The Evolution of the U.S. Healthcare System: How did we get here and where are we going?

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Economics: A tool to better understanding

- Using Economics as a framework to:

  1. Understand our healthcare challenges
  2. Identify how we got here
  3. Identify lessons learned - LL
  4. Evaluate the alternative approaches to address our healthcare challenges
  5. Identify the challenges and opportunities in future world for the healthcare stakeholders

Economics Understanding our Health Care Challenges

- Scarcity
- Choices
- Opportunity Costs
Economics
Understanding our Health Care Challenges

- Unlimited financial demands placed on the finite resources available to society
- Medical care must be placed within the context of other goals considered important by society
- To a large extent these are competing priorities

The culmination of healthcare cost, quality and access to care issues:

1. Negative impact on employers
2. Negative impact on Medicare/Medicaid
3. Negative impact on both the “haves and have nots”
4. Which will in turn negatively impact healthcare stakeholders
Economics
How did we get here?

- One of the goals of economics is to understand, explain, and predict the behavior of decision makers (individuals, organizations, government, etc.)

- Predicting the behavior of decision makers: The **pursuit of self-interest**

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Economics
How did we get here?

**Adam Smith:**

- “The pursuit of **self-interest** is the primary motivator of economic decision-making”

- “Guided by the ‘invisible hand’ of the mkt., this **self-serving behavior**, in turn, serves to promote the **interests of others**”
“It is not from the benevolence of the butcher, the brewer, or the baker that we expect our dinner, but from their regard to their own interest.” (“Wealth of Nations,” Adam Smith)

Using economics to view the evolution of the U.S. healthcare system and its impact on healthcare cost, access and quality:

1. 1930’s – 1965
2. 1965 – to present
Health Insurance
1930’s to 1965

- Healthcare primarily self-pay prior to 1938 negatively impacting quality & access to care
- Start-up of Blue Cross & Blue Shield
- Partnership: hospitals, physicians, employers, consumers (mutual self-interest - LL)

Economics
How did we get here?

Health Insurance - (mutual self-interest)

- Ensured hospital/physician financial viability (strongly supported by AHA and later AMA)
- Answer to national insurance
- Community rated/pooling - LL
- Focus on access and financial mechanism to support expansion of healthcare system - LL
Economics
How did we get here?

Health Insurance - (mutual self-interest)

- Financing now available to increased number of hospitals - LL
- Public could now go to the hospital/physician office - no longer self-pay
- Access ↑ -(more hospitals, more physicians, fewer barriers) - LL

Economics
How did we get here?

- Tax exempt status of health insurance (gov’t in a facilitator role) - LL

- 1948 - health insurance subject to collective bargaining. By 1954 the number of workers covered by negotiated health plans increased from 2.7 million to 12 million)

- 1960 – 65% of Americans covered by health insurance – The pursuit of self-interest - LL

- Costs ↑; start of moral hazard - LL
Economics
How did we get here?

- Which Americans were not covered by insurance in 1960?

- Per Kenneth Arrow: “When the market fails to achieve optimal state, society will, to some extent, recognize the gap, and non-market institutions (public/non-profit) will arise attempting to bridge it.”

- Medicare/Medicaid (mothers/children) - 1965

Economics
How did we get here?

1965 to the present

- A healthcare system is shaped by **how** you pay for services and **what** you pay for - LL

- **Medicare**, the primary architect of our healthcare system (800 pound gorilla) - LL

- Medicare’s payment methodologies’ and policies’ impact on healthcare costs (and in turn quality & access): “The pursuit of self-interest”- LL
Economics
How did we get here?

- Medicaid covered nursing home services; limited coverage for home care - LL

- States incented to shift other programs to Medicaid because of Federal match - LL

- Very little fiscal control at the Federal level

Economics
How did we get here?

- Medicare and Medicaid reimbursement methodologies in the 1960’s /1970’s

  1. Cost reimbursement for hospitals – The more you build the more you make - LL
  2. UCRs reimbursement for physicians – The more you charge the more you make - LL
  3. BCBS follows Medicare lead: Cost and UCR reimbursement methodologies - LL
Economics
How did we get here?

- Between 1965 and 1980 federal aid increased the number of medical schools from 88 to 126, the number of graduates from 7,409 to 15,135

- Increase of physicians mostly in specialty and sub-specialty area - \textit{LL}

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Economics
How did we get here?

- What happened to healthcare costs in the U.S. as a result of government and private health insurance coverage (\textit{moral hazard}) and Medicare & Medicaid reimbursement methodologies? \textit{LL}
Economics
How did we get here?

- The federal government share of healthcare costs jumped from 10.8% to 24% between 1960 and 1970 - LL

- In total, federal and state healthcare expenditures increased from $6.6 billion in 1960 to $27.6 billion by 1970 - LL

- End of 1970s, Medicare is growing at over 20% a year - LL

Economics
How did we get here?

- Overall healthcare expenditures increased at an average rate of 13% during the 1970s - LL

- By 1980 overall healthcare expenditures reached $230 billion - LL

  1. Up from $69 billion in 1970
  2. A jump from 7.2% to 9.4% of the GDP
Economics
How did we get here?

☐ DRGs implemented for hospital inpatient services -1984 (Medicare)

☐ Medicare outpatient services continue to be reimbursed on a cost basis

Economics
How did we get here?

