

Massachusetts Health Care Financing

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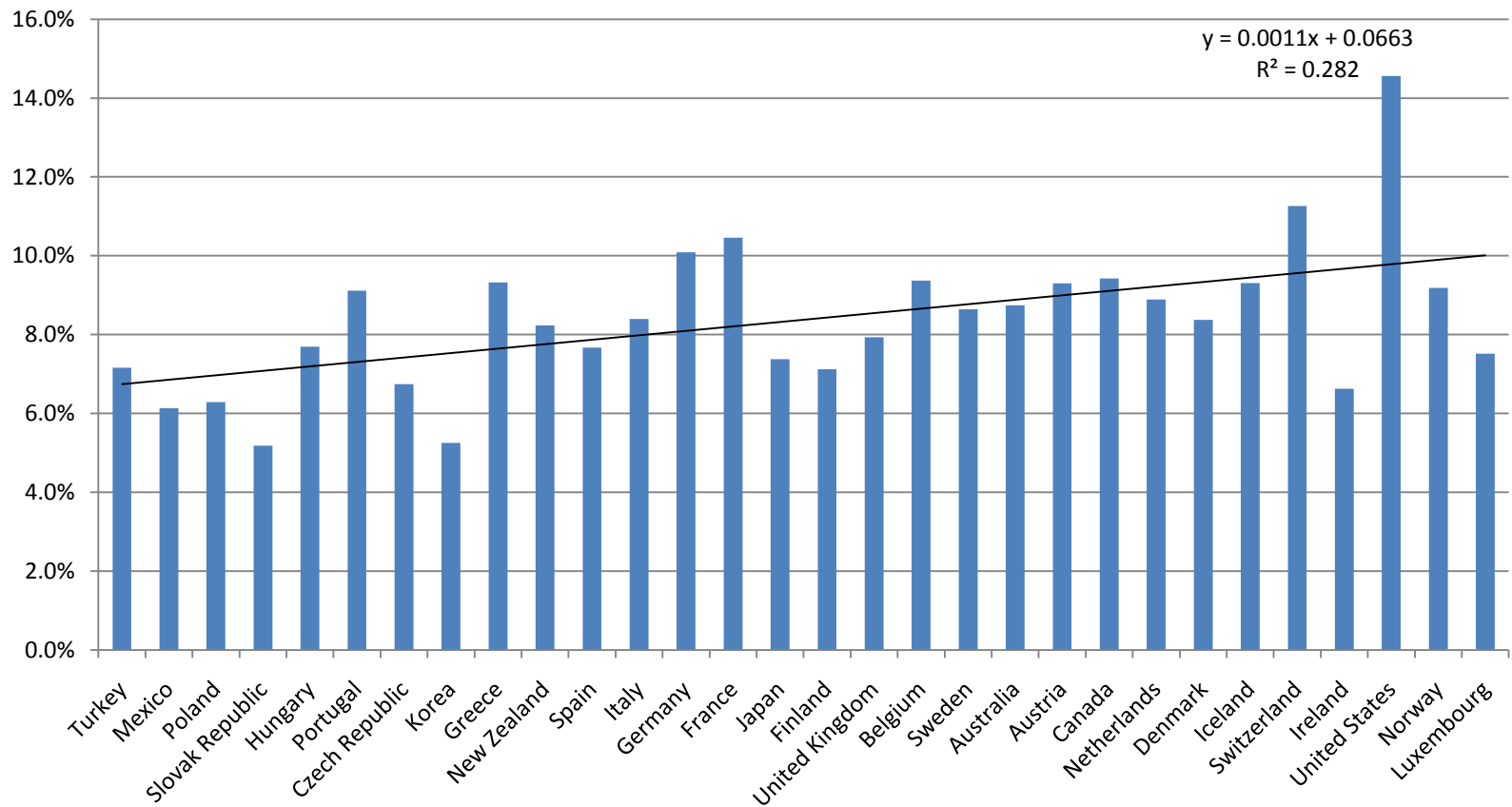
Two problems with our system of funding health care

- ***Private health care financing is increasingly expensive.***
 - Rising administrative expense.
- ***It reduces access to health care.***
 - Contributing to rising health care disparities.



We spend a lot on health care. More than any other country, rich or poor.

