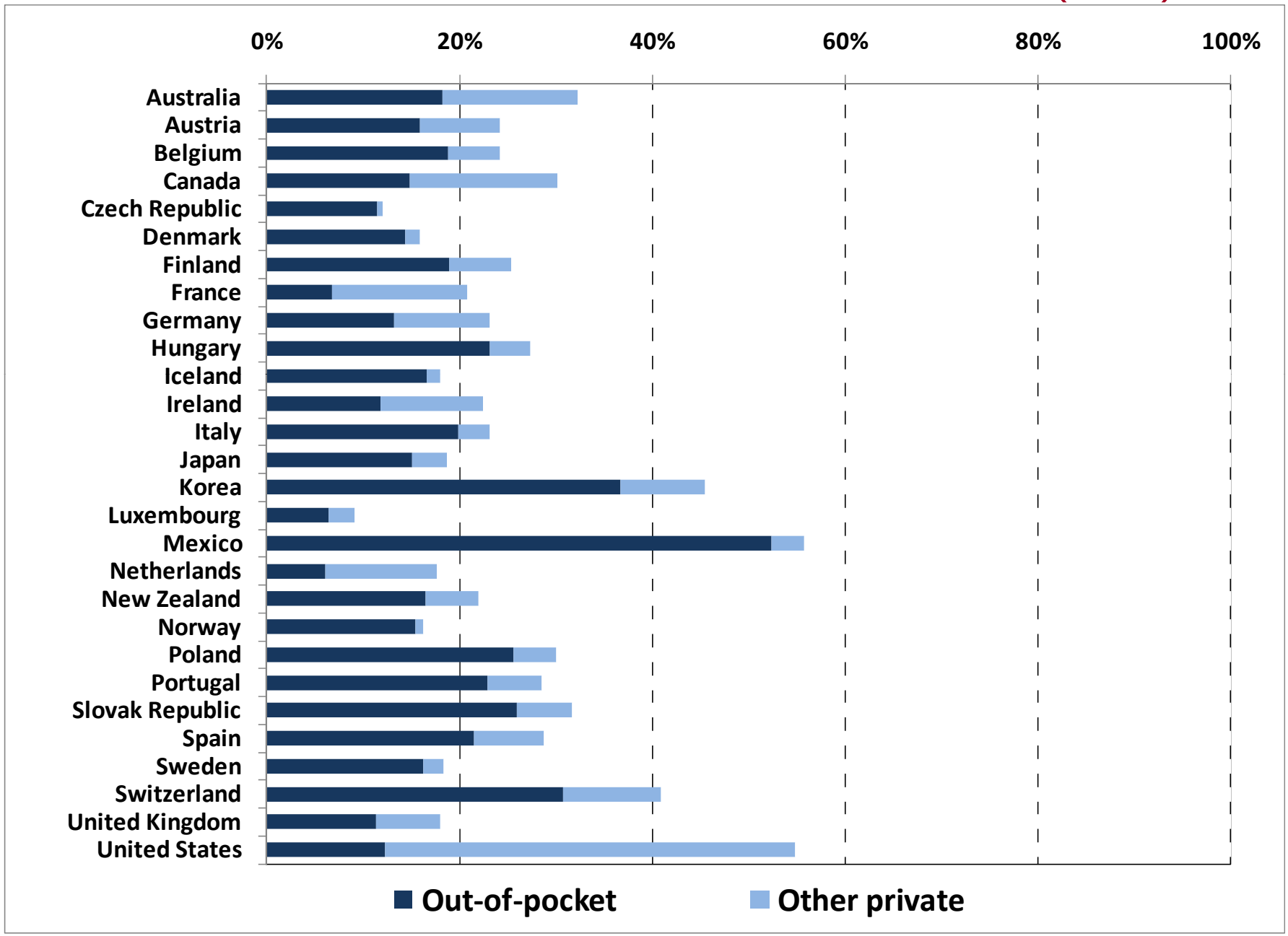
- The big three subsidies

  1. *Tax subsidy to employer-sponsored health insurance*
  2. *Inter-generational subsidy to Medicare (and, indirectly, to supplemental coverage)*
  3. *Intra-generational subsidy to Medicaid*

Out-of-Pocket Expenditures as Percent of Total, 1965-2007



Out-of-Pocket and Other Private as Percent of Total (2006)



The PPACA will make matters worse

- More utilization of low-valued care

  Permitted benefit tiers and coverage mandates require broader coverage than much currently purchased coverage

