Our Health Care Should Not Drive Us Crazy

39th Erich Lindemann Memorial Lecture

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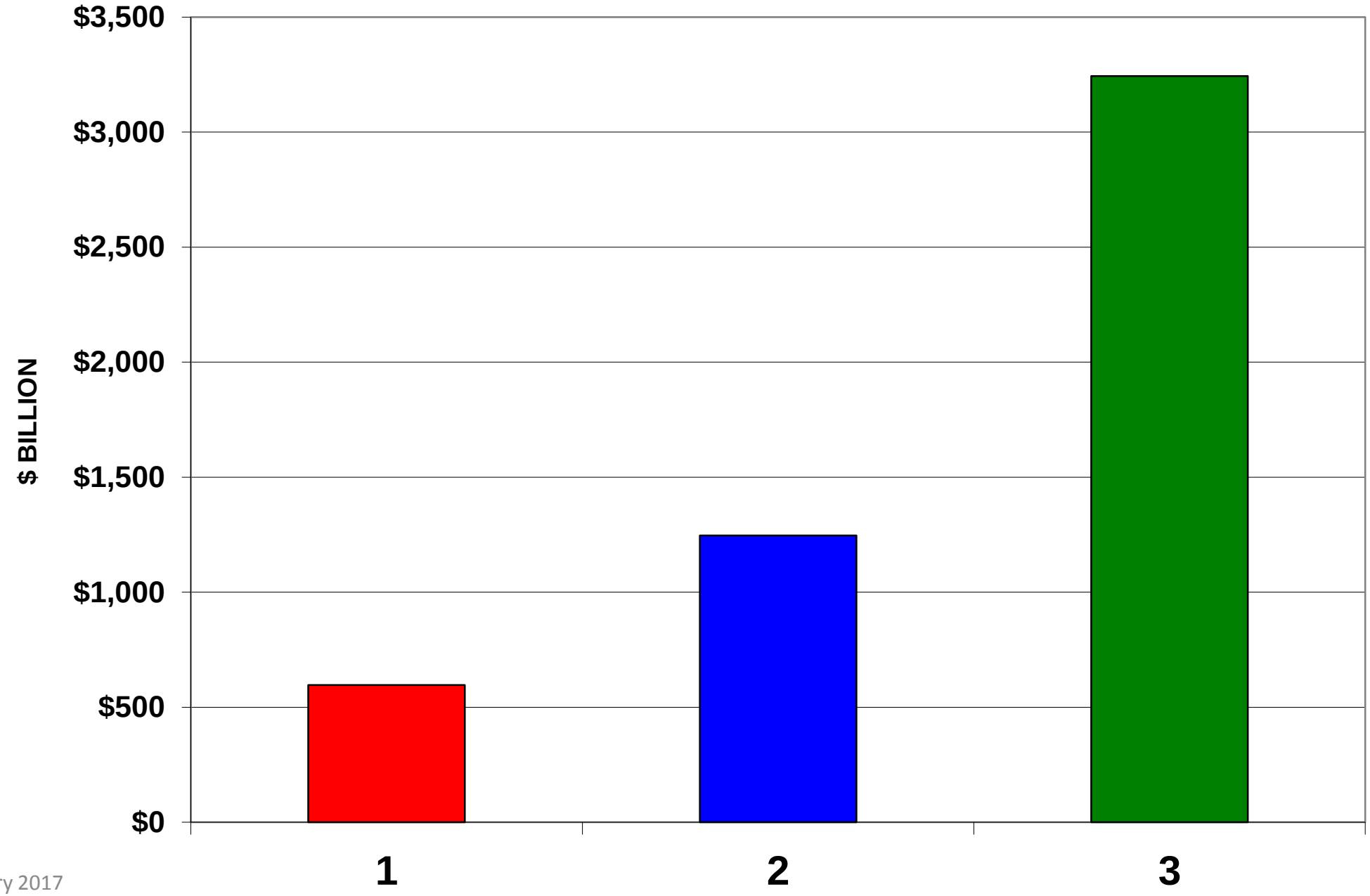
Five points

1. We already spend enough on health care
   - But badly
2. Why are health costs a big problem?
   - Bar access, particularly to mental, dental, residential, and pharmaceutical care
   - Crowd out everything else we care about
3. Lower supply of care: The mental health (+LTC) double standard
   - Parity or parody
4. Barriers to care: OOPs, debt, paperwork, narrow caregiver networks
   - Threats to security and sanity
5. Why don't we actually act to contain health costs?

Special bonus offer: Contain cost, enable access, and liberate money

Health, Education, and Defense Spending, 2015



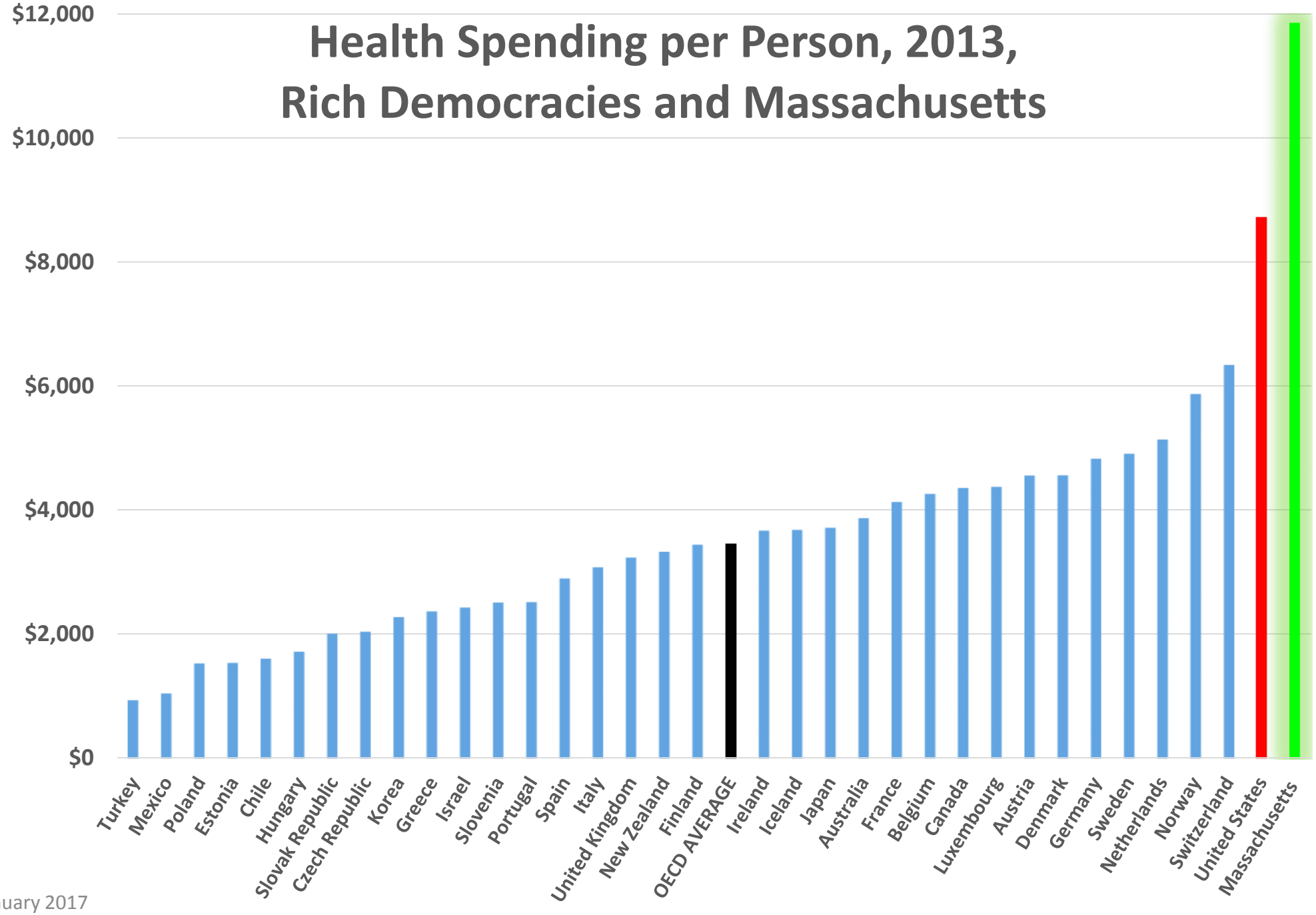
1. U.S. already spends enough on health care
Enough for what?

- To provide the care that works for all the people who need it

- Not every service that might conceivably benefit everyone
- Not enough to win immortality