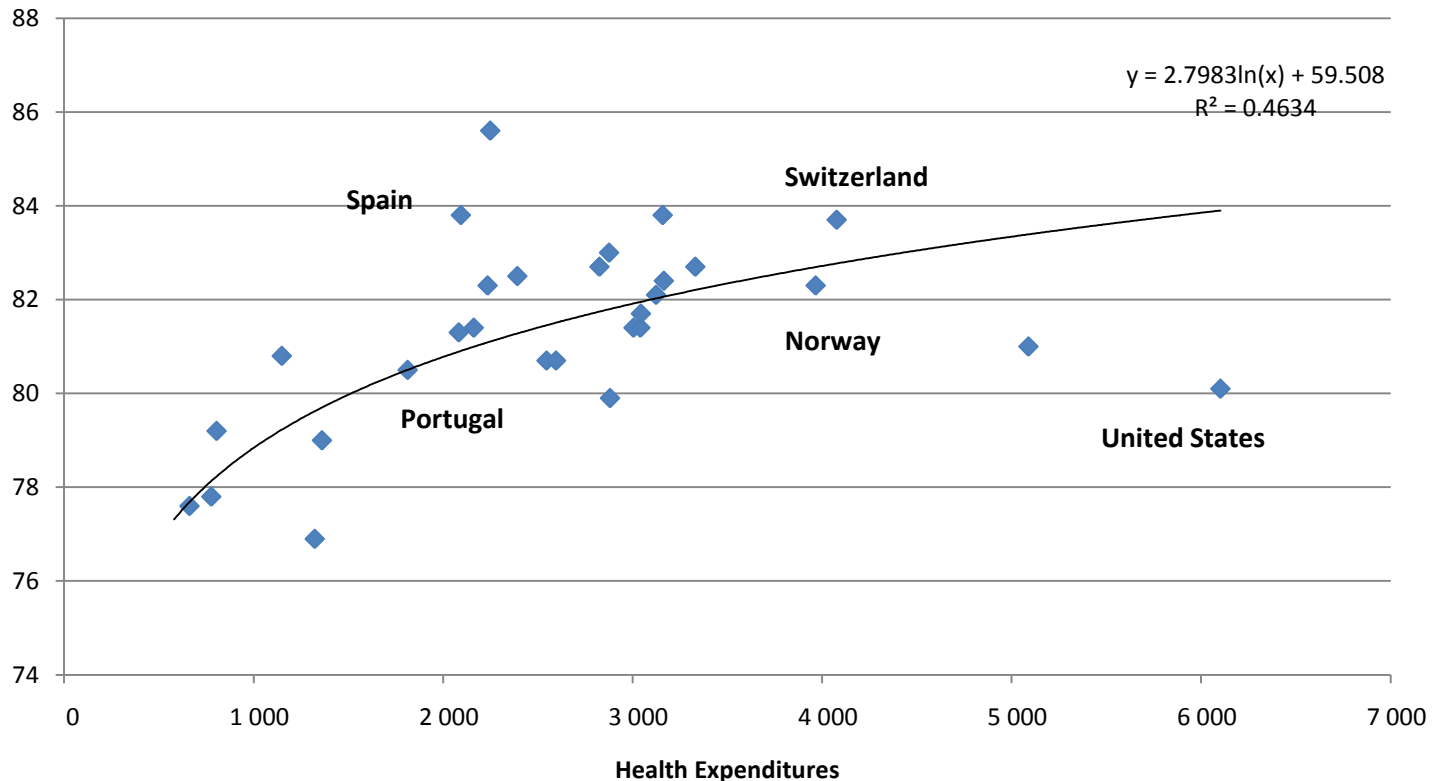
Health Spending as % of Income



If we spent the OECD average for our income, we would save over 4% of GDP or \$2000 person