  Reduced cost sharing for people with low incomes

  Excise tax on high cost health plans: too little, too late, too opaque

- Adverse selection and further cost pressure
- Destabilization of individual and small group health insurance markets

  Mandates, red tape, and threats

  Price controls (minimum medical loss ratios and more)

Health insurance premiums with the new regime

Study/analysis	Projection
PWC (AHIP)	Premiums 47% higher by 2016 – does not consider premium subsidies
Oliver Wyman (BCBS)	Avg. medical cost 50% higher after 5 years
CBO	Individual premiums up 10-13% by 2016 , even with significant savings in administrative costs, shift towards younger buyers. And ignoring adverse selection

PPACA's projected effects on Medicare

- Projected Medicare reimbursement cuts and budget savings may not be achievable (CMS Office of the Actuary Chief Richard Foster)
- More people will enroll in traditional Medicare as Medicare Advantage is squeezed
- Restrictions on types of care and will eventually follow
- Mechanisms:

  Accountable Care Organizations

  Patient Centered Outcomes Research Center

  Independent Payment Advisory Board

Demonizing private health insurers

- You have to create a devil (private health insurers) to justify a savior (a government insurer – the “public option”)
- Universal coverage with single payer system is the goal
- Distortions, misinformation, and falsehoods are the means, whether intentional or ignorant

  Pre-existing condition exclusions

  Cancelling coverage for those who get sick

  Profits and excessive administrative expenses as the cause of high premiums
- The stage is set for closing the deal: choke off private supply with a public insurer to the rescue

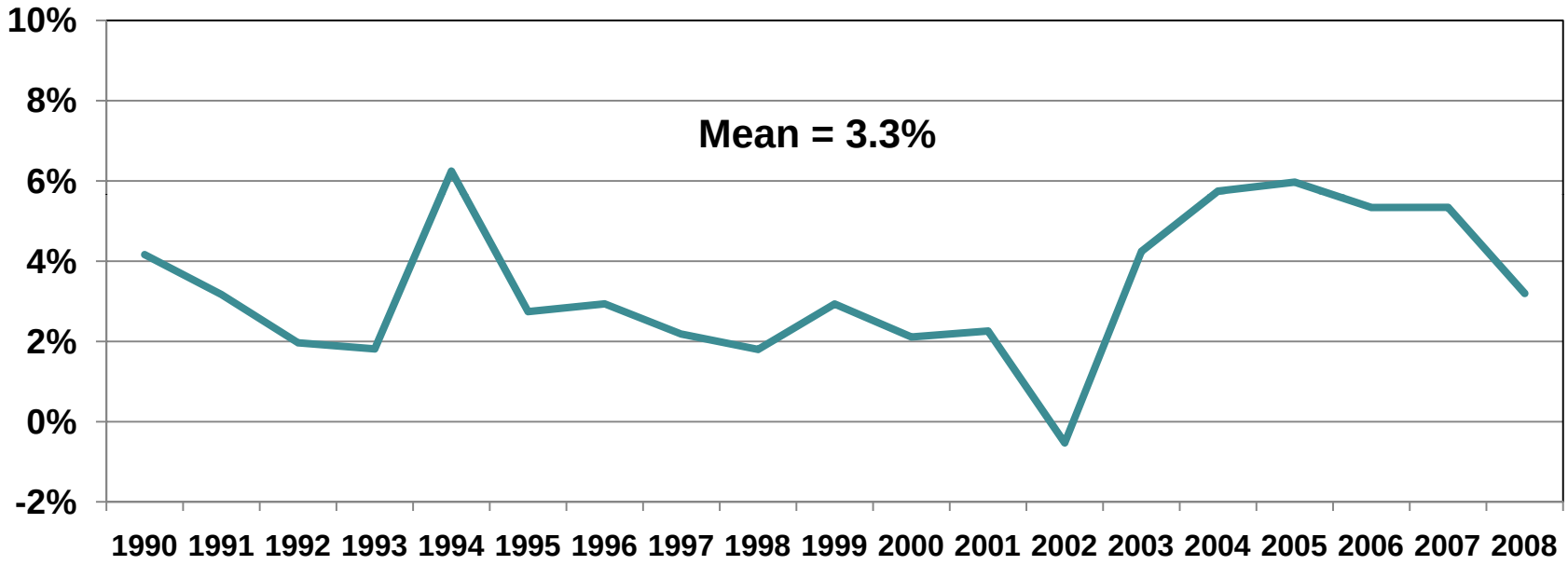
How big are these profits? (2009 ranking not yet out)

