U.S. HEALTH CARE FINANCING

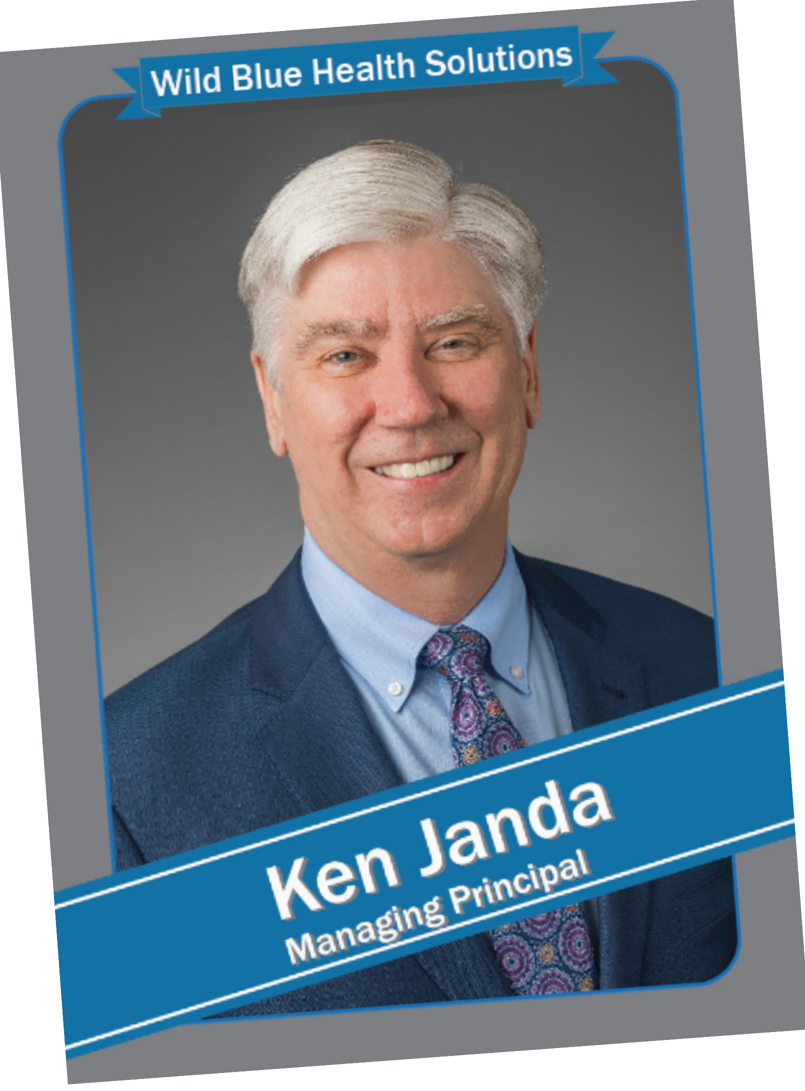
Ten Key Concepts for an Informed Health Care Conversation

For the Lone Star Family Health Center Residency Program

Slides at Wildbluehealthsolutions.com

Ken Janda - May, 2020

About Ken



- Principal, Wild Blue Health Solutions, a strategic consultancy taking on challenges in health care.
- Adjunct professor at University of Houston College of Medicine and Jones Business School, Rice University
- Former CEO (11 years) of non-profit health plan Community Health Choice, focused on low-income populations
- Over 25 years experience with national health insurers Prudential, Aetna and Humana
- Health policy wonk (Rice University, Texas Medical Center, Center for Public Policy Priorities and more)
- B.A. Rice University; J.D. U of H Law Center
- Native Texan…small town roots and values
- Husband, father of two and grandfather of four
- Community board volunteer (San Jose Clinic, Christ Clinic, Katy Education Foundation and others)
- Huge baseball fan. Still loves the Astros.
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Ten Key Concepts

1. U.S. spends over $3 trillion annually on health care: Where does it go? Who pays?
2. US compares unfavorably in spending and “value” to other OECD countries
3. Health Care Triple Aim: A way to define value
4. Health ≠ Health Care ≠ Health Insurance
5. Most health care is financed by insurance
6. Health insurance in the U.S. complicated and contributes to poor value
7. The way the US pays for the “uninsured” is inefficient and leads to poor outcomes
8. Cost = Price x Volume (+ admin costs)
9. Pay for Value not Volume
10. A Health Care Policy Home Run: The Four Bases

1. U.S. Spends $3.5 trillion on Health Care:

Where does it go?

Includes Noncommercial Research and Structures and Equipment.
Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizen centers, schools, and military field stations), and expenditures for home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, office of the Actuary, National Health Statistics Group

1. U.S. Spends $3.5 trillion on Health Care:

Where does it comes from?

Government Public Health Activities, 3%

Out of Pocket,[2] 10%

Health Insurance, 75%

Other Third Party Payers and Programs[1], 8%

Investment, 5%

Private Health Insurance, 34%

Medicare, 20%

Medicaid (Title XIX) Federal, 10%

VA, DOD, and CHIP (Titles XIX and Title XXI), 4%

Medicaid (Title XIX) State and Local, 6%

Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.

Includes co-payments, deductibles and any amount not covered by health insurance.

Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, office of the Actuary, National Health Statistics Group

1. Who Pays for Our Health Care?

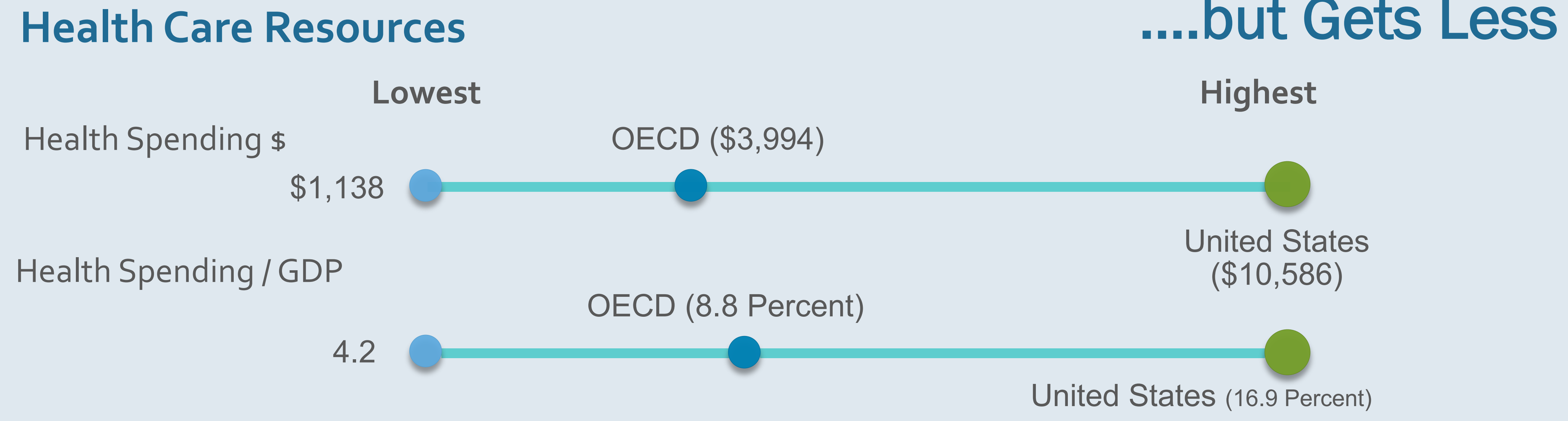
$3.6 trillion annually under current law

Federal Government
$1.28 trillion
Medicare
Medicaid/CHIP
State Governments
$302 billion
Households
$931 billion
Employers
$955 billion

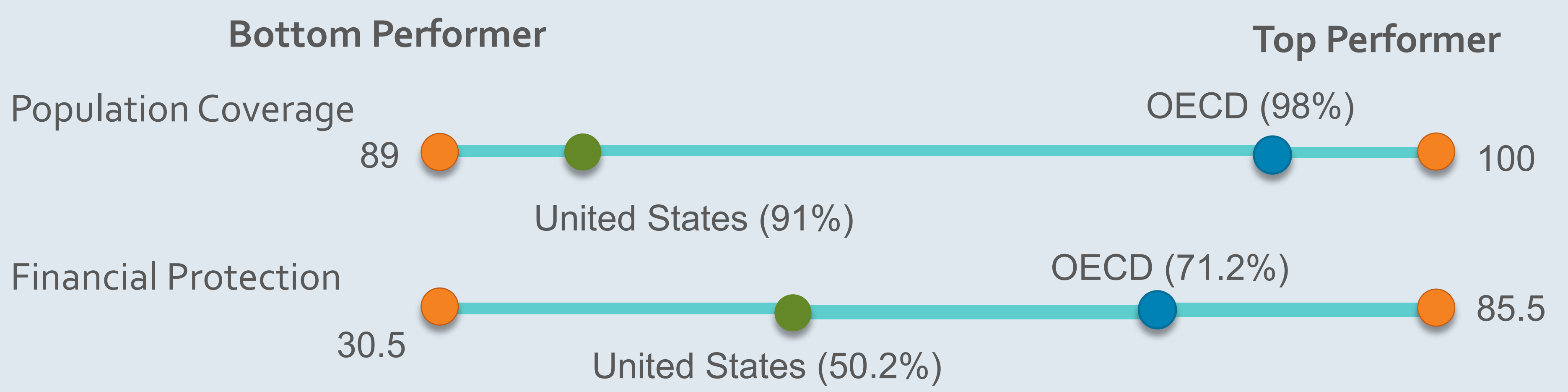
US Health Care Spending in 2020 from NY Times Upshot

2. US Spends More than Other Countries ....but Gets Less

Health Care Resources



Access to care



Source: OECD Health at a Glance 2019, 36 countries

2. US Spends More than Other Countries

....but Gets Less

Health Status

Bottom Performer **Top Performer**

Life Expectancy

OECD (80.7 Years)

74.8 84.2

United States (78.6 Years)

Avoidable Mortality

OECD (208 Per 100 000)

426 125

United States (262 per 100 000)

Chronic disease morbidity

13.1% 3.3%

United States (10.8%) OECD (6.4%)

Self-rated health

OECD (8.7%)

17.0% 2.3%

United States (2.6%)

Source: *OECD Health at a Glance 2019, 36 countries*

2. US Spends More than Other Countries ....but Gets Less

Risk Factors

Bottom Performer

Top Performer

Smoking

27.3

OECD (18.0%)

7.6

United States (10.5%)

Alcohol

OECD (8.9 liter)

12.3

1.4

United States (8.9 liter)

Overweight/Obese

OECD (55.6%)

74.2

25.9

United States (71.0%)

Air pollution

OECD (29.6 per 1000 000)

97.8

13.6

United States (24.1 per 100 000)

2. US Spends More than Other Countries

....but Gets Less

Bottom Performer

Top Performer

Effective Primary Care

428

OECD (225 Per 100 000)

58

United States (268 per 100 000)