We are not getting our money's worth

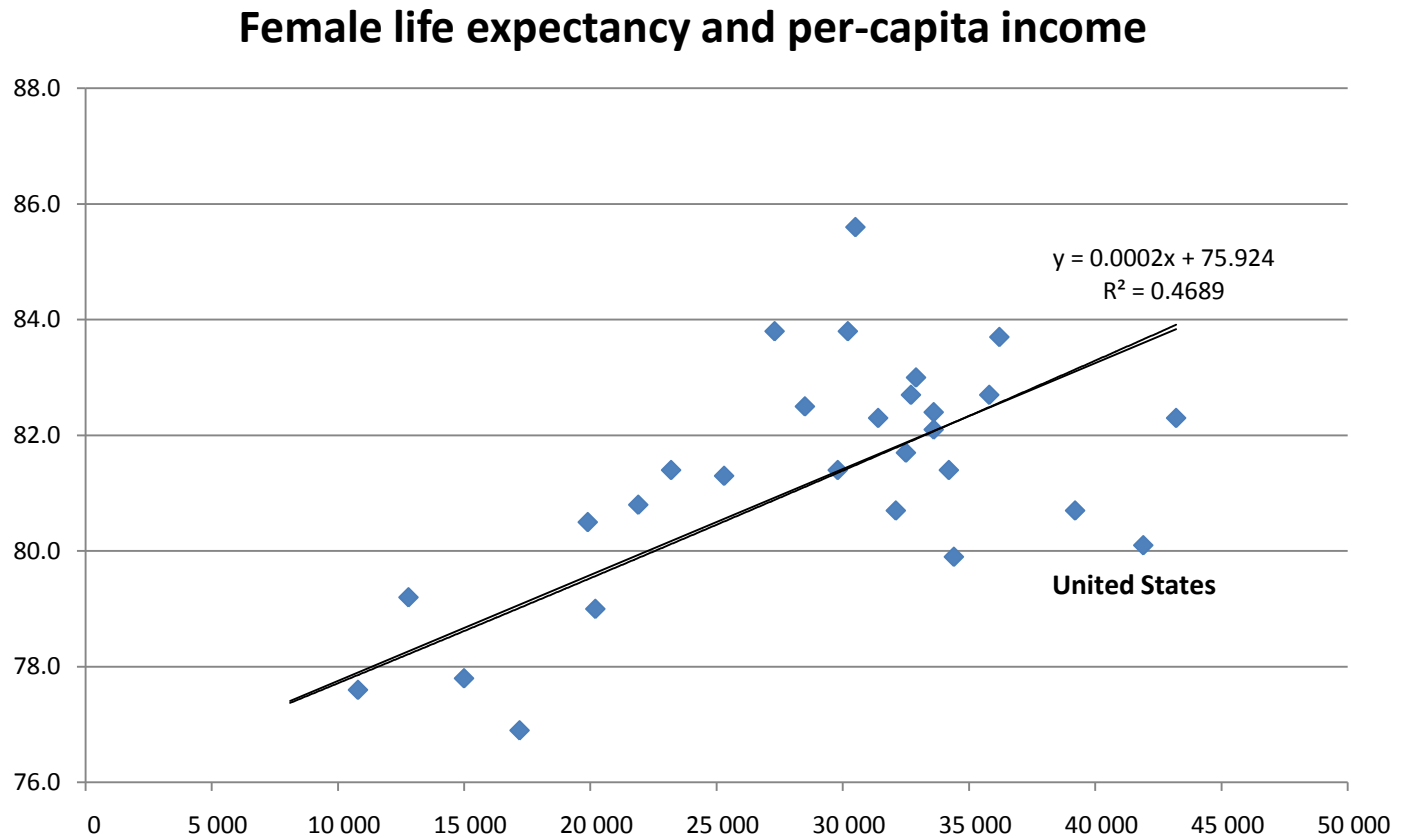
Female life expectancy and health expenditures, 2004



Results for men are the same available upon request.