Fortune industry rankings: net income as % of revenues

	2005	2006	2007	2008
Net income margin	7.1%	5.8%	6.2%	2.2%
Industry rank	21	33	28	35

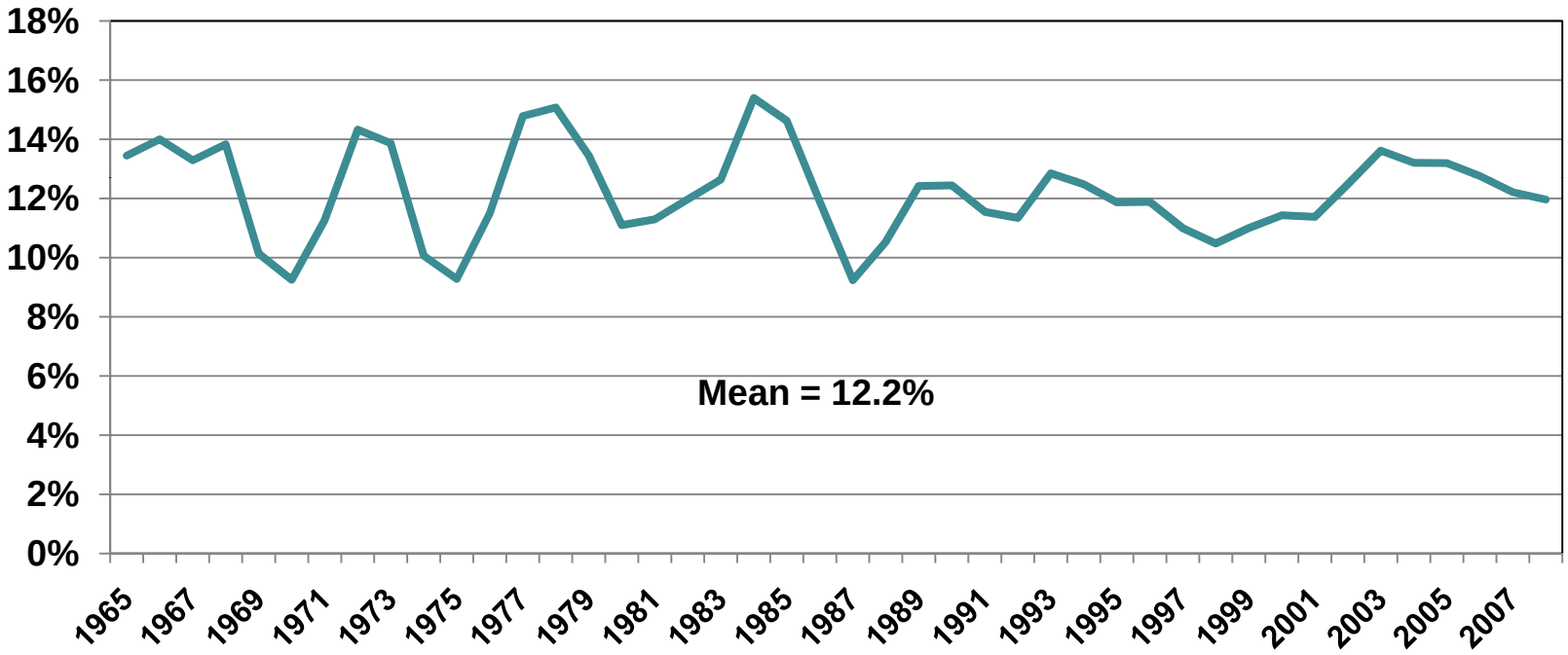
Fortune shows rankings for approximately the top 50 industries out of about 75 total industries.

Net income as percent of revenues for publicly-traded health insurers



Compustat, SIC 6324, hospital and medical service plans;
Harrington calculations

Overall margin for administrative, tax, and profit as % of premiums, including self-ins. equivalents, entire U.S.