Effective Secondary Care

OECD (6.9 per 1000 000)

27.5

2.3

United States (5.0 per 1000 000)

Effective Cancer Care

OECD (84.5%)

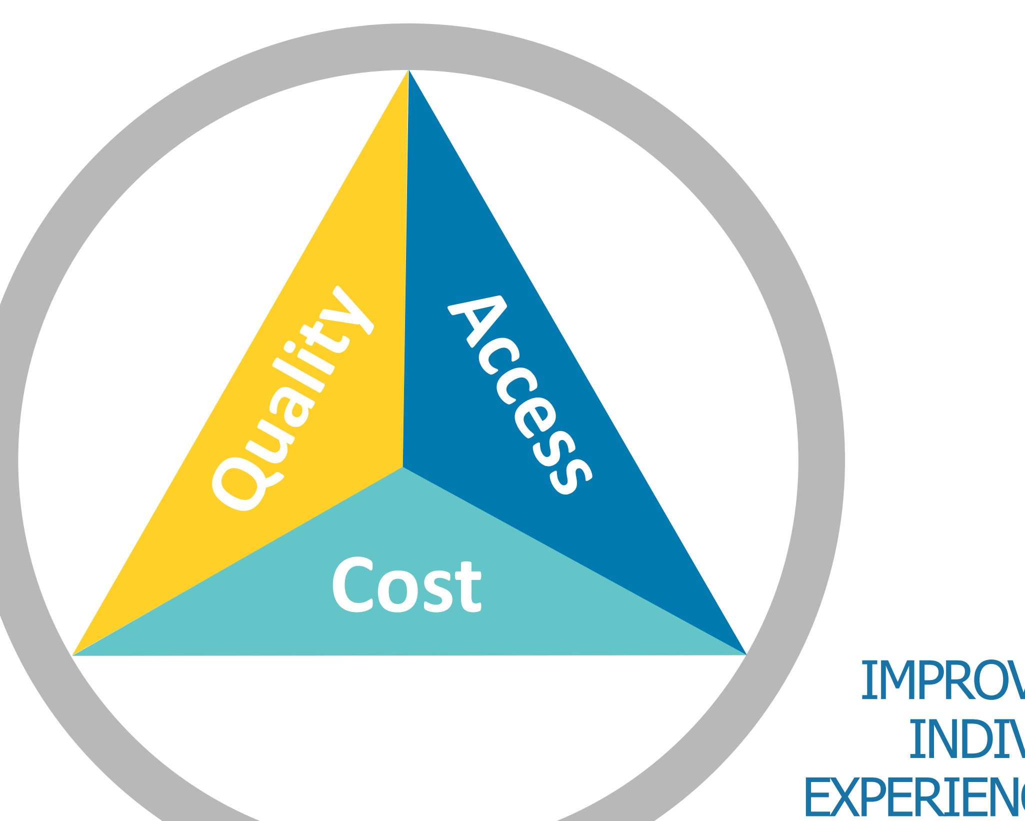
73.5

United States (90.2%)

Source: OECD Health at a Glance 2019, 36 countries

3. The Health Care Triple Aim:
Simultaneous improvements

IMPROVING THE HEALTH OF POPULATIONS



REDUCING PER CAPITA COSTS OF HEALTH CARE FOR POPULATIONS

IMPROVING THE INDIVIDUAL EXPERIENCE OF CARE

http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

4. Health ≠ Health Care ≠ Health Insurance

GOAL

HEALTH
Individual and Population, measured by both length and quality of life

CONTRIBUTORS

HEALTHCARE SERVICES
- Access and Quality
- Doctors
- Hospitals
- Pharmacies
- Ancillary Services

PERSONAL BEHAVIORS
- Tobacco Use
- Diet and Excercise
- Alcohol/Drug use
- Sexual Activity

SOCIOECONOMIC FACTORS
- Education
- Employment
- Housing
- Community Safety
- Transportation
- Food Security

PUBLIC HEALTH
- Water Sanitation
- Environment
- Communicable Diseases
- Immunizations

GENETICS
- Medical Research
- New Therapeutics

SUPPORTED BY MEDICAL EDUCATION AND RESEARCH

FINANCED BY

HEALTH INSURANCE 80%

PERSONAL PAYMENT 20%

? INDIGENT, UNINSURED BAD DEBT ?

FUNDED BY

- Government
- Employers
- Individuals

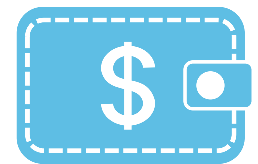
- Government
- Private Philanthropy
- Individuals (e.g. Education)

INSURANCE COMPANIES?

5. Most Health Care is Financed by Insurance
Spending is Highly Concentrated

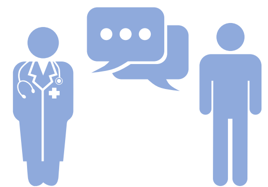
NIHCM Foundation analysis of data from the 2014 Medical Expenditure Panel Survey

5. Most Health Care is Financed by Insurance: Health Insurance is Critical



Expensive and you never know when you'll need high-cost care

Protect assets
(if you are lucky enough to have assets to protect)



Insurance is **access** to health care providers

Insurance facilitates **care coordination**

Everyone needs coverage!

Health insurance is important tool, but not the goal…

HEALTH

6. US Insurance is Complicated

Percentage of People by Type of Health Insurance Coverage

Type of Coverage	Percentage
Uninsured	8.5
With health insurance	91.5
Any private plan	67.3
Employment-based	55.1
Direct-purchase	10.8
TRICARE	2.6
Any public plan	34.4
Medicare	17.8
Medicaid	17.9
VA and CHAMPVA	1.0

Source: U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2019 Annual Social and Economic Supplement.