- Just enough

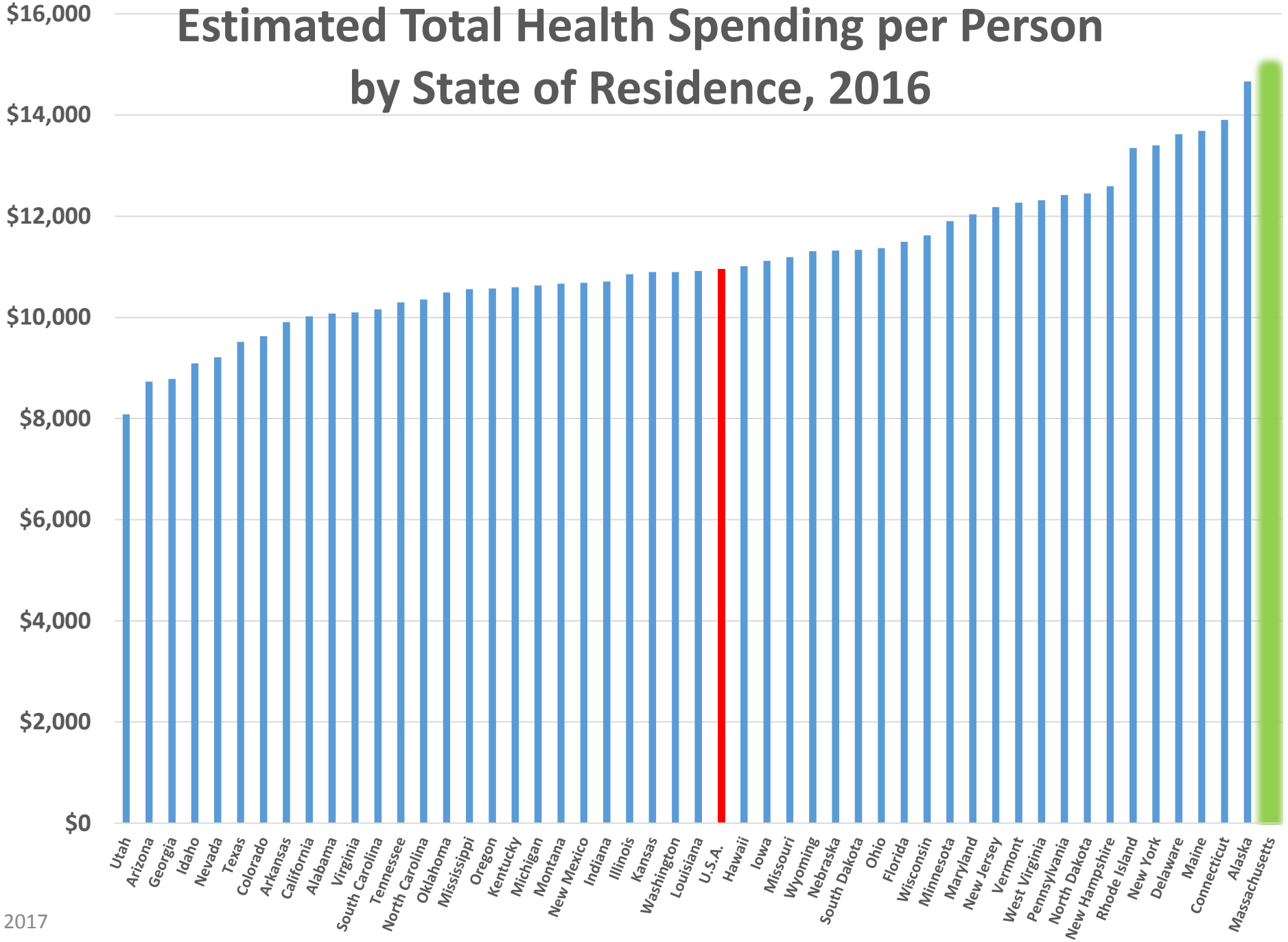
- How can we know that?


Health Spending per Person, 2013,
Rich Democracies and Massachusetts
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
Turkey
Mexico
Poland
Estonia
Chile
Hungary
Slovak Republic
Czech Republic
Korea
Greece
Israel
Slovenia
Portugal
Spain
Italy
United Kingdom
New Zealand
Finland
OECD AVERAGE
Ireland
Iceland
Japan
Australia
France
Belgium
Canada
Luxembourg
Austria
Denmark
Germany
Sweden
Netherlands
Norway
Switzerland
United States
Massachusetts

Mass. is no. 1!
(Not “among the highest”)

- Estimated Mass. statewide health spending in 2016 = $102 billion
- That’s about $15,000/person
- 36% above U.S. health spending per capita of ~ $11,000
- Spending on Mass. residents would drop by $27 billion in 2016 if we spent at the national per capita average
  - Context: total Mass. state tax revenue in SFY 2015 = $25.2 billion

Estimated Total Health Spending per Person by State of Residence, 2016



Is Massachusetts health care affordable?

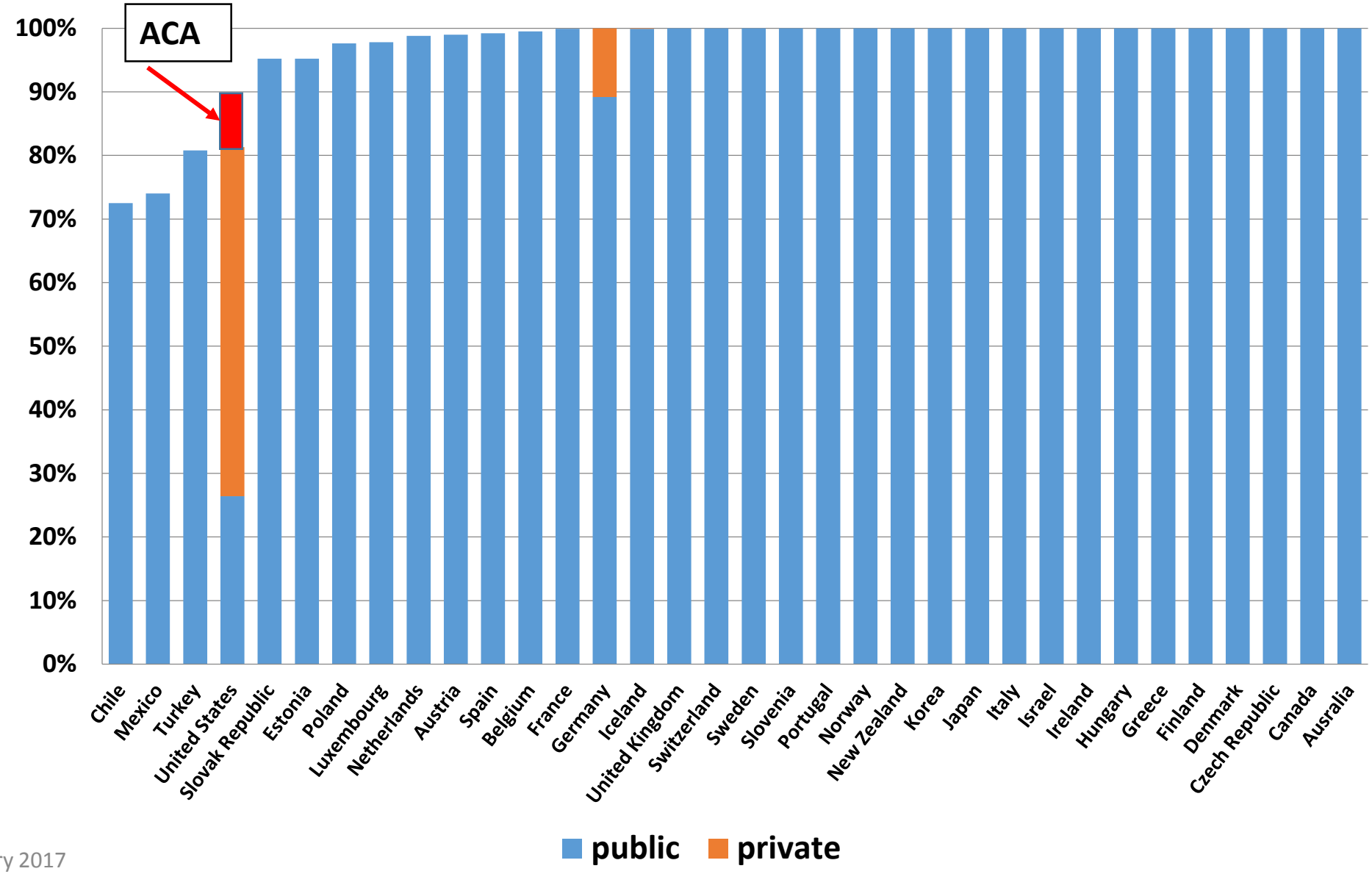
- **YES**: Torchiana cited Commonwealth Fund study using 2013 MEPS data
  - Average family health insurance premium as % median income (< 65)
    - 18% in Mass.
    - 22% nationally
- **NO**: According to CMS and BEA data for 2009,
  - Personal health spending per person on Mass. residents = 36% above U.S. mean
  - Personal income per person = 26% above U.S. mean
- **NO:** Today's covered health services sponge up money we need for everything else we care about
- **NO**: Our age-adjusted mortality rate equals Utah's, and they spend only 54 percent as much as we do per person
- **NO:** Mass. ratio of social service to health spending was lowest in U.S. in 2009

Sources: Schoen and others, "State Trends in the Cost of Employer Health Insurance Coverage, 2003-2013," Table 3B, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1798_schoen_state_trends_2003_2013.pdf. Canavan and others, "Health Care and Social Service Spending and Outcomes: How Does Massachusetts Compare with Other States?" Mass. BC/BS Foundation, May 2016, p. 5 (Executive Summary), http://bluecrossfoundation.org/sites/default/files/download/publication/HCandSS_May2016_ExecSumm_FINAL.pdf.