http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp

The broad, market-oriented agenda

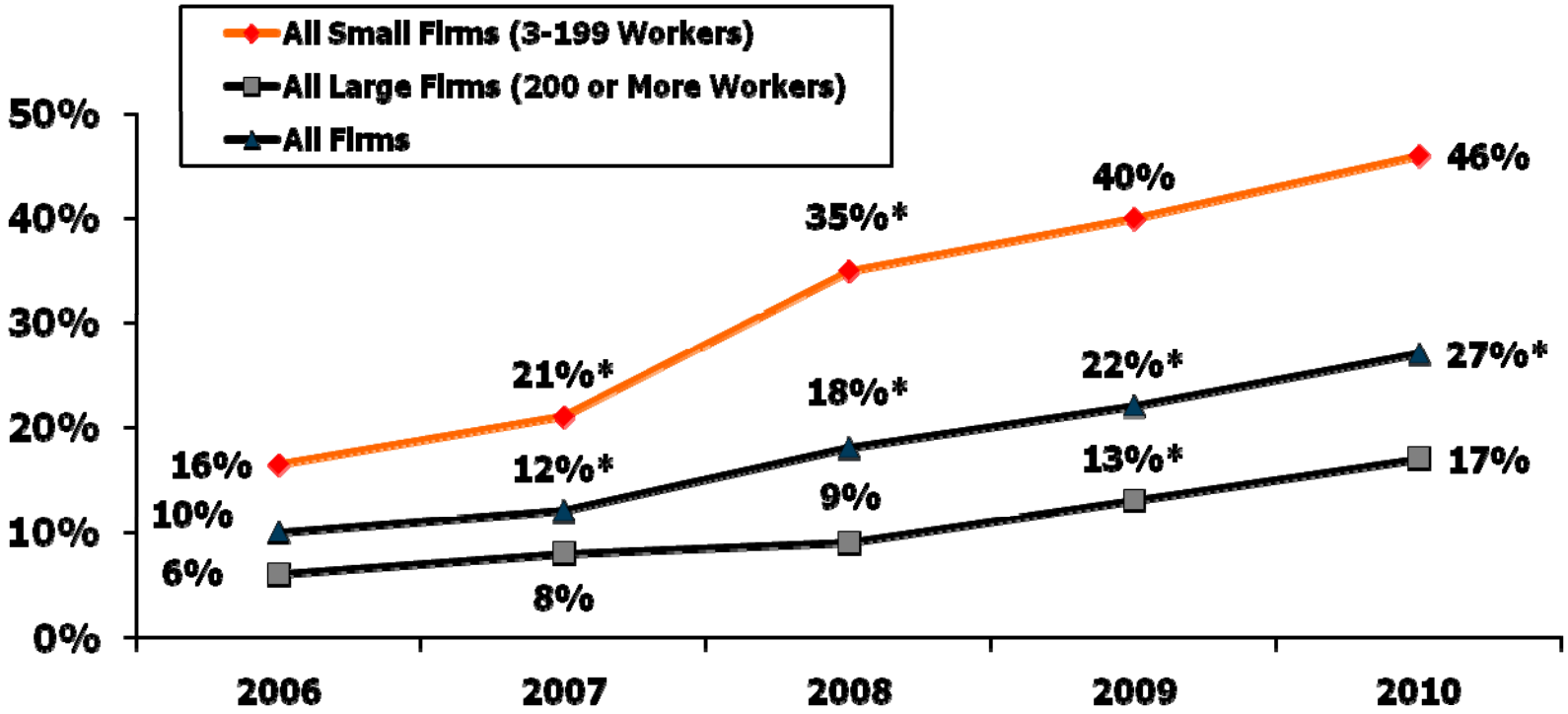
- Overall

  *Encourage greater consumer sovereignty and responsibility for medical care so that **those who are able** devote more attention to the cost of medical care as well as the benefits*

- Three broad steps:

  1. *Don't discourage greater cost-sharing in private health insurance that is taking place in response to cost growth.*
  2. *Reduce the tax subsidy to generous, employer-sponsored health insurance.*
  3. *Transform Medicare to promote choice and responsibility.*

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, By Firm Size, 2006-2010



*Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Because we do not collect information on the attributes of conventional plans, to be conservative, we assumed that workers in conventional plans do not have a deductible of $1,000 or more. Because of the low enrollment in conventional plans, the impact of this assumption is minimal. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2010.