☐ What was the impact on hospitals’ outpatient services as a result of Medicare’s reimbursement methodologies? LL

☐ What was the impact on the ancillary service industry as a result of DRGs? LL
Economics
How did we get here?

- Combination of DRGs (IP) and cost reimbursement (OP) result in a catalyst that ignites outpatient infrastructure and technology and fosters the growth of the ancillary service industry (e.g. home health, skilled nursing, etc.) - LL

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Economics
How did we get here?

**Payment for Services by Silo - LL**

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Economics
How did we get here?

☐ Medicare’s payment methodologies also impact the under 65 population

☐ Managed Care Organizations have historically followed Medicare’s payment methodologies with providers (lack of financial clout vs. Medicare) - LL

Economics
How did we get here?

☐ A healthcare system is shaped by how you pay for services and what you pay for (the pursuit of self-interest) - LL

☐ The results? - LL
Economics

How did we get here?

How you pay for services and what you pay for:
- Siloed
- Inappropriate use of high cost technology
- Inappropriate end-of-life costly efforts vs. appropriate hospice services
- Excess infrastructure & technology
- Lack of focus on primary care, preventive services, wellness, etc.
- Chronic diseases that are not addressed in a coordinated and sustained manner

Economics

How did we get here?

- Additional economic factors shaping our healthcare system *(self-interest driven)*:

Consumers

1. Moral hazard - LL
2. Asymmetric information - LL
3. Results in no real competition - LL
How did we get here?

The Consumer

**Self-interest**

Consumers lack of financial accountability

- **Moral hazard** and the absence of user-friendly information - major contributors to increased healthcare costs (e.g., over utilization of HC services, no real competition) - **LL**

- Per CDC: life-style based chronic diseases account for 75% of the nation’s HC costs - **LL**

Lessons learned

- **Medicare reform is key** (MCOs will follow <65)

- The role of self-interest in:
  1. How you pay for services and what you pay for
  2. Moral hazard
  3. Adverse selection (insurance)
  4. Asymmetric information
  5. Lack of real competition
Economics
Lessons learned

- History has shown that any healthcare reform initiative must address **cost, access and quality** in a coordinated approach.

- History has shown that for healthcare reform to be **sustainable** it must address **cost**:
  1. **Medicare reform**
  2. **Moral hazard** - financial/lifestyle accountability
  3. **Asymmetric information**

Economics
Evaluating alternative approaches to address our healthcare challenges

- Based on history and economics can we design an environment/economic framework which increases the likelihood of a value-based health system in the U.S. being created and sustained (e.g., market approach, global cap, hybrid, two-tier, etc.)?

- Starting with Medicare reform
Economics
Evaluating alternative approaches to address our healthcare challenges

The Market Approach to Medicare Reform

- Congressman Paul Ryan (Medicare Advantage)
- User-friendly information combined with financial accountability by consumer sets the stage for value driven competition (MCO example)
- Economic theory: The market approach is the most efficient way to allocate scarce resources, but there will be equity issues

Competition (self-interest) between suppliers of services to meet demands of purchasers will foster innovation, efficiency and value

Competition takes production out of the hands of the less efficient and places it in hands of more efficient – constantly promoting more efficient methods of production (e.g. computers, cars, etc.)

Winners and losers
Economics
Evaluating alternative approaches to address our healthcare challenges

The Global Cap Approach to Medicare Reform
- Federal Health Board (e.g. Federal Reserve)
- Rationalization of healthcare services?
- Based on a national budget which would force the U.S. to determine the societal balance of healthcare cost, access and quality
- Impact on innovation?

A Hybrid Approach to Medicare Reform
The Government as a Facilitator
- “Harnessing the base motives of material self-interest to promote the common good is perhaps the most important social invention mankind has yet achieved.” (Schultz)
- “Instead of creating incentives so that public goals become private interests, private interests are left unchanged and obedience to the public goals are commanded.” (Schultz)
A Hybrid Approach to Medicare Reform
The Government as a Facilitator

- Risk based reimbursement methodologies – ACOs: The pursuit of self-interest: (combining risk & reward – bundled payments) (paying for keeping people well - capitation)
- Facilitating user-friendly cost/quality data
- Consumer financial & lifestyle accountability (e.g. Medicap – moral hazard)
- A role for managed care?
- The role of health insurance exchanges?

Many countries in the world are evolving to a two-tier approach to healthcare reform

1. Basic preventive and primary care for all and catastrophic care with limitations (Rationalizing, Clinical Effectiveness, etc.)

2. The ability to buy health insurance, etc. to receive access to quicker service and additional healthcare options through private providers
Challenges and opportunities in future world for the healthcare stakeholders

- Widget example – Costs are still the issue

- Perfect Storm: No longer business as usual

- The combination of consumer financial & lifestyle accountability along with user-friendly cost & quality information will result in winners & losers on the provider side.

- Demonstrating perceived & actual value