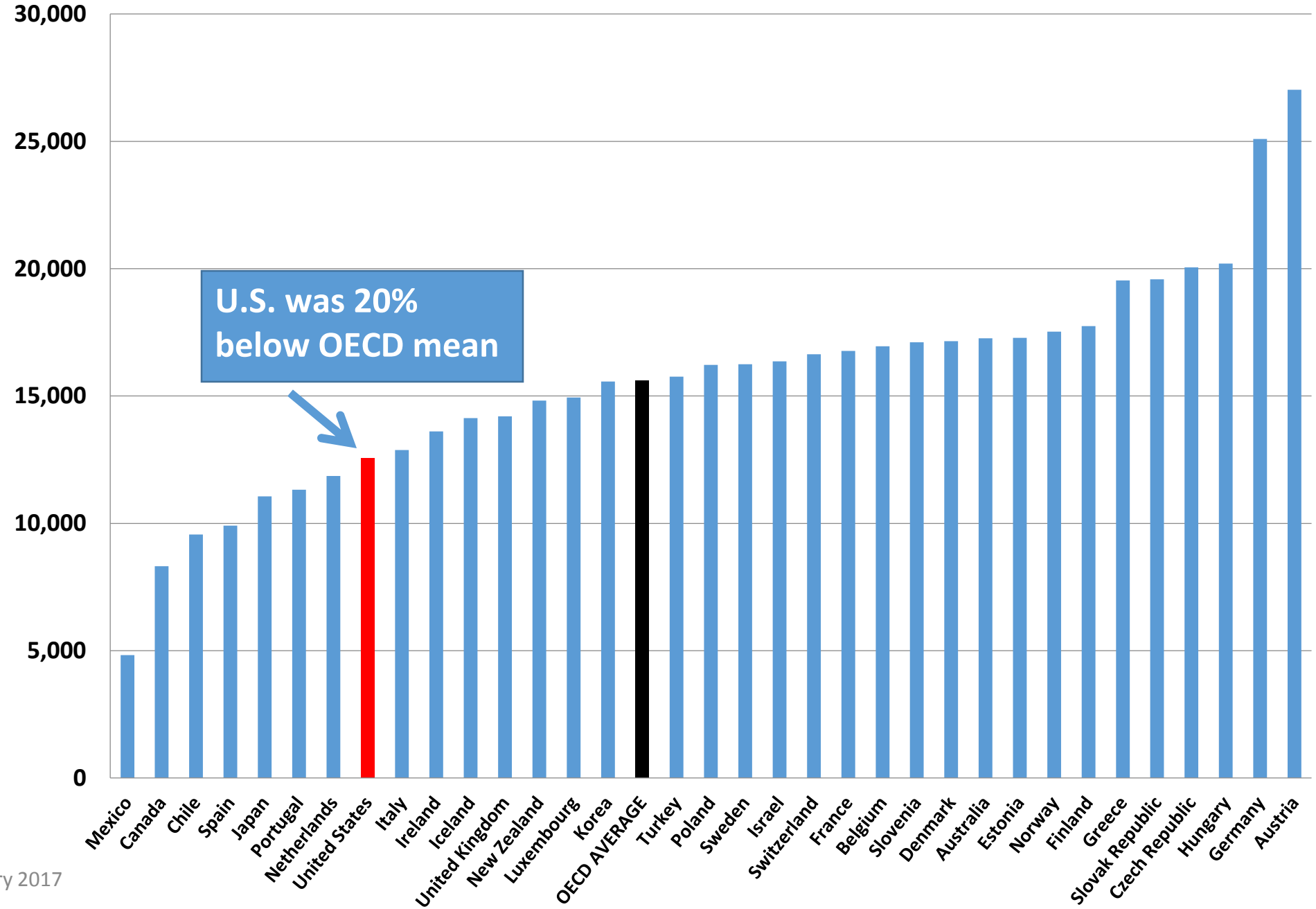
U.S. spends badly

- We don’t cover everyone
- We provide less care per person
- We waste half of what we spend

Share of People with Health Insurance, Rich Democracies, 2011/2015



Hospital Discharges per 100,000 People, OECD, 2012 or Nearest



Doctor Consultations per Capita, 2011 (or Nearest)

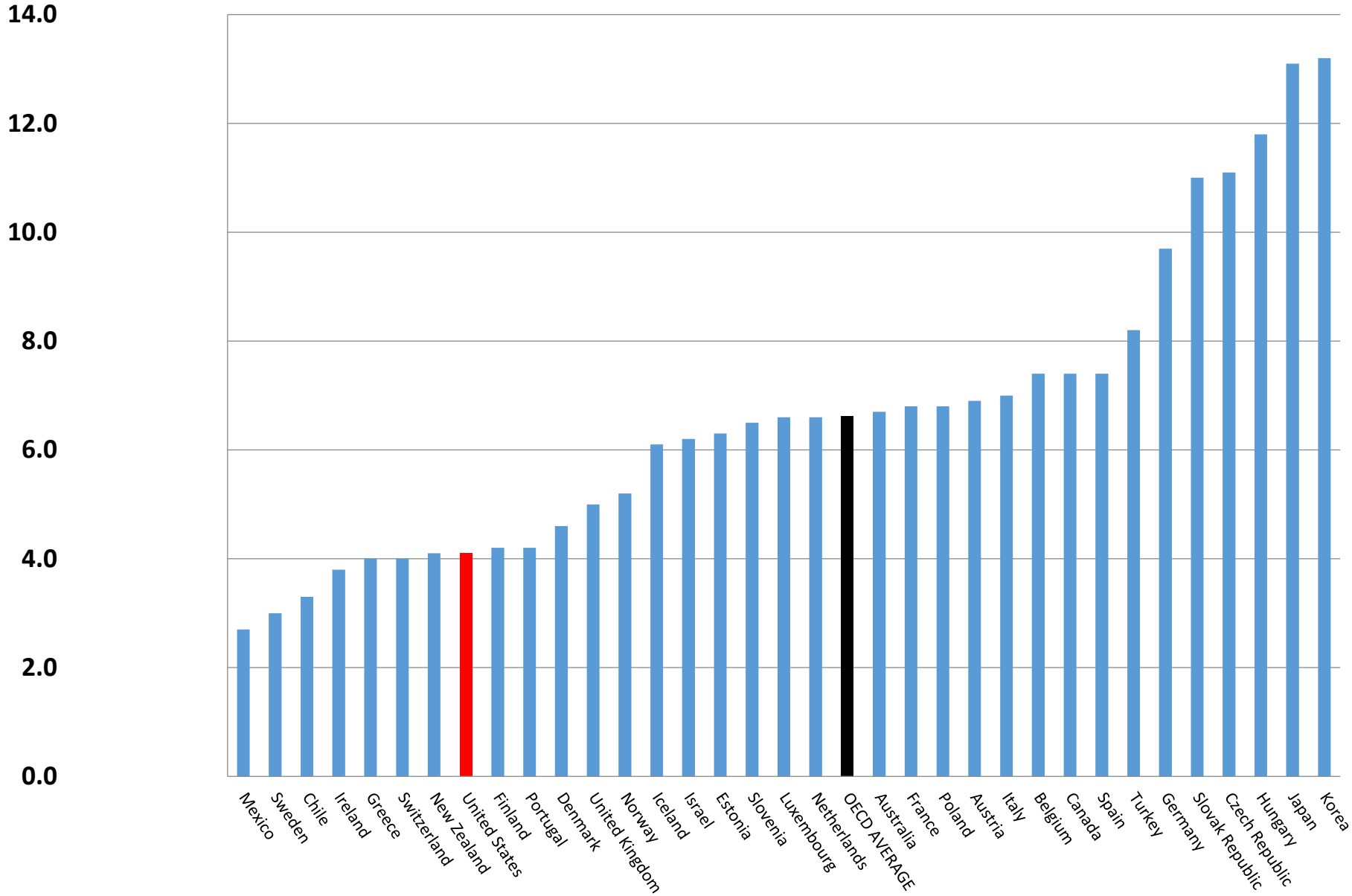
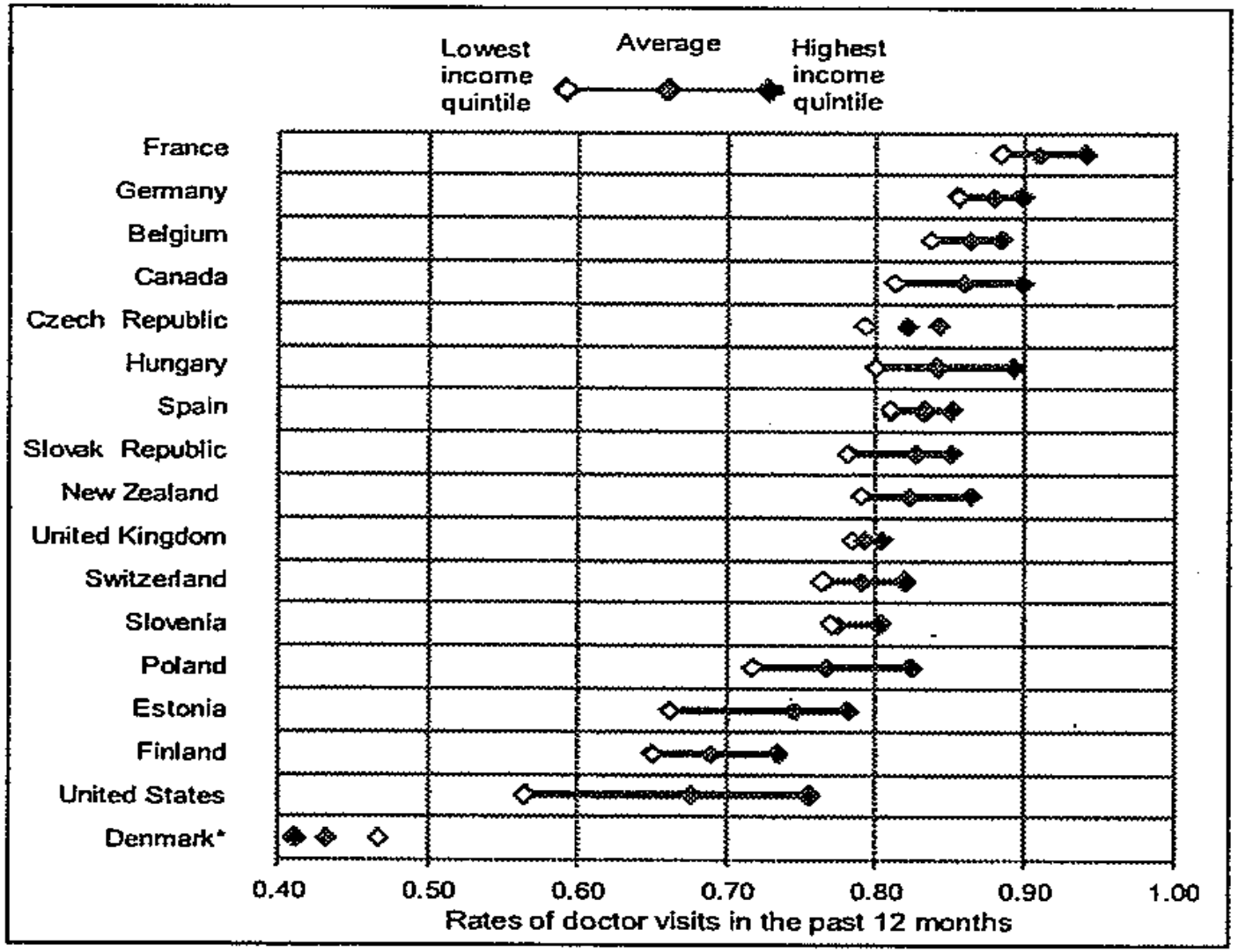


Figure: Needs-adjusted Probability of a Doctor Visit in Last 12 Months, by Income Quartile, 2009 (or latest year)