U.S. Health Insurance is Complicated

Predominant Coverage by Age and Income - After ACA (Most States)

>400%

Private/Employer Sponsored Coverage

400%

$50,000

$100,000

Employer sponsored Coverage/ ACA Marketplace (premium subsidies)

250%

CHIP

ACA Marketplace

Premium and Cost–Sharing Subsidies

State Option

Federal Poverty Level (FPL)

133%

$17,000

$34,000

100%

$12,500

$25,000

Medicaid

Medicaid LTC

Medicare

0%

Single

Family of 4

INCOME

Newborns (<1 year)

Children (Ages 1-18)

Pregnant Women

Parents*

Childless Adults

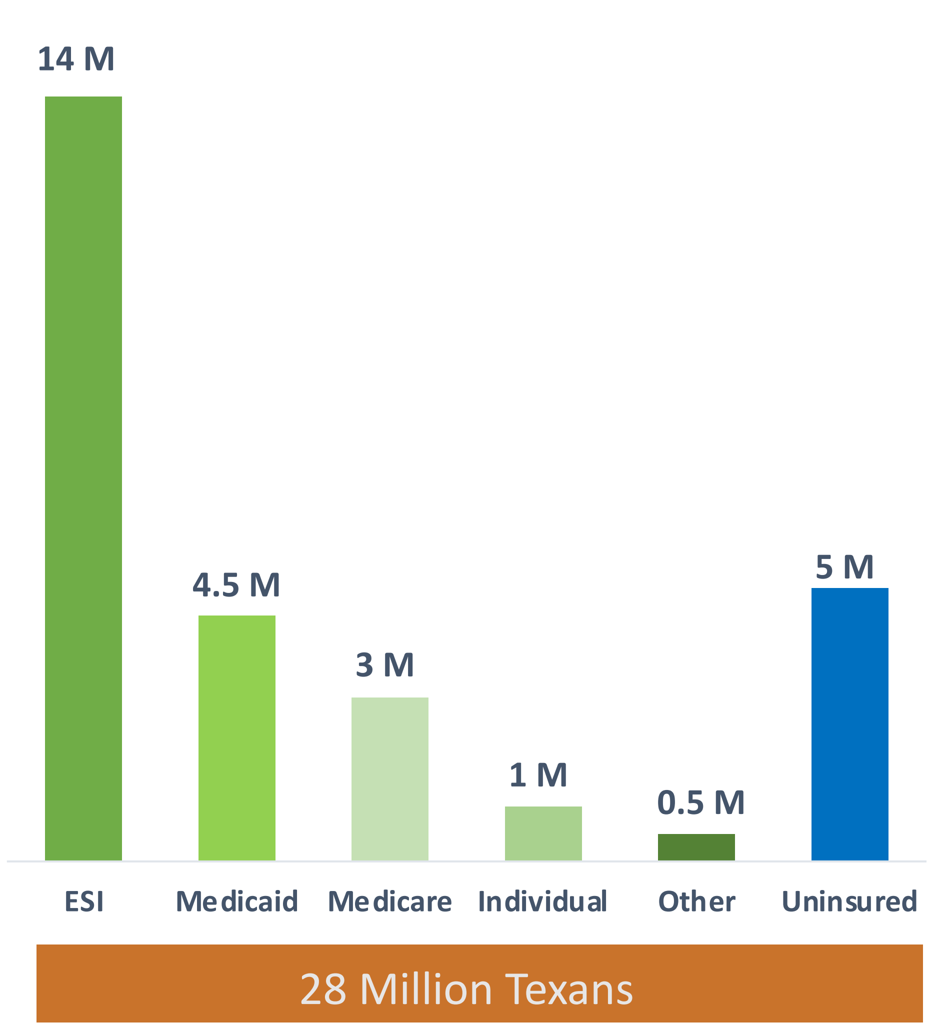
Disabled

Over Age 65

6. Health Insurance is Complicated

Predominant Coverage by Age and Income- Texas

6. Health Insurance is Complicated
The Texas Health Insurance Market - 2018



Medicaid 17%
Medicare 10%
Individual Market 6%
Other Public 2%
Uninsured 18%
Employer 47%

I SEE

UNINSURED PEOPLE

7. The Uninsured: 5 million, 17% of All Texans

If Minute Maid Park filled with Average Texans

=

7,000 of these fans are uninsured

7. Who are these uninsured people?

Homeless guy panhandling outside

Son of immigrant parent afraid to sign-up for CHIP

Construction worker

Daycare worker

Child of a teacher

Pre-65 retiree waiting for Medicare to start

Home health care worker that helps your aging Mom

Guy who mows my lawn

Lady that cleans your office at night

Laid off energy co. worker who can't afford COBRA

Front desk person at your doctor's office

Part-time peanut vendor

Waiter at Vic and Anthony's

7. Uninsured Rates Vary by State

2013-2017

Uninsured Rate Among The Top 25 Most Populous Metro Areas

WORST			BEST		
1.	Houston	18.0%	21.	Detroit	5.0%
2.	Dallas	16.5%	22.	Baltimore	4.8%
3.	Miami	15.5%	23.	San Francisco	4.6%
4.	San Antonio	14.5%	24.	Minneapolis-St. Paul	4.0%
5.	Atlanta	13.5%	25.	Boston	3.5%

Source: https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

7. Uninsured Rates Vary by Age

ACA drove big decrease, 2013-2017

Uninsured Rate by Single Year of Age: 2013, 2016, and 2017
(Civilian noninstitutionalized population)