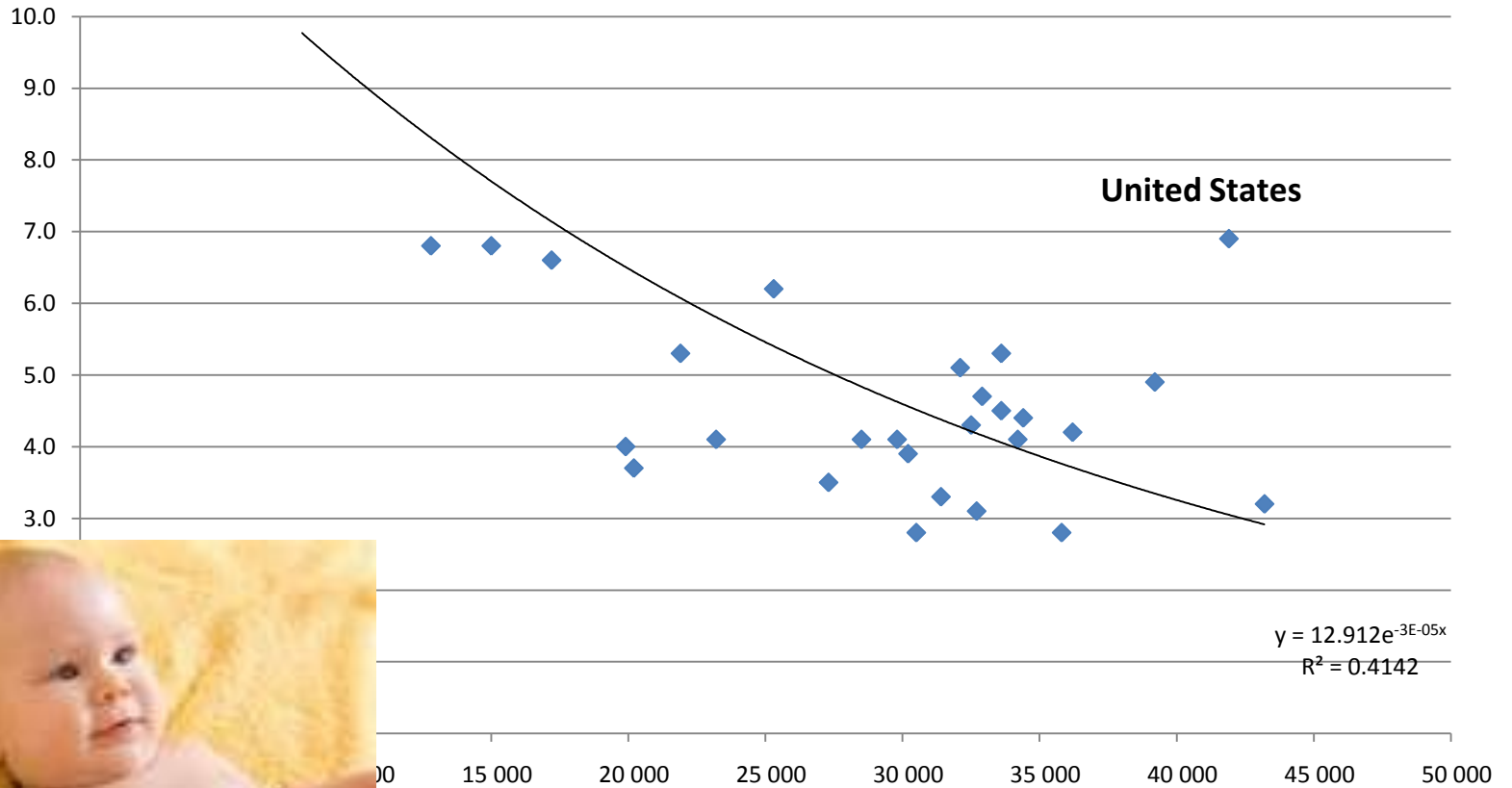
*If we had the average OECD life expectancy, we'd be buying 4 more years of life.
If we had the average OECD expenditures for our life expectancy, we'd be spending over \$4500 less per person.*

We don't live as long as we should.