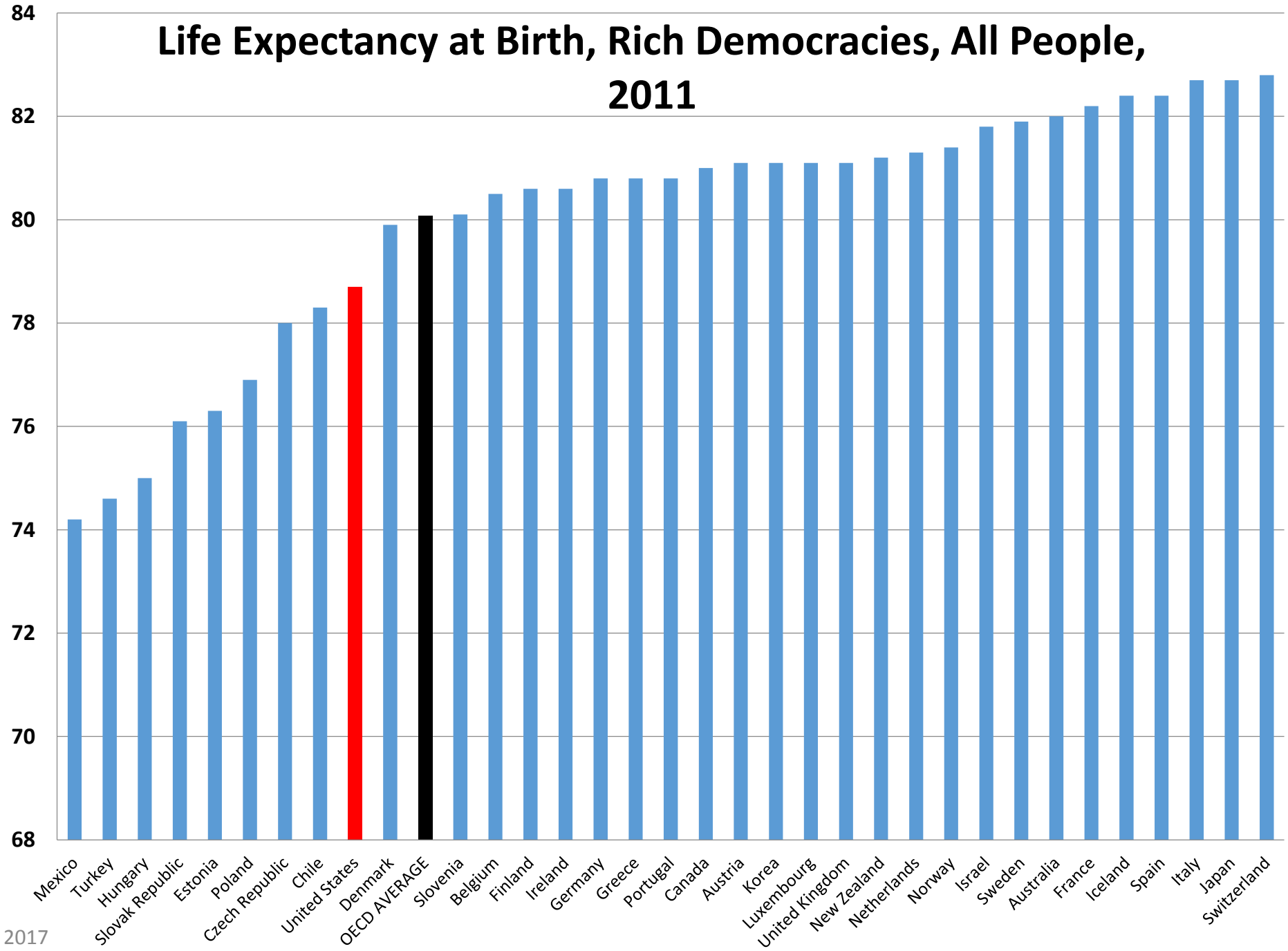
Note: Denmark reports three months of data only.

Source: Marion Devaux and Michael de Looper, *Income-related Inequalities in Health Services Utilisation in 19 OECD Countries, 2008-2009,* OECD Working Papers, No. 58, 2012, p. 17.

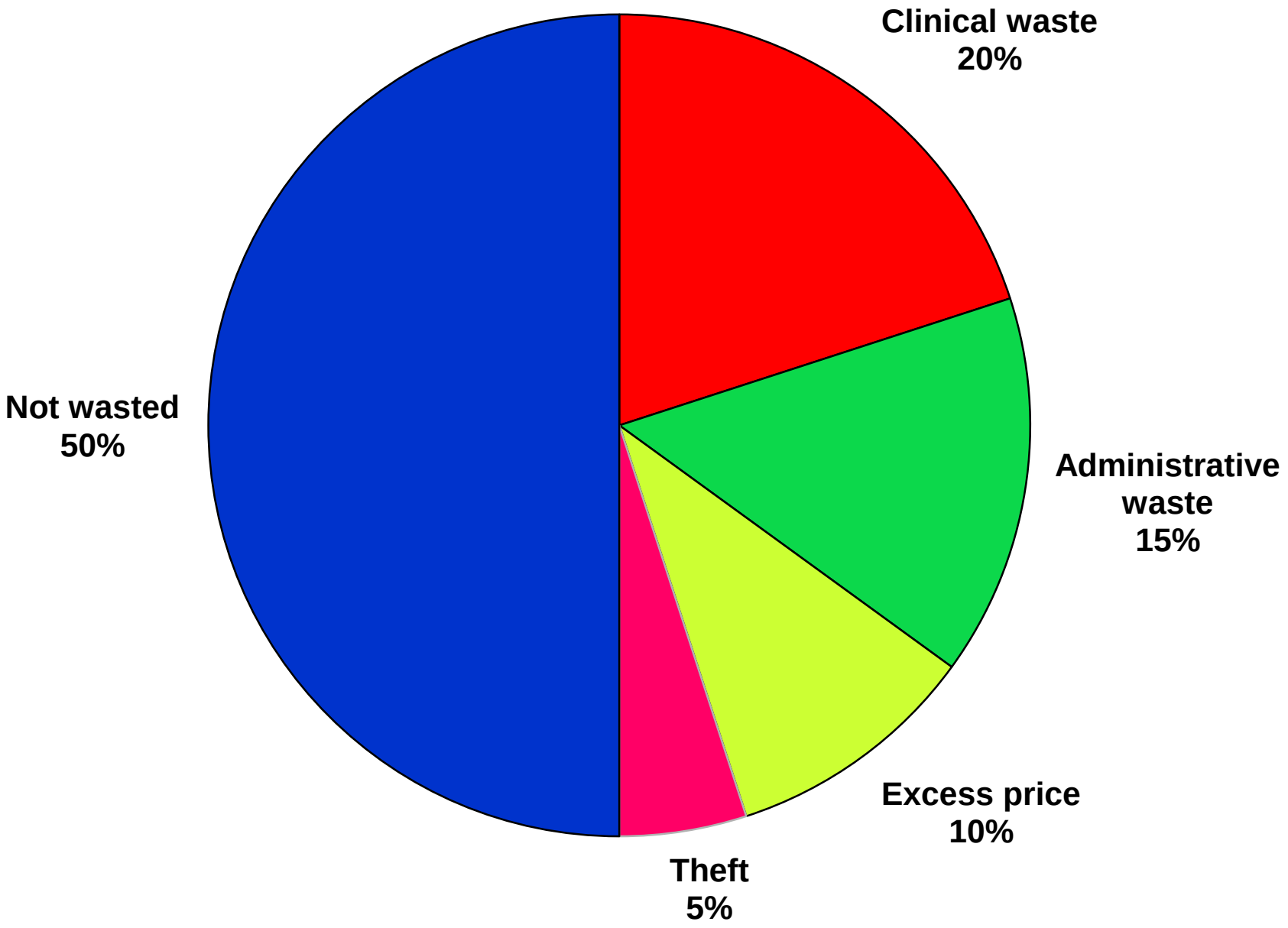
U.S. – OECD PCPs/1,000 People

	U.S.	OECD – 30-nation median
Practicing physicians/ 1,000 people	2.6	3.3
Share in primary care	1/3	1/2
PCPs / 1,000 people	**0.87**	**1.65**
→ Non-PCPs/1,000 people	**1.73**	**1.65**

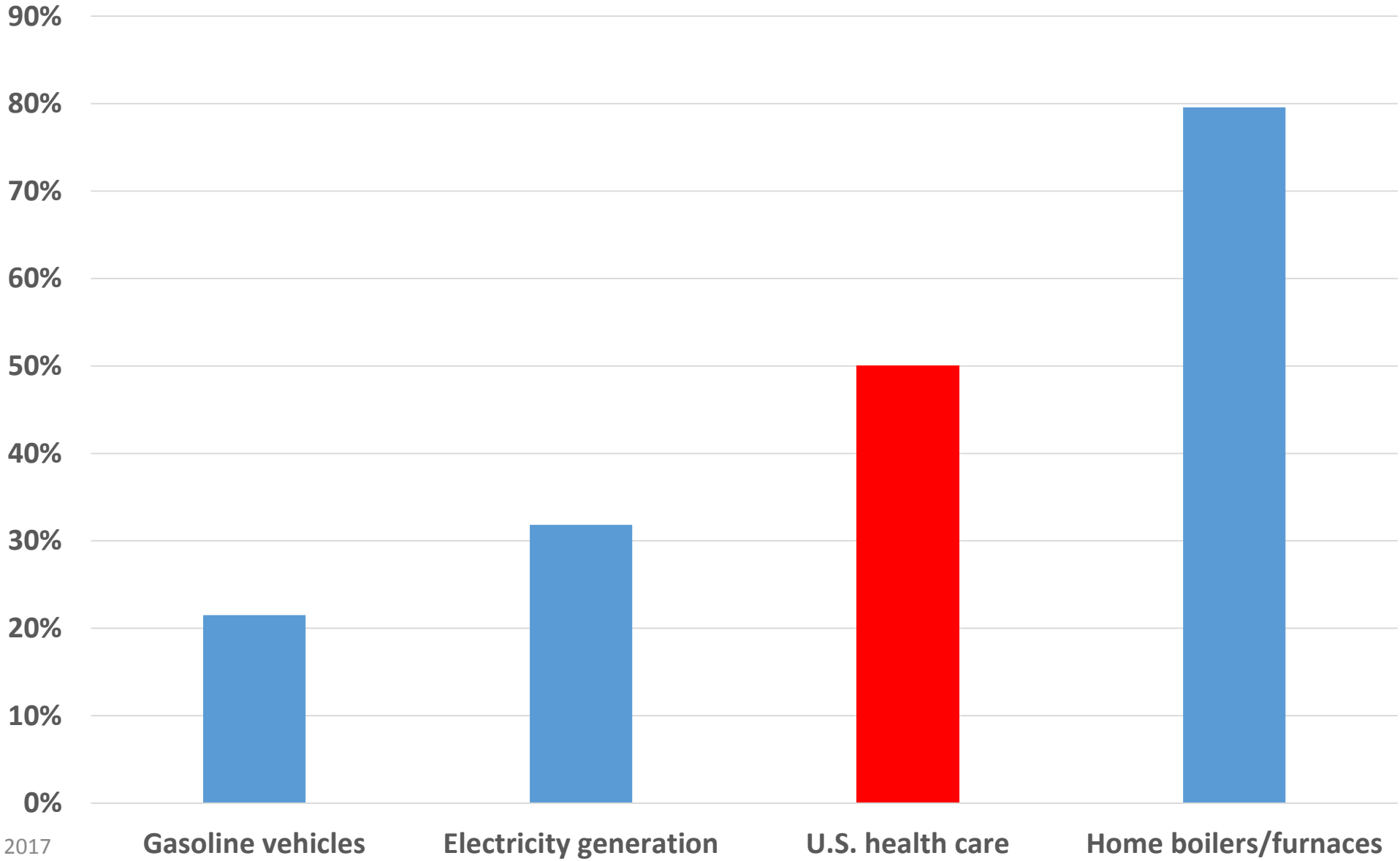
Source: OECD, Frequently Requested Health Data, October 2012, http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm; Health United States, 2011; and various estimates of PCP share in other nations.