Percent

2013
2016
2017

35
30
25
20
15
10
5
0

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75+

Age

Source: https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

7. Who are These People?
Uninsured Rates Vary by Income

Source: https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

7. Why are there so many uninsured Texans?

1. Health care is expensive and therefore health insurance is expensive
2. You don't need it TODAY. Unlike food or housing or transportation…
3. Almost everyone with insurance has someone else that pays most of the cost (employer, state or federal government)
4. Texas employers are the stingiest in the country… anti-union, accustomed to endless supply of immigrant labor. Nationally, about 60% of people have employer-sponsored insurance, only 47% in Texas.
5. Less than 30% of Texas small employers offer a health plan at all.
6. Many large employers exclude part-time workers from health insurance, some intentionally keep people under 30 hours/week to avoid ACA mandate.
7. Texas has the most restrictive eligibility for Medicaid in the country, and did not expand Medicaid under the ACA
8. Texas has the second most undocumented immigrant workers (exploited by employers, lack a voice to complain, don't understand employer-sponsored insurance)
9. Texas leaders have actively worked to kill the ACA without offering any alternative

7. Insurance Matters

Health Outcomes by State

Some in TX say it's OK to have 5 million uninsured.

Better performance

Worse performance

HI MA MN WA CT VT RI IA CO NH UT ME WI CA NY ND OR ID MD NJ PA NE DC SD MI MT DE IL VA AK KS AZ OH NC NM IN IN AL TN KY SC GA MO FL LA WV AR NV TX OK MS

CA 14th

NY 15th

FL 42tH

U.S. AVERAGE

Strong correlation between outcomes and insured rates

Texas is 48th in composite of 47 indicators

States are arranged in rank order from left (best) to right (worst), based on their overall 2019 State Scorecard rank.

Source: Commonwealth Fund 2019 State Rankings on Health System Performance

7. We Pay for the Uninsured:
Inefficient and Poor Outcomes (Coverage is Better)

CURRENT FRAGMENTED SAFETY NET "SYSTEM"

For 1.3 million eligible for Medicaid expansion, coverage would:

- Draw down more federal dollars
- Save the state money (90/10 match)
- Reduce administrative burden
- Produce better health outcomes

LOW INCOME/ UNINSURED PATIENTS

Where do I go for care?

PROVIDERS
(Determine eligibility)

Private physicians
FQHCs
City / County Clinics
Local Mental Health Authority
Urban County Public Hospitals
Private Hospitals
State Hospitals
Veteran Affairs
Charity Clinics
Jail

FUNDING SOURCES*

Federal Funding: Medicaid, CHIP, DSH, Federal Funds for MHMRA, FQHC Grants, Ryan White, UC/1115 Waiver, Federal VA Funds

Local Taxes

IGT

Philanthropy

Patient Fees

State Funding: Medicaid, DSH, CHIP, Direct Pay to State Owned Hospitals/ Providers, State Funds for MHMRA, Healthy Texas Women, UC/1115 Waiver, State Dept. of Criminal Justice

*Not exhaustive, other state funding sources currently exist for safety net care

7. Five Million Uninsured Texans

8. Cost = Price x Volume

Critical Formula of Health Care Financing

- Utilization rate (volume) x Unit cost (price) = Total cost
- Utilization usually expressed as per member per year (PMPY)
- Cost usually expressed as per member per month (PMPM)
- Utilization is highly dependent on who is in the risk pool (mix of old, young, healthy, or sick.)

6 Rxs PMPY (utilization rate)

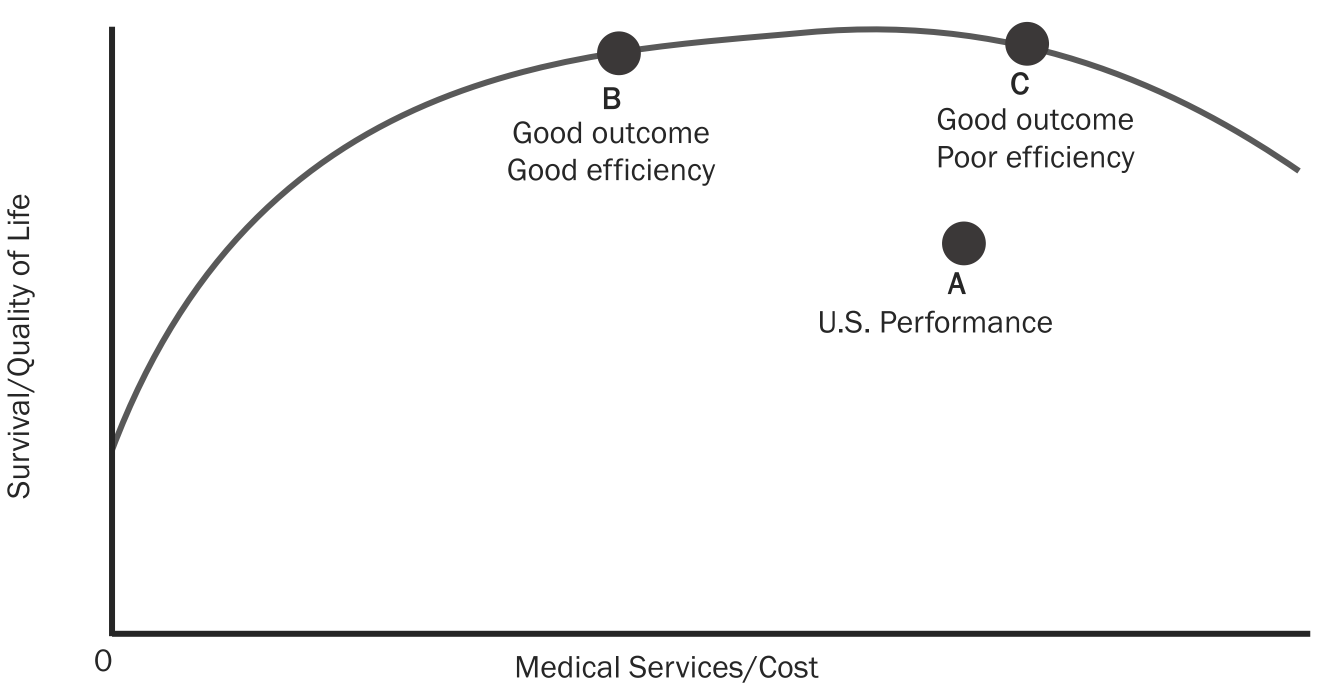
X $100 per Rx (unit cost)
$600 cost per year / 12 months = $50 PMPM