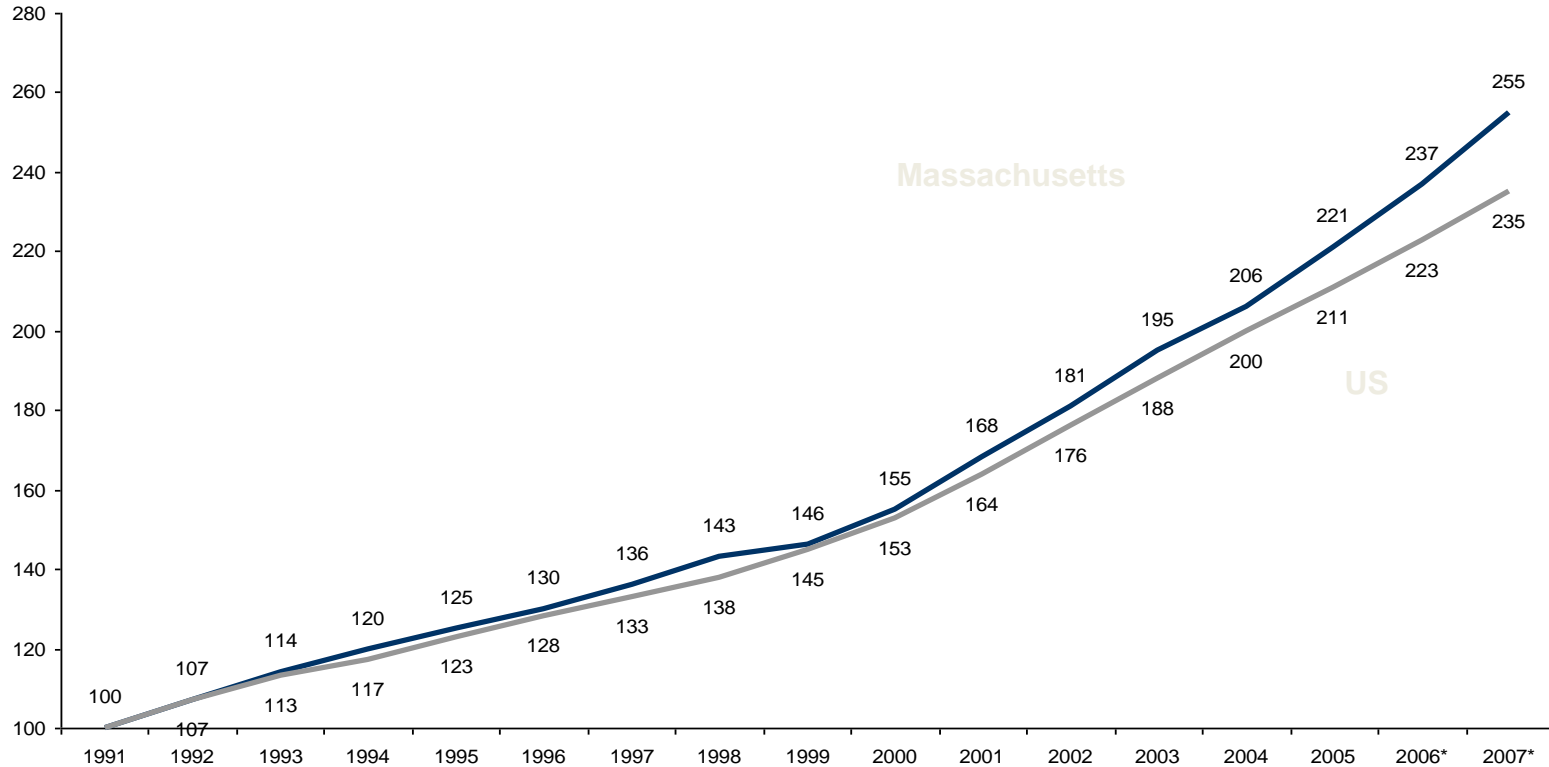
American children die too often

Infrant mortality and per-capita income



MA Per Capita Health Expenditure Trends Basically Track with US,

Index of Health Expenditures Per Capita, MA and US, 1991-2007



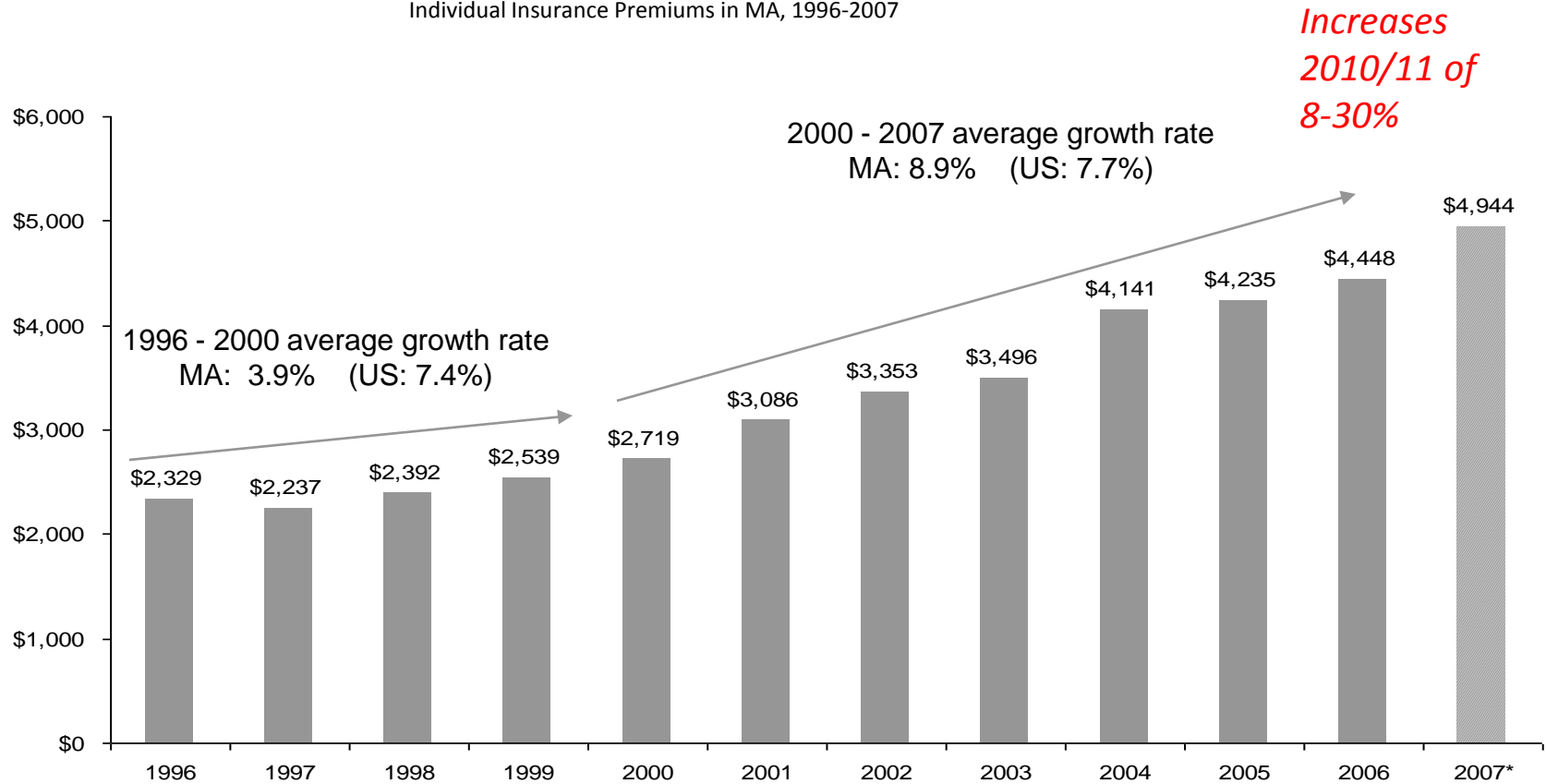
Note: The health expenditures are defined by residence location and as personal health expenditures by CMS, which exclude expenditures on administration, public health, and construction.