Life Expectancy at Birth, Rich Democracies, All People, 2011
84
82
80
78
76
74
72
70
68
Mexico
Turkey
Hungary
Slovak Republic
Estonia
Poland
Czech Republic
Chile
United States
Denmark
OECD AVERAGE
Slovenia
Belgium
Finland
Ireland
Germany
Greece
Portugal
Canada
Austria
Korea
Luxembourg
United Kingdom
New Zealand
Netherlands
Norway
Israel
Sweden
Australia
France
Iceland
Spain
Italy
Japan
Switzerland

Types of U.S. Health Care Waste



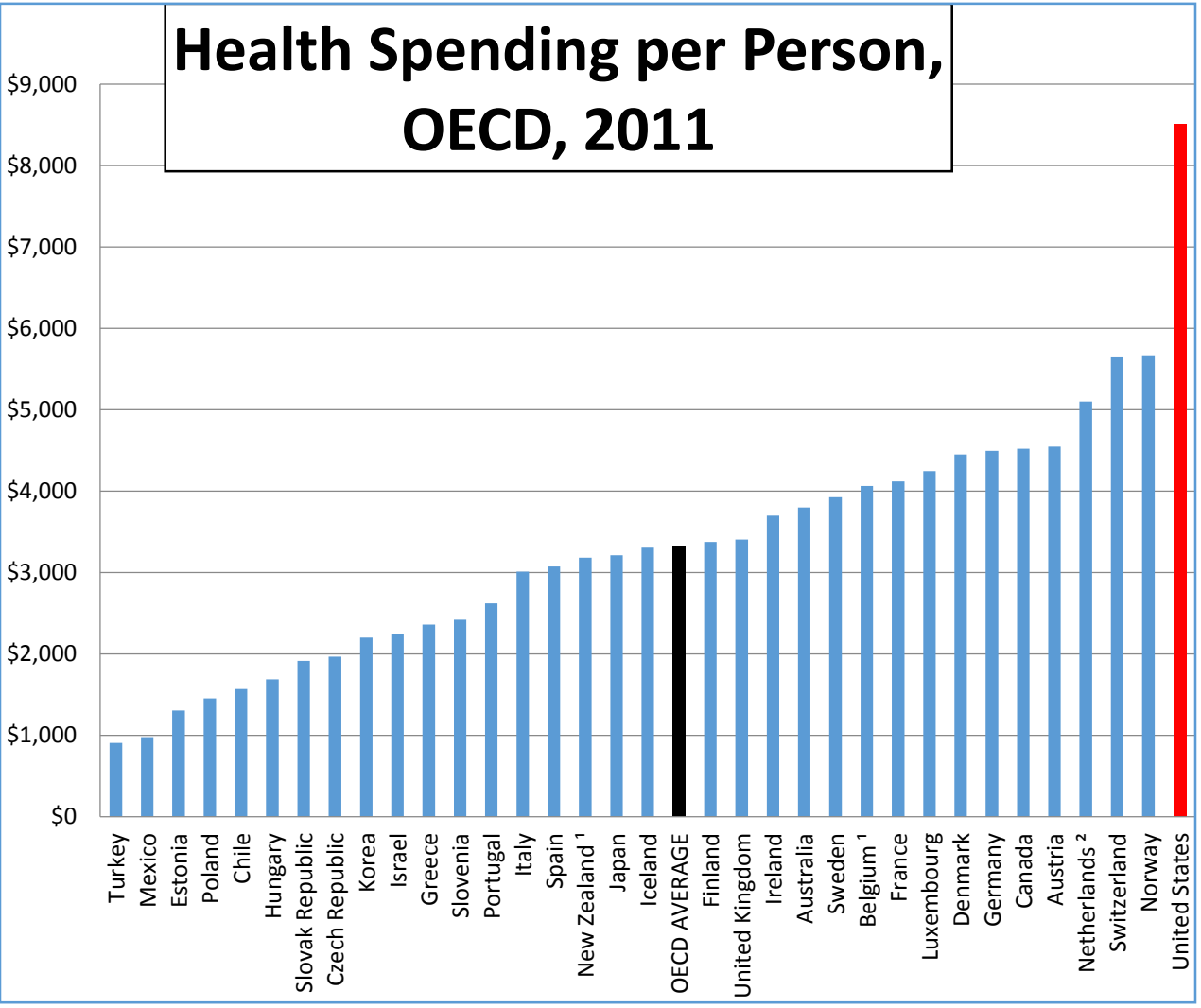
Efficiency: Autos, Electricity Generation, U.S. Health Care, and Home Boilers, ca. 2014

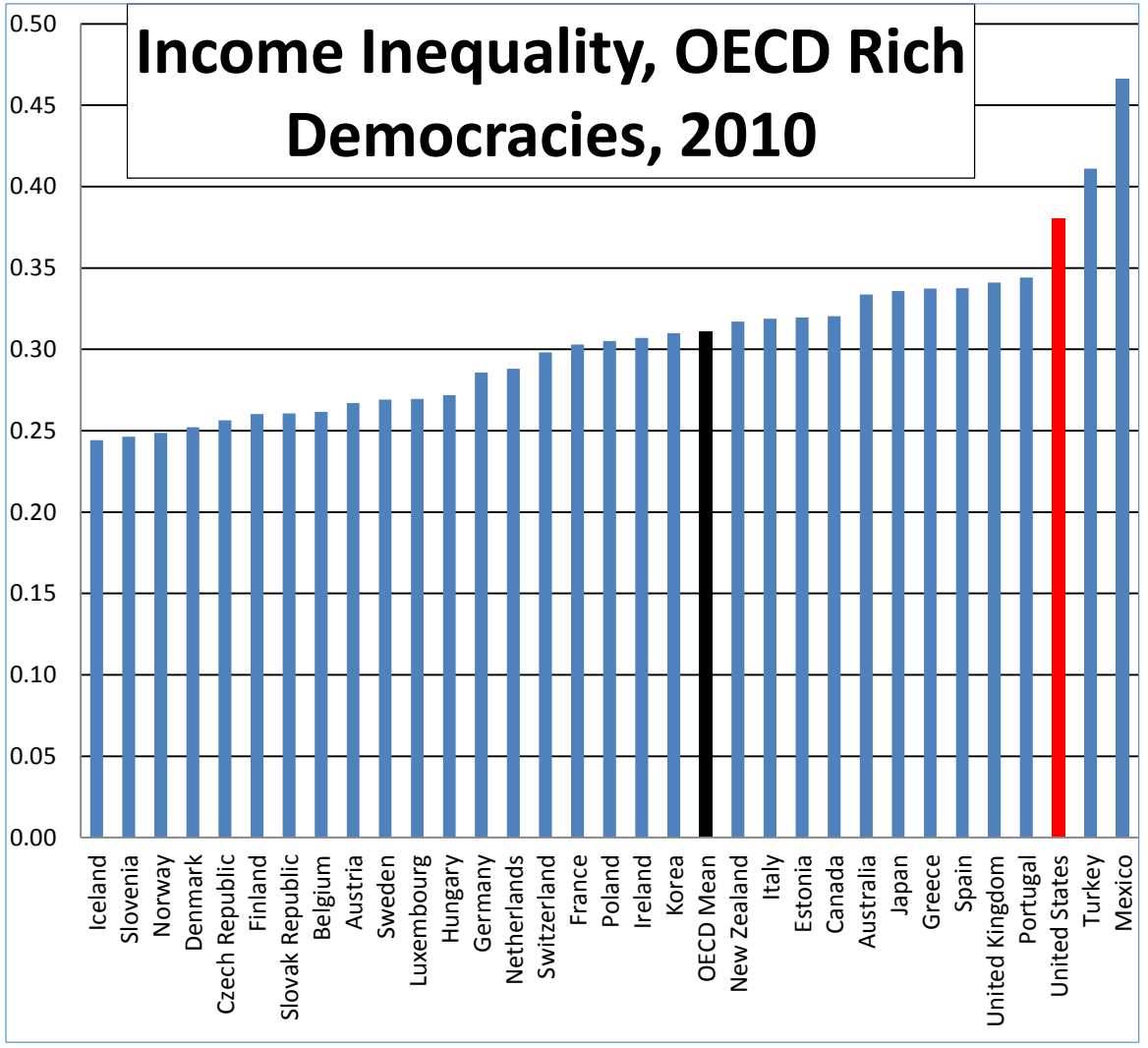


2. Why are high health costs a big problem?

a. Make it expensive and politically hard to cover all people
b. Make it expensive and politically hard to cover all types of needed care
c. Sponge up dollars needed to improve
   - Education and job training
   - Housing
   - Nutrition
   - Infrastructure
   - Environment
   - Criminal justice
   - Everything else you care about

