

Class Paper Three

Financing Healthcare in the United States: Current Methods and Future Directions

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Introduction:

Financing healthcare in the United States is a highly complex system of fragmented and interrelated (or unrelated) institutions that provide funding for services based primarily on the demographics of the population being served. In contrast to other countries which have implemented some form of socialized medicine, in the United States, where healthcare is received and the level of care provided is largely a function of who is paying, which is based on the demographics of the patient. The primary demographic factors driving healthcare funding are age, employment status, insurance status (whether public, private or employer-sponsored) and personal wealth. Our system and its development throughout the 20th century mirror the values of our society, primarily capitalistic and profit-driven by nature. While this philosophy has resulted in unprecedented advances in technology and improvements in health, increased costs, the aging of our population, and chronic disease conditions are severely stressing financing of healthcare in the United States. The purpose of this paper is to explore alternatives in healthcare financing, discuss the feasibility of implementation, explore the legislative and regulatory changes necessary, and finally, explore the impact on government programs for specialized classes of citizens like the military and the poor.

Our group focused on three areas of healthcare financing; privately funded, government sponsored, and employer-funded. These topics will be explored in more detail below.

Alternative Financing Methods:

Private Funding:

Throughout the early history of our country, healthcare was, with few exceptions, essentially a fee for service system. Patients provided direct payments for services rendered for themselves or their families; in effect this was self-insurance in its most literal form. Most providers based their fees on the individual's ability to pay; the higher fees paid by those who could afford it helped subsidize the care of those who paid less. Those unable to pay were at the mercy of friends, family, or charitable organizations for basic care. This system held advantages for those with funds for needed care. Choice of provider or services was limited only by one's ability to pay, and the limited therapies of the time. Conversely, this system was less than satisfactory for those without the means to pay for care. Without cash, the sick were at the mercy of providers who did perform a limited amount of pro bono work, or the aforementioned charitable organizations; public hospitals were by and large places where the poor went to die.

The advent of the 20th century brought the beginnings of private health insurance. These early plans primarily protected against loss of income and certain acute illnesses. Insurance plans gained massive popularity in the 1940's and 50's when employers began paying premiums as a fringe benefit; this will be addressed later in the paper. Benefits of privately purchased health insurance include the advantages of freedom of choice for provider and coverage, and offers protection against catastrophic loss due to serious illness (definition of insurance). Disadvantages of private insurance plans are difficulties in differentiating between choices, responsibilities for filing claims and meeting eligibility criteria, and the necessity of financial discipline to pay for coverage.

Today, due to the high costs of medical care and individual health insurance policies, these forms of payment are not seen as a solution to address the problems of healthcare financing reform. Although realistically, out of pocket expenses are expected to increase through co-payments and cost-sharing with employers, and federal and state taxes to finance healthcare programs are truly a form of out of pocket expense for those who pay taxes; these factors must be kept in mind when exploring alternate financing schemes.

Government Funding:

The government's role in financing healthcare expanded exponentially in 1965 with the inauguration of Medicare and Medicaid. These programs greatly expanded protection against catastrophic loss due to medical expenses for the elderly and the indigent, and helped establish the common belief that affordable access to health care is an American and human right. Government financing of healthcare now accounts for approximately 60 percent of total expenditures. This includes direct funding for programs such as Medicare, Medicaid, TRICARE, VA, and numerous other smaller agencies. The government also makes substantial investments in regulation, research and surveillance through agencies such as the NIH, CDC, and DHHS. Approximately 15 percent of government funding is through tax subsidies and credits, as well as educational loans and grants. The advantages of government funding include the desire to provide care for those who cannot help themselves (poor children, those who cannot work, and the elderly) as well as investments in programs for the "greater good" such as clean water, safe food, effective drugs, and research and development are not disputed. The federal government is in a position to set policy and allocate funds where they can do the most good for the most people; however, whether this often occurs is open for debate. Special interest groups and influential lobbyists have a direct influence on policy development and reform, or lack thereof. Another disadvantage of governmental funding is the inherent inefficiency and administrative costs associated with managing such a large and complex system.

The consensus of our group is while we do not see the role of government decreasing in healthcare due primarily to political and financial interests, nor should it necessarily decrease in its current roles, we do not advocate an expansion of federal government's role into some form of national health insurance. An attempt to establish such a system, which has had varying levels of support for over 60 years, would generate another huge bureaucracy with associated costs that our current tax base cannot support. The increase in taxes that would be needed to fund such a plan would likely cripple our economy, and do not have the support of those in power or the voting public. We do agree that reforms and improvements in Medicare and Medicaid are needed, to include better correlation between outcomes and monies spent, more emphasis and funding for preventive services to help limit the costs of catastrophic illnesses, and limits on heroic measures and their associated astronomical costs for ultimately fatal outcomes. Another area for investigation is alleged fraud against Medicare and Medicaid by unscrupulous organizations, especially nursing home companies. A recent investigation published by US News and World Report looked at the issue of funding for nursing homes. Many of these large companies that claim an inability to operate on payments provided by Medicaid report 20-30 percent profit margins to their investors, and use complex accounting techniques to hide profits and shelter earnings from taxes, while not meeting minimum levels of care for their patients or tolerable working conditions for their staff. This situation warrants further investigation and reforms as necessary. In summary, while the government plays an important role in the health of

the nation, national health insurance is neither a political or financial possibility at this time, or in the foreseeable future. Implementation of the strategies discussed above (emphasis on prevention and education, fraud reduction, and limits on heroic procedures) can make our current government system more efficient and allow it to continue its important role in the nation's health.