75 admissions/1,000 members (utilization rate)
X 4.0 days average length of stay

300 days / 1,000 members = 0.3 days per month
X $3,000 average cost/day (unit cost)

$900 cost per year / 12 months = $75 PMPM

8. Cost = Price x Volume



Controlling Prices

- Discounts, fee schedules
- Generic vs. brand drugs
- Less costly location, level of care

Controlling Utilization

- PCP gatekeepers
- Evidence-based guidelines
- Prior authorizations
- Concurrent reviews
- Complex care management
- Capitation, bundled payments

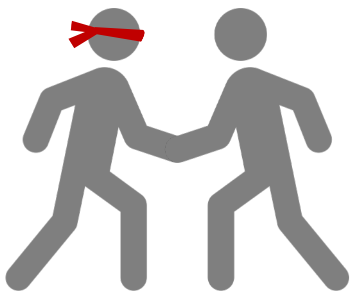
Increasing cost-effective services for better outcomes

- Immunizations
- Prenatal care
- Wellness/preventive exams
- Condition/disease management programs

Source: Chandra, Amitabh, Anupam B. Jena, and Jonathan S. Skinner. 2011. "The Pragmatist's Guide to Comparative Effectiveness Research." Journal of Economic Perspectives, 25(2): 27–46

8. Cost = Price x Volume

Moral Hazard



Acting in an adverse manner because you do not bear the full consequences of your actions

- Incentives for overutilization and charging higher prices
- Both patient and provider incentives to receive/provide as many services as tolerable with little regard to cost/value
- Insurance compounds moral hazard
- Don't worry…your insurance will pay for it!
- Leads to costly administrative reactions to stop fraud, waste and abuse

8. Cost = Price x Volume

Price discrimination

As a general rule…

$ — Medicaid pays least (.7) — Medicare is benchmark (1.0) — Employer-sponsored (2.0) — $$$$

Employer-sponsored (2.0)
- Physicians and other professionals (1.25)
- Hospitals (1.5 – 3.0)
- Hospital based physicians (3.5 – 8.0)

Low Medicaid payment rates discourage providers from participating. Bad policy.

Certain providers receive supplemental Medicaid payments: hospitals, FQHCs.

Employers are increasingly unhappy with much higher payment rates than Medicare. Tired of subsidizing government programs and/or provider inefficiency/extravagance.

Providers complain about Medicare, but prepare for operation with all patients at or near Medicare.

8. Cost = Price x Volume

Market Prices or Price Controls?

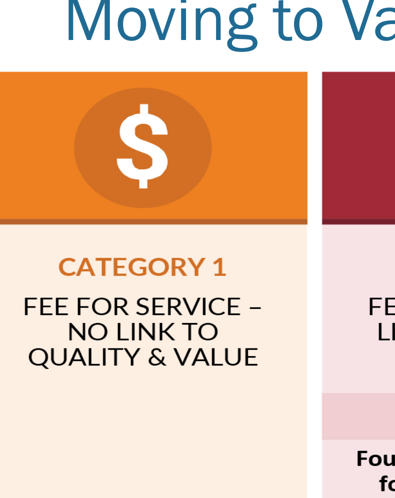
Examples of Market Failures

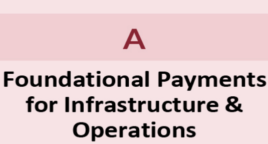
- *Emergency room services*
- *Hospital based physicians: Emergency, Anesthesiology, Pathology, Radiology*
- *Drugs on patent*

9. Pay for Value, not Volume

Moving to Value-Based Care and Contracting

Most health care services in the US still paid FFS





CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
FEE FOR SERVICE – NO LINK TO QUALITY & VALUE	FEE FOR SERVICE – LINK TO QUALITY & VALUE	APMS BUILT ON FEE -FOR-SERVICE ARCHITECTURE	POPULATION – BASED PAYMENT
	A **Foundational Payments for Infrastructure & Operations** (e.g., care coordination fees and payments for HIT investments)	A **APMs with Shared Savings** (e.g., shared savings with upside risk only)	A **Condition-Specific Population-Based Payment** (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B **Pay for Reporting** (e.g., bonuses for reporting data or penalties for not reporting data)	B **APMs with Shared Savings and Downside Risk** (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B **Comprehensive Population-Based Payment** (e.g., global budgets or full/percent of premium payments)
	C **Pay-for-Performance** (e.g., bonuses for quality performance)		C **Integrated Finance & Delivery System** (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