Source: Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, National Health Statistics Group, 2007.

*2006 and 2007 MA data are projected.

Insurance Premiums Also Began to Rise More Rapidly After 2000

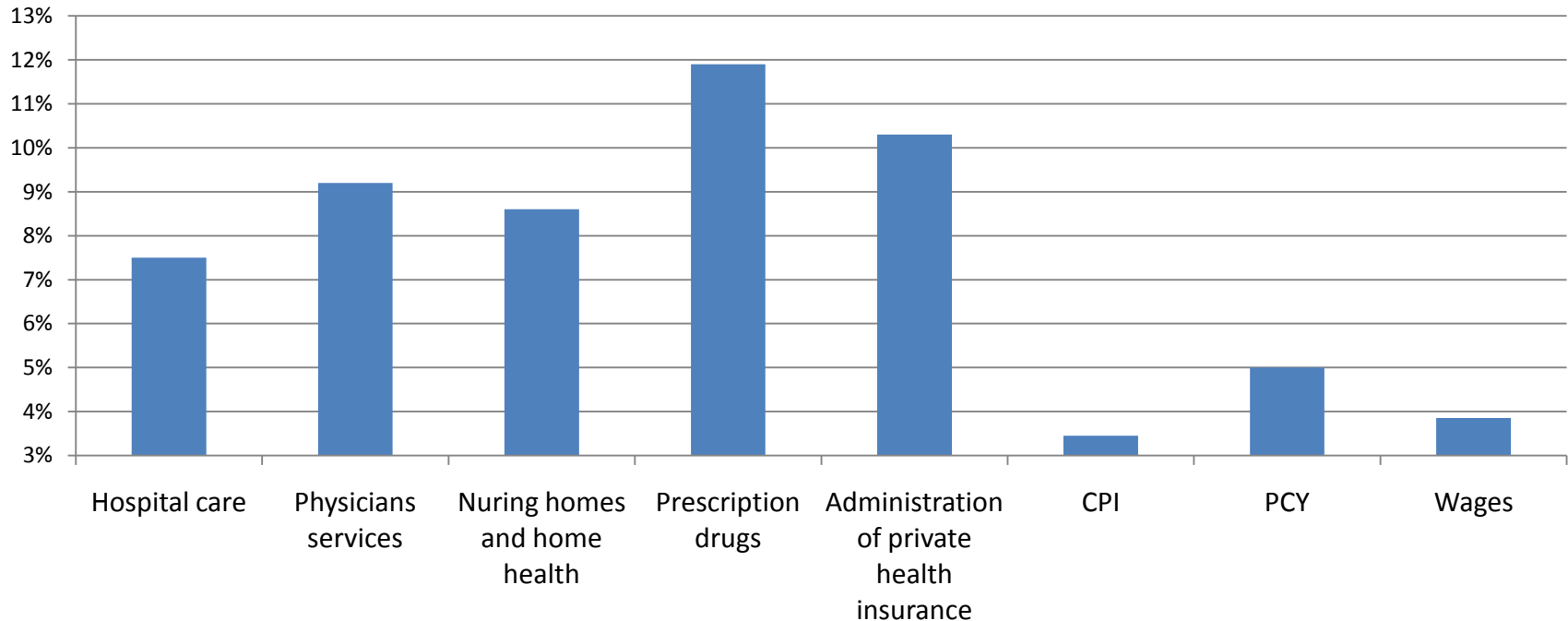
Individual Insurance Premiums in MA, 1996-2007



Sources: 1) 1996-2006 MA: Agency for Healthcare Research and Quality (AHRQ), Medical Expenditure Panel Survey (MEPS)-insurance component. 2) 2007 MA: DHCFP Massachusetts Employer Survey 2007. 3) 2007 US: Kaiser/HRET, Survey of employer-Sponsored Health Benefits 2008.