Employer/Employee Funded Health Insurance:

Employer-sponsored health insurance gained popularity in the 1940's and 50's when a series of legal and tax developments, as well as wage freezes in place during WWII, encouraged businesses to provide this "fringe benefit". Initially, there were no employee contributions, few restrictions, and no co-payments required by these plans. This benefited providers of healthcare services, as well as patients. Employees had little concern about cost and even less about over-utilization, as "the boss" was paying the bills. With employers picking up the entire tab for coverage, employees were removed from the economic consequences of their consumption. The medical community was more than willing to provide whatever the patient wanted, especially for those whose insurer didn't question the necessity or cost of procedures. This led to a rapid expansion in the growth of health insurance, as well as escalating costs for services provided, and in turn, increased premiums for coverage. Initially, employers were able to absorb these increased costs because of the tax breaks provided, the relatively small percentage of payroll that insurance premiums amounted to, and the ability to pass increases in healthcare premiums on to employees in the form of smaller wage gains or reduction of other benefits. As salaries began to stagnate and employers began to pass some of the costs of coverage on to employees through restrictions on coverage and partial premium payment, workers began to realize that ultimately they were the ones paying for their healthcare.

Managed care strategies under many different names and permutations have been tried in an attempt to control costs. On the whole, these generated significant consumer dissatisfaction as many developed the perception that the bottom line and cost containment were more important than their health or the health of their families. From their point of view, they experienced a marked decrease in services while being expected to directly pay an ever-increasing percentage of what care they did receive. This has led to many managed care companies improving service and choices to their enrollees, which has led again to increasing costs. The threat of legislation supporting patient's rights and mandating certain standards on the industry such as the Health Insurance Portability and Accountability Act will no doubt lead to further changes in employment-based health insurance.

The trends of increased direct cost-sharing, restricted coverage, or the elimination altogether of employer-sponsored coverage especially in smaller companies seems destined to continue under the present system. Greater awareness and involvement in healthcare decisions by employees is warranted, and is part of our strategy for reform. It is our belief that employees should be educated about the true costs of their health insurance, and play a larger role in choosing their coverage. The use of defined-contribution health insurance products, which give the employee a set amount of funds in an account to spend as they see fit, holds promise for improving the situation. People have differing health needs, concerns and desires; this system would allow some flexibility based on their unique family situation. Basic catastrophic coverage will remain a necessity, and plans offered for purchase should offer significant incentives for preventive medical services and education about disease prevention and healthy lifestyles. This strategy

offers some hope in containing costs and improving care by making the insured more involved in their healthcare, and more likely to see the economic impact of unhealthy lifestyles, as they will feel more ownership and responsibility for dollars spent on coverage.

Future Directions:

Our conclusions, which have been discussed and addressed throughout this paper, is that while our current system has significant shortcomings and inefficiencies, it is unrealistic given the political, social and financial nature of our society, that any one system will be developed that will replace our current structure. Rather, we offer modifications to our current state of affairs that, if implemented, will help to improve the care provided and the efficiency of the system as a whole. The millions of citizens without health insurance, especially the working poor whose income is too high to qualify for Medicaid or other government programs but who cannot afford private health insurance, and whose employers cannot afford to provide coverage, are a group of people whose plight we have no easy, realistic solution for. Given all the special interest groups and lobbyists involved, and other governmental programs competing for tax dollars, especially in our current economic climate, and serious societal concerns about homeland defense and war, any additional government programs, such as offering incentives or partial financing of premiums for the working poor, while a commendable goal, seem unlikely. Politics and policy today seem tied to public opinion polls to ever greater levels, and the reality of the situation is healthcare, while receiving much media attention, just isn't that high on the average citizen's radar scope, especially when confronted with the increased tax liability that would be required to pay for reform.

As has been tried in the past, a national health care commission composed of all interested parties in health care could be a way to integrate our nations health care efforts, and explore options available for reform. Until politicians are convinced that this issue is of primary interest to the voting public however, federal initiatives seemed doomed to stagnate, as others that were discussed in chapter 5 of our reading.

The Executives feel other federal systems, such as those for the military, veterans and federal employees could benefit from the increased emphasis and incentives for preventive services discussed for other sectors of healthcare. Over time, depending on the success of the defined-contribution plans discussed for employer-employee relationships, this concept could be expanded for these programs. This would allow the military to focus more on their mission specific roles, and improve choice for beneficiaries, while improving the overall health of the population. We recommend a wait and see approach, however, as the military is still wrestling with the implementation of TRICARE! The military currently pays lip service to prevention, but for proper implementation, training, manning, and infrastructure, to include facilities and information technology for data collection and analysis must improve. Those of us on the front lines often know and want to do the right thing, but are limited in the tools and time to do it.

In summary, while the Executives do not wish to be branded as hopeless cynics, we did want to offer a realistic analysis of this complex topic, and offer possible solutions, which we feel are reasonable given past history and the current national environment. We did not reach the current state of affairs overnight; therefore change and reform must be incremental, and ultimately must be the will of the people, as communicated through their vote on Election Day.