Moving to value-based payments has been slower than expected

https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

9. Implications of Value-Based Care

Care Team

Care management

Social determinants of health

Data:
Coding, analytics

New compensation models for doctors

10. Our Goals: A Health Policy Home Run

3B Simplify Funding and Administration of Programs

- Reduce administrative burden through consistent program administration across Medicare, Medicaid, and private plans
- Reduce complex supplemental provider funding in government programs
- Integration/interoperability of systems

2B Coverage for Everyone

- A basic benefit plan for all based on age, income, disability
- Choices and ability to "buy up" for additional services
- Everyone in the pool
- Subsidies based on age and income

HP Slow Cost Increases through Provider Payment Reform

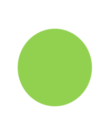
- Encourage coordinated, less fragmented care (medical homes, ACOs, etc.)
- Restructure provider payments to reward efficiency and quality (value-based payments)
- Assure fair payment rates across programs and providers, incl Rx

1B Personal & Community Accountability for Health

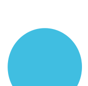
- Healthy behaviors
- Choices, transparency and consumerism
- Everyone pays something: based on income
- Community/social influences

10. Ken Sees the Future
for Health Insurance

Short-term there will continue to be gridlock in Washington, DC.

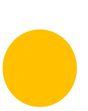


Texas will continue and expand Medicaid Managed Care, but still high uninsured



Medicare Advantage will grow

Small group market will disappear, replaced by QSEHRAs/ICHRAs



Many large employer will move to defined contribution

We can do a lot in Texas.

A Texas health insurance exchange to make it easier for individuals and employers to buy

Medicare and Medicaid will continue move to VBC*

Large employers will demand reduced price discrimination

Looks like Medicare Advantage for All

*(**VBC**) Value based Contract

*(**QSEHRA**)Qualified Small Employer Health Reimbursement Arrangement

*(**ICHRA**) Individual coverage health reimbursement arrangement

10. Ken Sees the Future
for Health Consumers

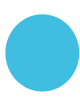
Short-term there will continue to be gridlock in Washington, DC.

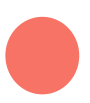
Focus on price of insurance

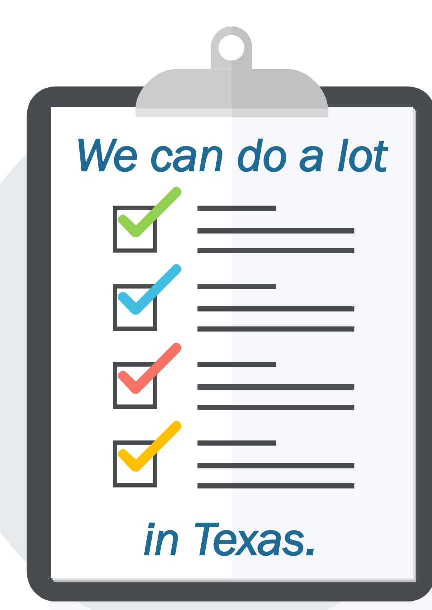
Are bigger deductibles, more cost-sharing a good or bad thing?

Obamacare, HSAs, HRAs, STLDI… I'm confused

Is my doctor in the network? But access is more than "Is my doctor in the network?"







On demand care: urgent care centers, telemedicine

Picking a system rather than just a PCP (e.g. Kelsey Seybold, Memorial Hermann, etc.)

Consumer experience trumps clinical quality. Are health plan quality measures aligned with consumer needs?

Make it easier: mobile devices, personal health records and other consumer expectations

*(**VBC**) Value based Contract

*(**QSEHRA**)Qualified Small Employer Health Reimbursement Arrangement

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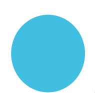
10. Ken Sees the Future

for Health Insurers

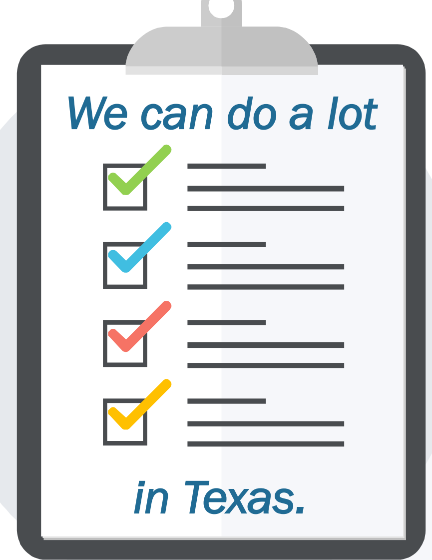
Short-term there will continue to be gridlock in Washington, DC.

- Texas will continue and expand Medicaid Managed Care, but still high uninsured



- Medicare Advantage will grow
- Small group market will disappear, replaced by QSEHRAs/ICHRAs

- Many large employer will move to defined contribution



- Need to understand and improve SDoH*, behavioral issues and other non-medical ways to improve health

- Customer service will matter

- Narrow networks will thrive
- Transition to VBC will happen: implications for data sharing, provider relationships

- Lines between market segments will blur, disappear
- Regional plans can compete with the nationals (at 500K+ members?)

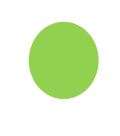
*(**VBC**) Value based Contract
(**SDoH**) Social determinants of Health

*(**QSEHRA**)Qualified Small Employer Health Reimbursement Arrangement

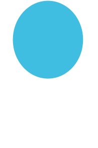
*(**ICHRA**) Individual coverage health reimbursement arrangement

10. Ken Sees the Future
for Health Financing Policy

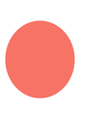
Short-term there will continue to be gridlock in Washington, DC.