Cost drivers in health care

Annual Change in Health Costs 1980-2005



US administrative cost-rate 3x that of best practice countries.

Reducing administrative cost share to the level of the 2nd highest country would save \$40 b.

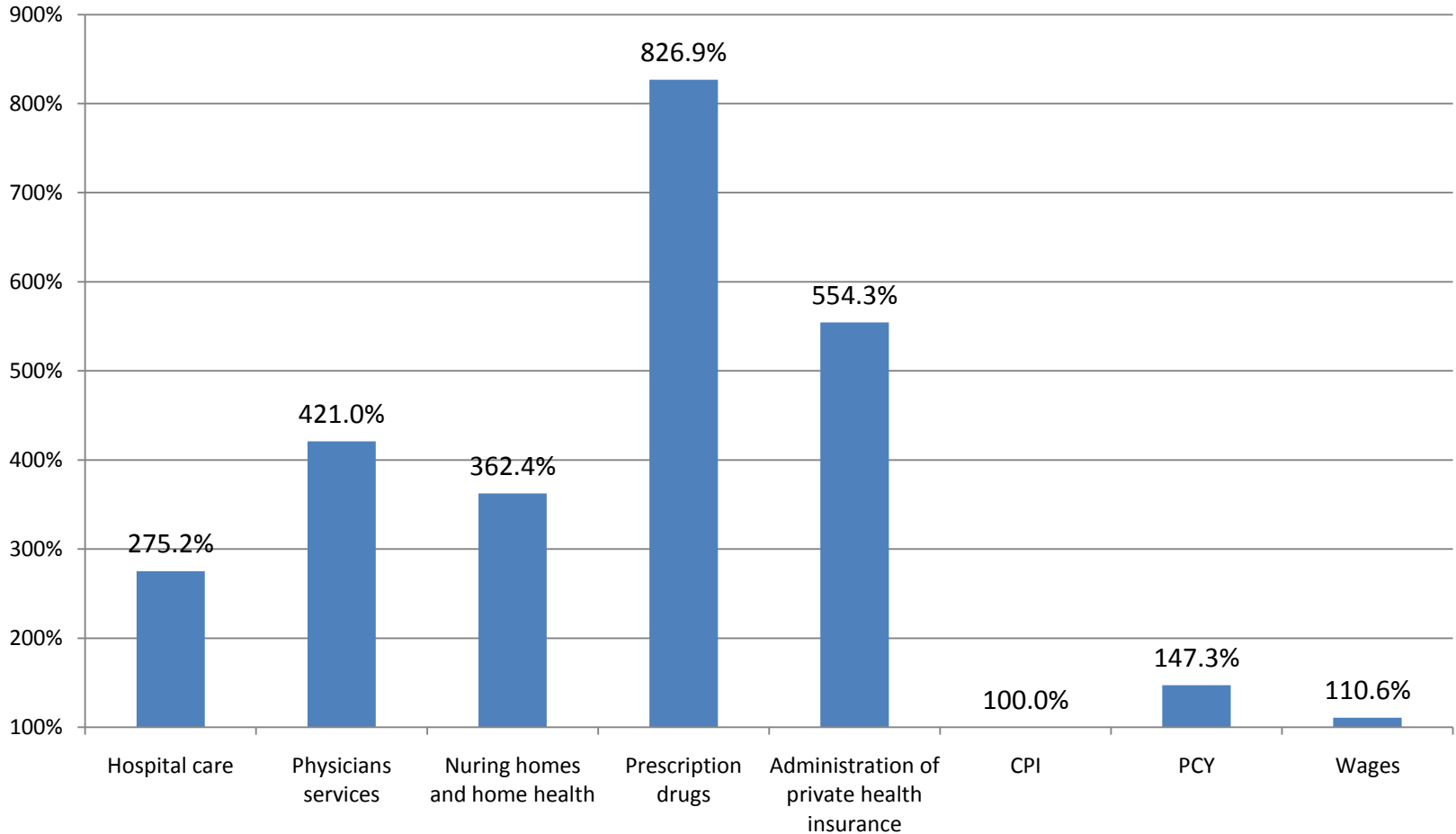
Lowering private administrative costs to Medicare level would save \$200 billion.

http://www.commonwealthfund.org/usr_doc/Davis_slowinggrowthUSHltcareexpenditureswhatareoptions_989.pdf

These are quality controlled price indices from the Bureau of Labor Statistics.