A financially and politically toxic mix

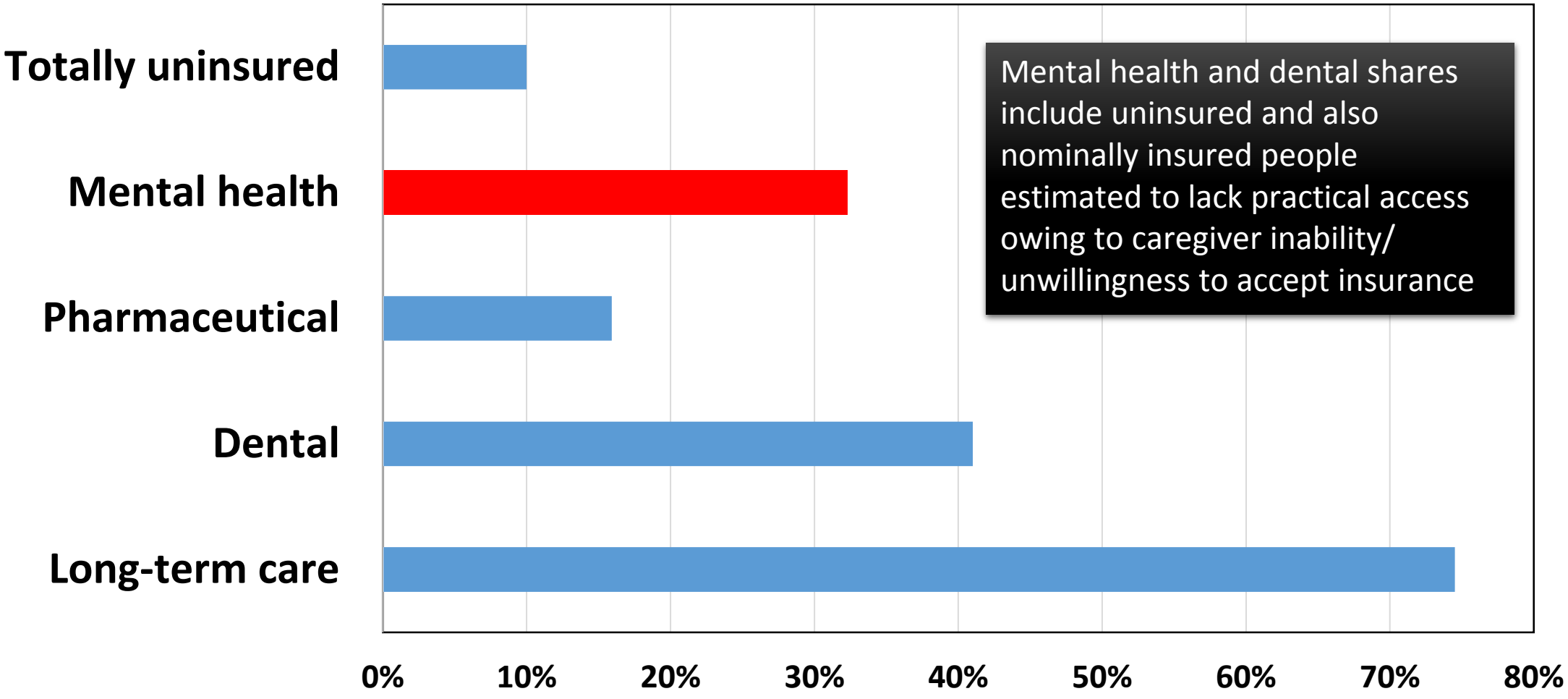





LEAD TRUCK

Estimated Shares of Americans Lacking Insurance Coverage, 2015

High Health Costs Block Coverage for Many Services



3. Less care
Double standard for mental health (and LTC)

a. Lack of coverage or inferior coverage

b. Why?

   i. Fear that good coverage would be expensive—stemming from
      - High cost per day – require lots of help from other people
      - For many people in need
      - For a long time – chronicity
        - Dramatic improvements notionally less frequent than in acute care
      - Putatively weak measures of outcomes

   ii. Lower prestige and influence of both patients and caregivers, stigma/denial

c. Resulting in
   - Ongoing coverage discrimination
   - Demand that innovations be proven <u>both better and cheaper</u>

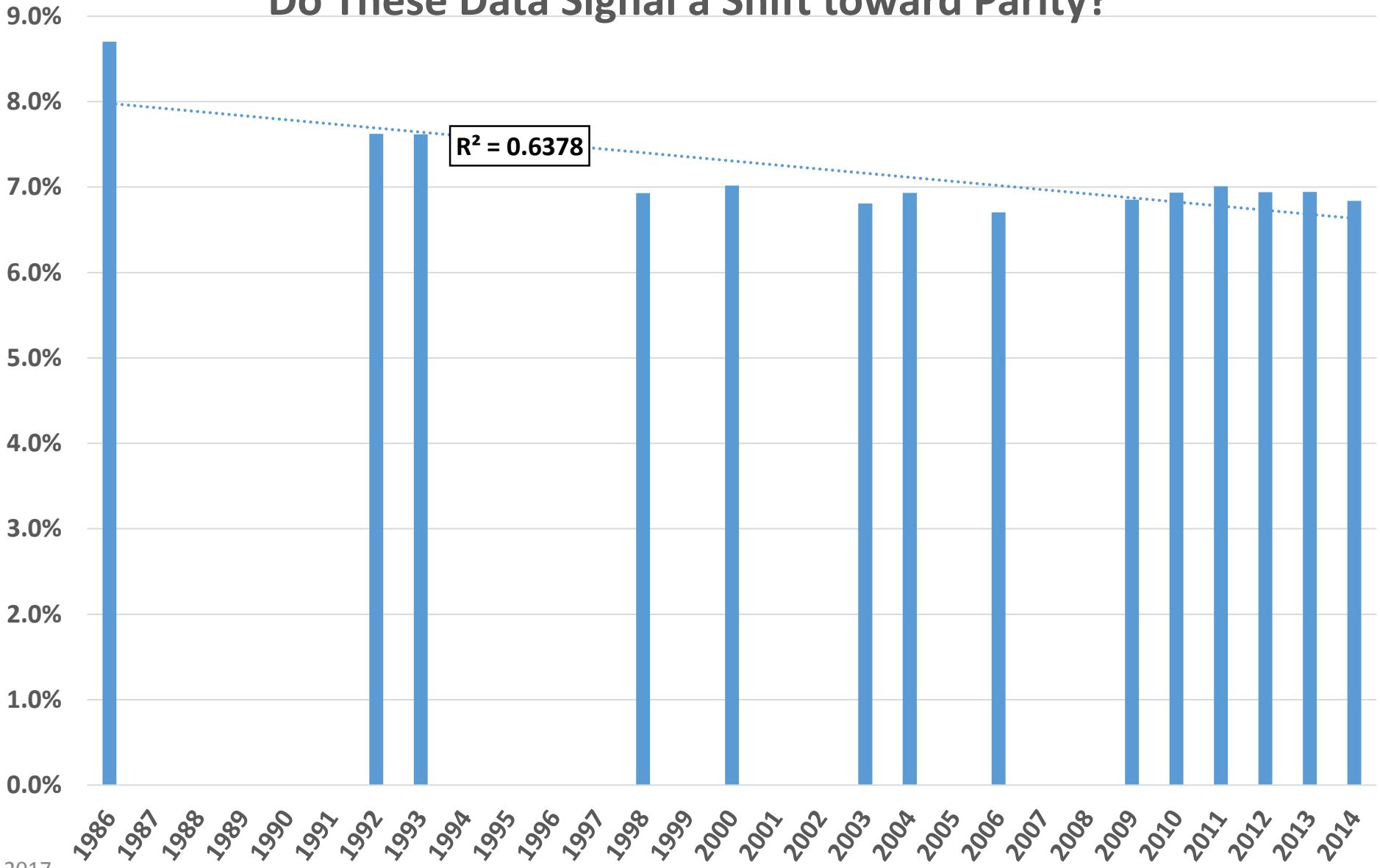
Parity or parody?

Year	Action	Result
1961	Pres. Kennedy asks FEHBP parity	Fitfully implemented, cut back heavily in 1981
1970s 1980s	States enact minimum benefit laws for alcoholism (38 states), drug use(25), mental health (18)	
1996	MH Parity Act – same annual, lifetime dollar caps as med-surg care for groups > 50 workers	Employers/insurers limited MH hospital days, outpatient visits
2006	37 states have some MH parity law	Highly variable in breadth, enforcement; ERISA exempts self-insured employers
2008	Wellstone-Domenici Mental Health Parity and Addiction Equity Act, P.L. 110-343	Did not mandate MH benefits; expected to boost insurance premiums by 0.4 percent ($25B) over 10 years

Source: Abstracted from Barry, Huskamp, and Goldman, "A Political History of Federal Mental Health and Addiction Insurance Policy," *Milbank Quarterly:* 2010; 88(3):404-433.