Medicaid expansion/1115 waiver, Reduce reliance on supplemental provider payments

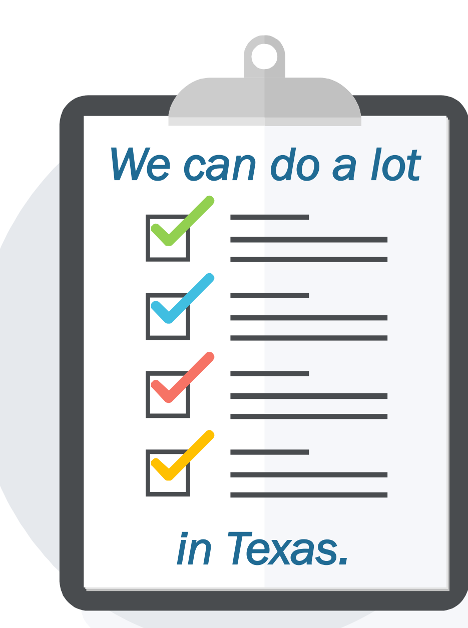


1332 waiver for reinsurance and other ways to lower costs in the individual marketplace



More employer-sponsored insurance to level the playing field in construction and other industries

Provider Payment Reform: Value based, transparent and reduced price variation



Continuous enrollment and other administrative steps to get those eligible for Medicaid enrolled

A Texas health insurance exchange to make it easier for individuals and employers to buy

Support QSEHRAs and ICHRAs to make it easier for employers

Reduce administrative burdens across the board

Replace county indigent care programs with one state plan???

*(QSEHRA)Qualified Small Employer Health Reimbursement Arrangement

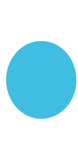
*(ICHRA) Individual coverage health reimbursement arrangement

10. Ken Sees the Future
for Health Care Providers

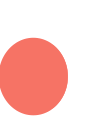
Short-term there will continue to be gridlock in Washington, DC.

- Narrower networks: pick your payer partners (payment rates, administrative hassles)

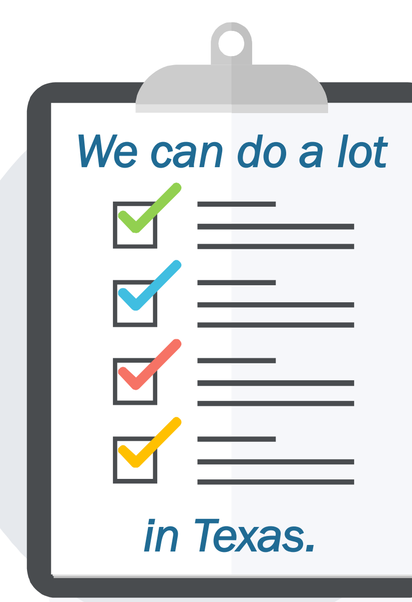
- Provider Payment Reform: Value based, transparent and reduced price variation



- Sharing of data with insurers and patients (EHRs, PHRs, claim systems)

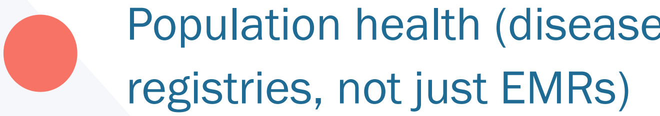


- Improved consumer experience required



- Care coordination

- Medicaid growth in specialties serving adult population

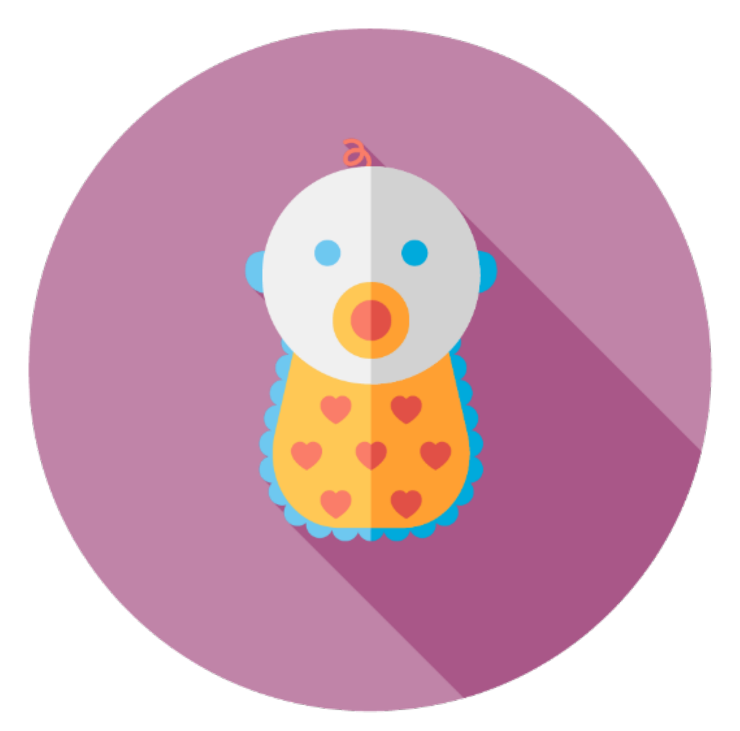


- Population health (disease registries, not just EMRs)
- Social determinants of health

*(QSEHRA)Qualified Small Employer Health Reimbursement Arrangement

*(ICHRA) Individual coverage health reimbursement arrangement

Final Thoughts? Discussion?



Thank you!

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