Figure 1. Growth of HSA/HDHP Enrollment from March 2005 to January 2010

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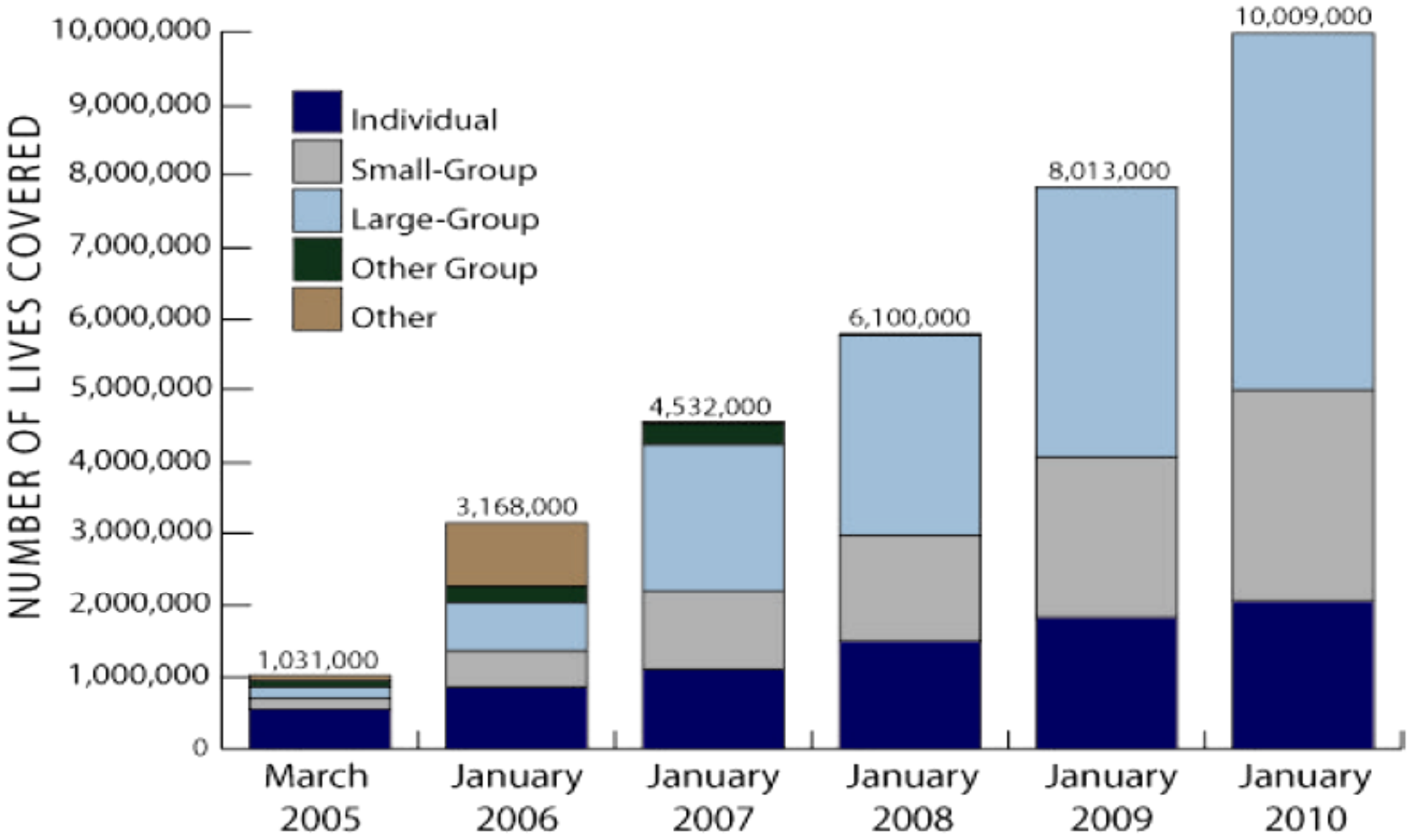
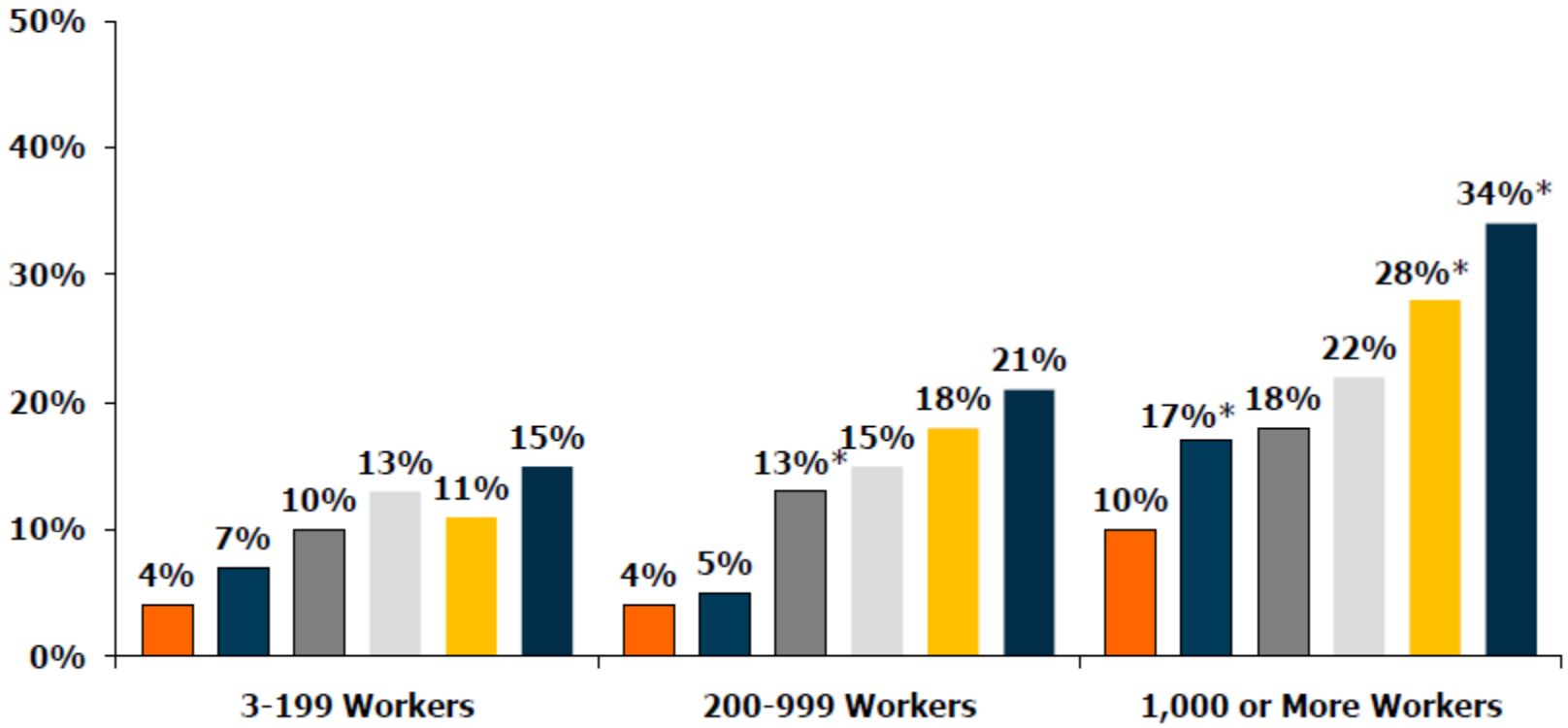