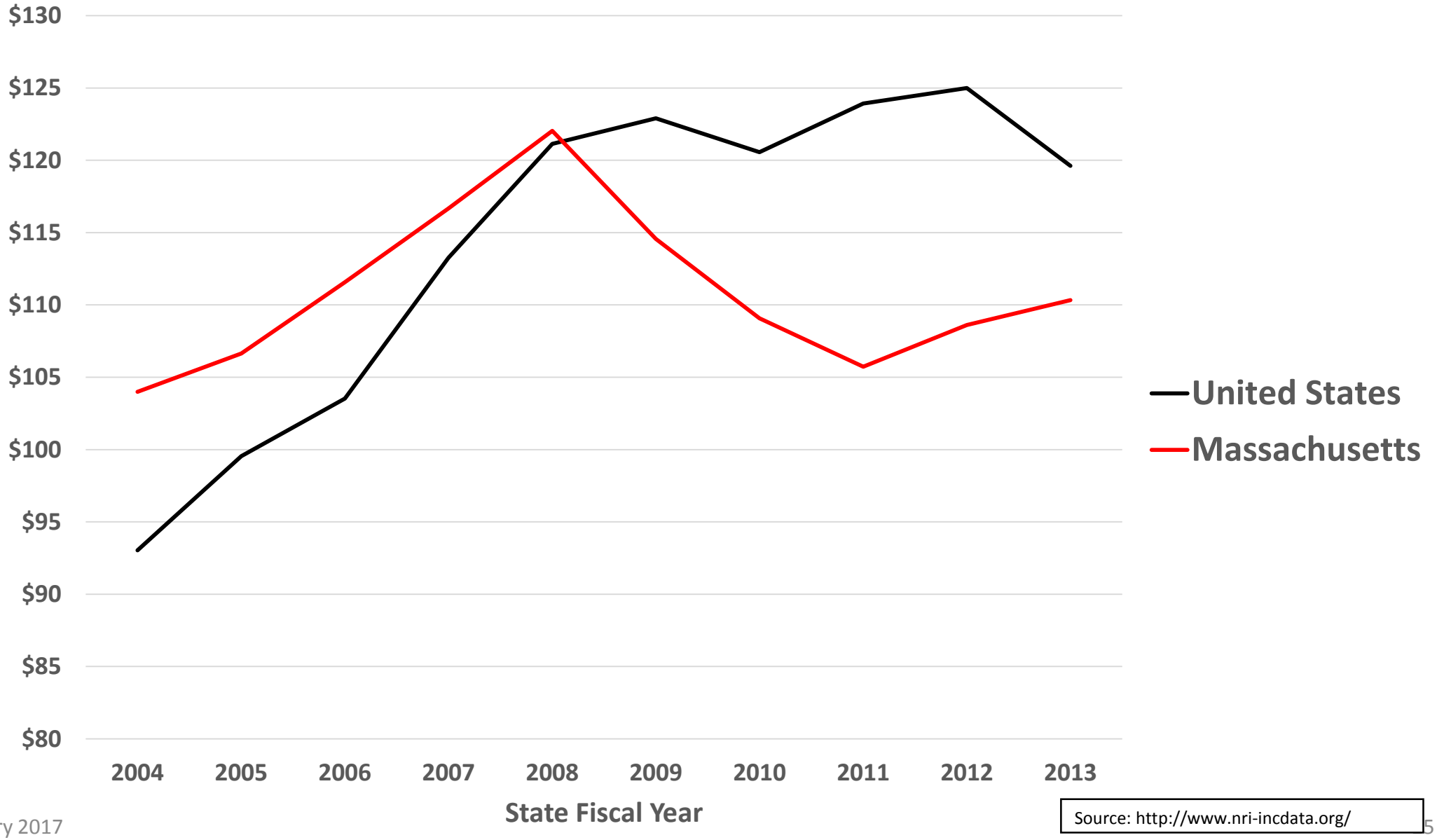
Mental Health and Substance Abuse Spending as a Share of National Health Expenditures, 1986 -2014

Do These Data Signal a Shift toward Parity?



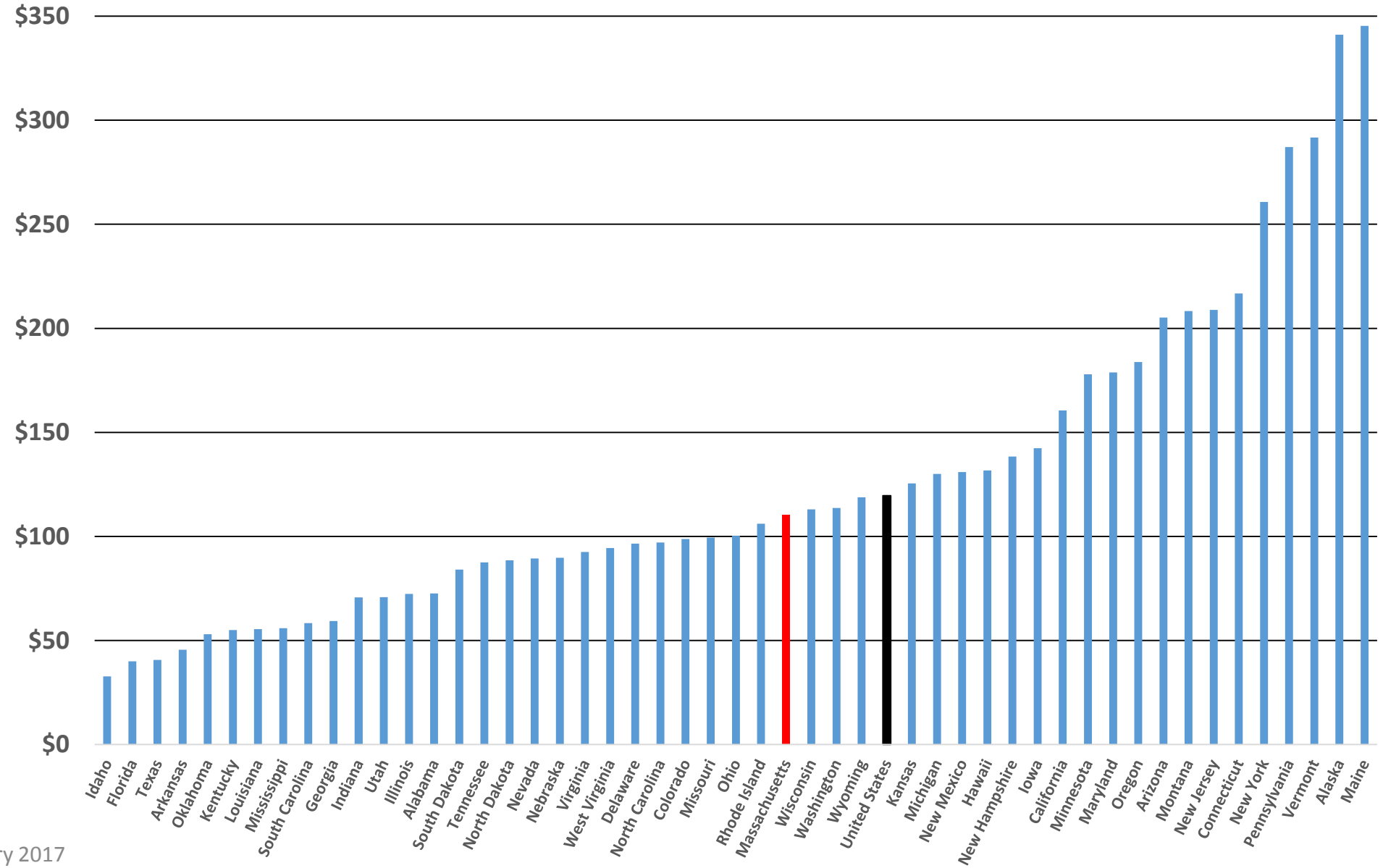
Sources: SAMHSA, Estimates 1986-2009, Projections 2004-2014, Projections 2010-2020; Mark and others, 2014.

U.S. Average and Massachusetts Mental Health Agency per Capita Spending, 2004-2013



Source: http://www.nri-incdata.org/

State Mental Health Agency per Capita Spending, SFY 2013



4. Barriers: OOPs, debt, paperwork, and other threats to security and sanity

Medical security

- Count on competent, appropriate, kind, and timely care
- Unafraid of medical debt or bankruptcy or losing insurance coverage

Driving us crazy

- Why is U.S. tops in paperwork and narrow caregiver networks
- And very high in out-of-pocket cost and medical debt/bankruptcy?

Complexity/administrative waste for caregivers

a. Complexity associated with multiple payers and their different
   - Payments for the same care
   - Rules for referrals and other private regulations of care
   - Formularies, step therapy, and other Rx regulations
   - Forms and data requirements
   - Quality measures
b. Endemic mistrust between payers and caregivers
c. Payers' lack of accountability for adequate payment for good care
d. Gaming, manipulating, jockeying, and fraud/theft

Elements of complexity for patients

a. Establishing eligibility
b. Choosing a plan
c. Identifying covered caregivers, services, rules/procedures, forms
d. Learning OOPs
e. Individual insurers' plans differ from employer to employer
f. Over time, many or most elements can change if patient changes eligibility or network

Rising OOPs

a. From 2004 to 2014, health care payments by
   - Individuals and families rose 77%
   - Insurers rose 58%

b. Share of insured workers with high-deductible health plans rose from
   - 4% in 2006 to
   - 24% in 2015

c. Deductibles, co-insurance, and annual OOP maximums continue to rise

Sources: KFF 2015 Employer Health Benefits Survey, 22 September 2015;
Claxton and others, Payments for cost sharing increasing rapidly over time, 12 April 2016.