Exhibit 11: Among Firms Offering Health Benefits, Percentage That Offer an HDHP/SO, by Firm Size, 2005-2010



* Estimate is statistically different from estimate for previous year shown (p<.05).

Note: The 2010 estimate includes 0.3% of all firms offering health benefits that offer both an HDHP/HRA and an HSA-qualified HDHP. The comparable percentages for 2005, 2006, 2007, 2008 and 2009 are 0.3%, 0.4%, 0.2%, 0.3% and 0.1%, respectively.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2010.

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We need to change the tax treatment of health insurance

- Reduce the tax incentive for workers, especially the higher paid, to be compensated with generous health insurance coverage of moderate expenditures
  - *Will spur the growth of high-deductible and related plans*
  - *Will encourage more people to choose plans with strong managed care*
  - *Will promote greater competition among providers*
  - *Will stimulate an avalanche of information to guide choice*
- Equalize the tax treatment of individual and employer-sponsored coverage to improve portability and choice
- There exist a variety of means to achieve these goals, including replacing the exclusion with refundable tax credits

We need to transform Medicare

- Improve incentives for enrollees to consider costs as well as benefits by expanding choice
- Broad approaches (with suitable phase-in period)

  Replace traditional Medicare with a menu of options with financial incentives to consider lower-cost options

  Replace traditional Medicare with a premium support (defined contribution plan)
- The choice for post-1960 generations must be made clear:

  Subsidized coverage with greater incentives to consider costs, or

  Much greater government control on their care

Other steps that will help us and our children

- Allow insurers to price risk with sensible safety nets for high risk buyers that don't encourage people to wait until they need care to seek coverage
- Promote competitive health insurance markets

  Don't strangle private insurance with mandates and price controls

  Consider methods of promoting a national market for health insurance
- Encourage medical liability reform

Conclusion – a fork in the road

- Generous “nominal” insurance with top-down restrictions on choice

OR

- “Real” insurance, where we and our doctors have to consider the costs and make tough decisions given with insurance protection against truly high costs
- The 2010 and 2012 elections will determine the path taken