Six effects of higher OOPs

a. Greater financial uncertainty
   - "Am I covered? How much will I have to pay OOP?"
   - Magnified if cared for out of network and face balance billing

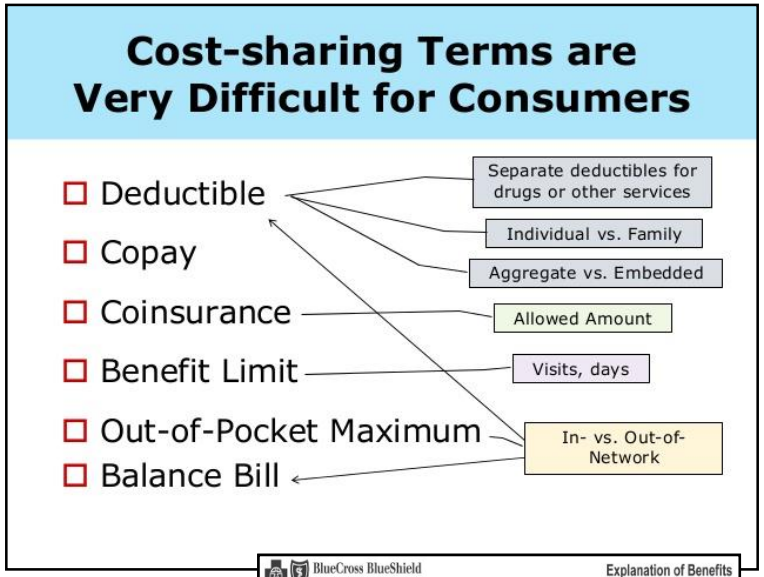
b. Individuals bear greater financial risk
   - Less financial risk is shared through insurance

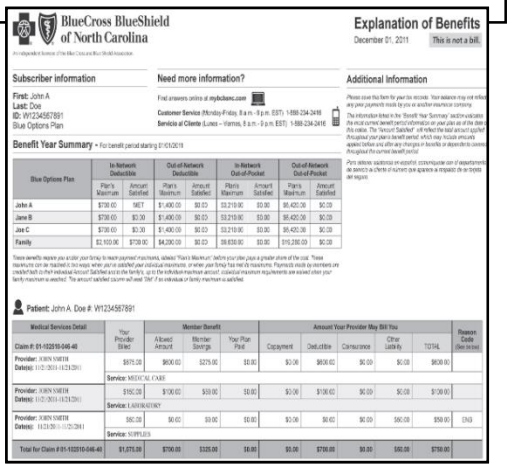
c. Sicker and older people pay more when get care

d. OOPs deter prompt care-seeking and prescription-filling
   - Many PBMs replace relatively affordable Rx co-pays with costly co-insurance

e. Especially by poor
   - OOPs are the <u>most regressive form of financing health care</u>
   - Higher OOPs compound effects of growing U.S. income inequality

f. Breaks inter-generational compact: today's older workers <u>get</u> weaker subsidies from today's younger workers than they, themselves <u>gave</u> when young

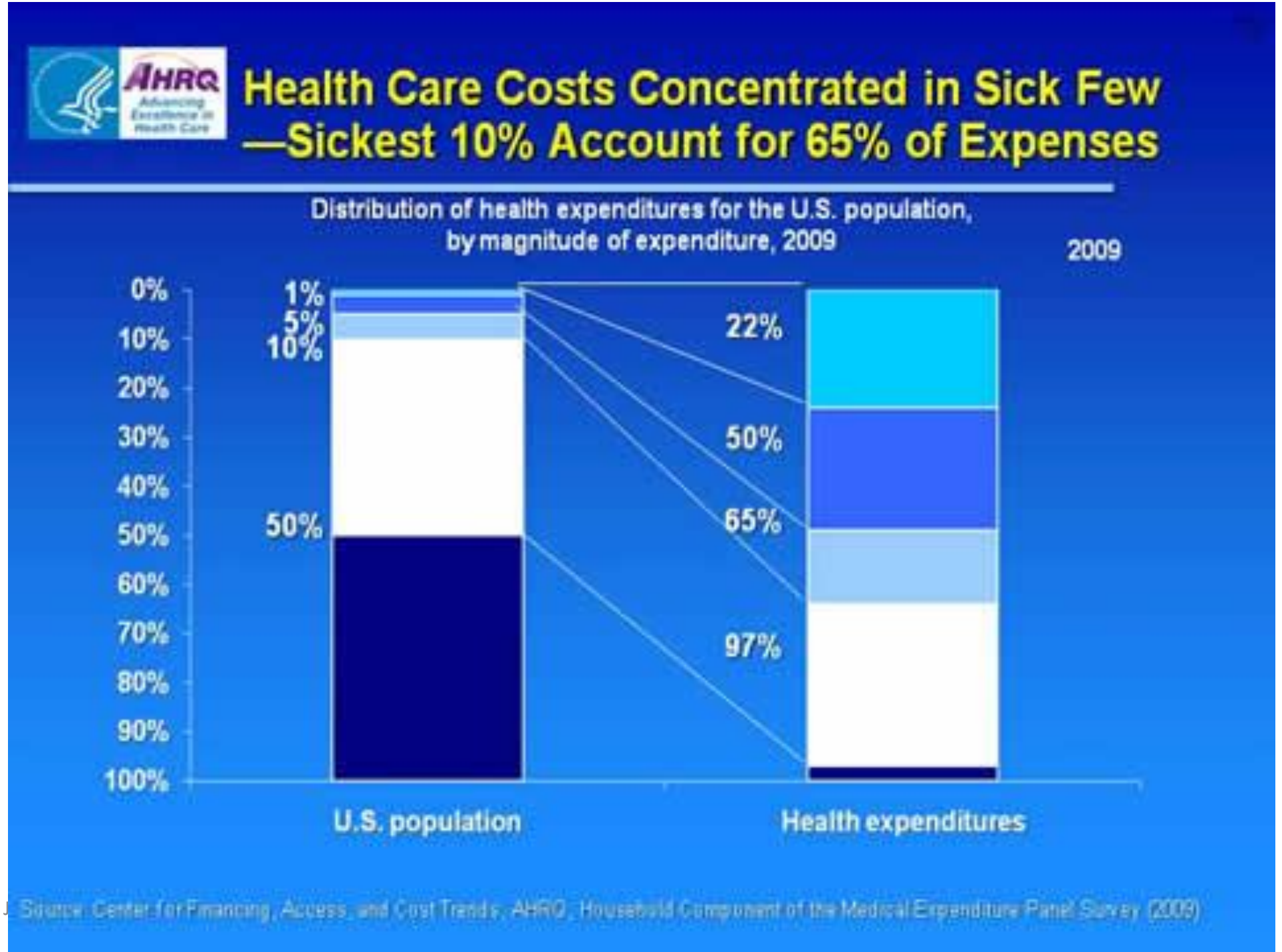




Four ways to make sense of higher OOPs

- Expediency: Allow employers to shed costs by gradually deinsuring workers
- Ideology: Worried about high U.S. health costs and failure of past efforts to control cost, many economists urge pushing health care toward free market conditions
  - Induce "consumers" to shop by price and quality
  - Therefore need "skin in the game"
- Stunted empathy: Pushers of higher OOPs can't imagine circumstances of people unable to afford higher OOPs
- Politics: In a given year, few people incur high health costs, so boosting OOPs inflicts little financial harm on most Americans

Health Care Costs Concentrated in Sick Few —Sickest 10% Account for 65% of Expenses



17 J. Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey (2009)

Remodeling human patients into consumers

Social engineering at its dumbest and most cynical

- It's only logical: Higher OOPs needed to induce humans to shop by price and quality → to cut health care costs
- Consuming requires useful data on price and quality
  - Accurate and meaningful data on price hard to obtain
  - Data on quality are even worse
  - Willingness and ability to use meaningful data are doubtful
  - Salient question = is the care needed?—not, where to buy it?
- Boosting OOPs <u>well before</u> price/quality data available

  → Higher OOPs = telling sick people to go play in traffic

5. Why don't we actually contain health costs?
a. Why are we infatuated with OOPs?

- Despite widespread worry about high costs
  - Actual political pressure to actually contain health costs is very weak
- Raising OOPs is a 2-for-1
  - Gives appearance of working to slow cost growth
  - Without actually doing so—which would upset hospitals and other caregivers
- Higher OOPs cut Medicare's, Medicaid's, and insurers' accountability to contain cost
- Employers, benefits advisors, and economists generally comfortable with higher OOPs
- OOPs harm individuals when they get sick
  - But that's OK because few people are sick each year, and aren't politically organized to resist
  - Especially low-income sick people, who are most harmed by OOPs
- Boosting OOPs magnifies anarchy in U.S. health care
  - But that's OK because high endemic anarchy makes rise in anarchy imperceptible

“Let Mikey try it”

5. Why don't we actually contain health costs?
b. Why are we infatuated with narrow networks?

- Narrow networks – a tool insurers are accustomed to using
- Insurers extract lower prices from doctors, hospitals – in short run
- Looks like a competitive tool
- Until caregivers merge
  - To shrink their need to compete and
  - To boost their leverage over insurers
- Excitement of deal-making = movement without progress
- Patients suffer reduced choice and more disruption/confusion
- Weak public efforts to assure network adequacy to protect access
  - Medicare Advantage, Medicaid, and ACA Marketplace patients

ANARCHY: Why?

1. All 6 conditions for functioning free market unattainable in health care
2. Tiny political support for competent government action to contain cost
   a. Wide mistrust of government's competence + motives
   b. Cooperation among multiple payers essential but legally difficult
   c. Hard to extricate from swamp of financial and regulatory complexity, mistrust
   d. Caregiver power
   e. Magical belief that higher health costs entail no sacrifice, no trade-offs
      - One-half of Americans covered through job
      - Most believe health insurance is warm personal gift from employer
3. Weakening professionalism and fiduciary duty: "Enrich yourselves!"

ANARCHY: How?

<u>Embrace fantasy remedies</u>

(Often good ideas but lack supporting evidence or adequate financing)

- Accountable care organization (paying for value, not volume)
  - But high volumes of care are not big source of high U.S. costs
- Reward hospitals and doctors and drug makers for quality/efficacy
- Patient-centered medical home
- Integrate primary care and behavioral health (each under-financed now)
- Medicare Advantage: higher costs via gaming risk and dodging sick
- Medicaid managed care to lay off public accountability
- Soon: Medicare vouchers to end Congress's accountability for cost

ANARCHY: So what?

No one's accountable for

a. Containing cost
b. Ensuring access for all
c. Promoting appropriate and high-quality care
d. Assuring balanced configuration of doctors, hospitals, and other caregivers

- Anything else in U.S. health care

ANARCHY: Alternatives

a. Contain costs using techniques that work in other rich democracies
   - Payers assume accountability for restricting revenue/containing costs
     - Agree on annual spending, nationally, financed by pooling all payers' revenue
   - Budgets for hospitals
   - Salaries for hospital-based doctors
   - Set fees to generate target incomes of doctors in private ambulatory practices
   - Regulate drug prices
   - Invite thieves to spend 1 year in jail for each $100,000 stolen

b. Promote patient access by insuring all, slashing OOPs, ending narrow networks, and standardizing benefits

c. Boost appropriateness by via evidence on what works and who needs it

d. Improve configuration of care by boosting pay to primary care doctors and by identifying and stabilizing all needed hospitals