These increases add up

Cost differential 1980-2005



Private health insurance is the cause of rising administrative costs

Private insurance necessarily leads to problems causing administrative waste.

- **Adverse selection:**
 - by buyers who buy insurance because they know they will need it (a.k.a. *moral hazard*).
 - by sellers who screen out those who they anticipate will need insurance (a.k.a. *cherry picking* and *lemon dropping*).
 - As many as half of American adults have “pre-existing conditions”
- **Samaritan’s dilemma: We treat all patients even if they didn’t buy insurance.**
 - Treatment often after problem has compounded, and in expensive setting.
 - Uncompensated care cost \$56 billion in 2008.
- **Third-party buying: Employer-provided coverage with incentive to minimize costs.**

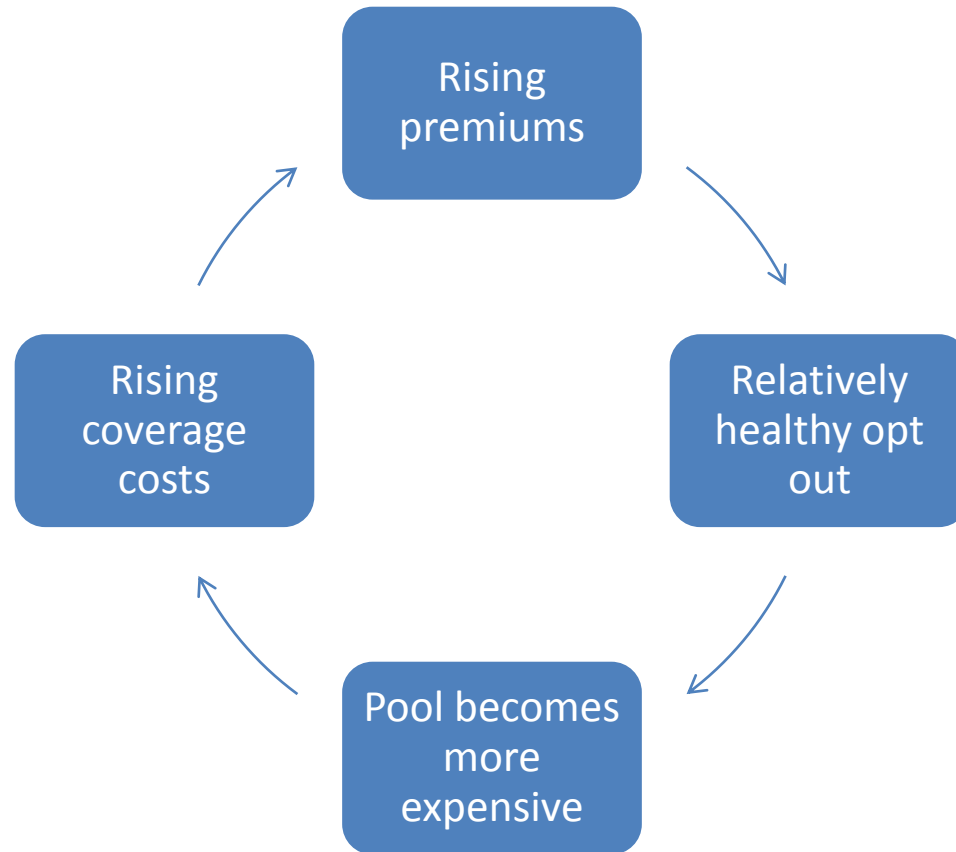
Private insurance raises costs when companies use waste to resolve fundamental problems

- 70:10 rule –70% of costs go to 10% of people.
 - *Shoe companies profit by selling more shoes. Insurance companies profit by supplying less, by reducing their market.*
 - Find the 10% and drive them out to raise profits with falling premium!
 - Fail to identify and drop them, and face insurance “death spiral.”
- How to cherry pick/lemon drop?
 - Upper-floor offices
 - Paperwork and increasing hassle-factor.
 - Rescissions (California companies dropped 20,000 sick people)
- Private insurance loses scale economies.

Cheating pays *for private companies*

- Dump the sick on family, charity, state programs.
- It negates the idea of insurance for everyone.
 - This year, someone else may be sick. Next year, it may be you.
- Raises costs for all of us through administrative waste.
- Makes us less health.
 - Raises stress
 - Those who lose insurance become sicker

Failure to cheat risks insurance death spiral



Massachusetts tries to regulate administrative costs in insurance companies

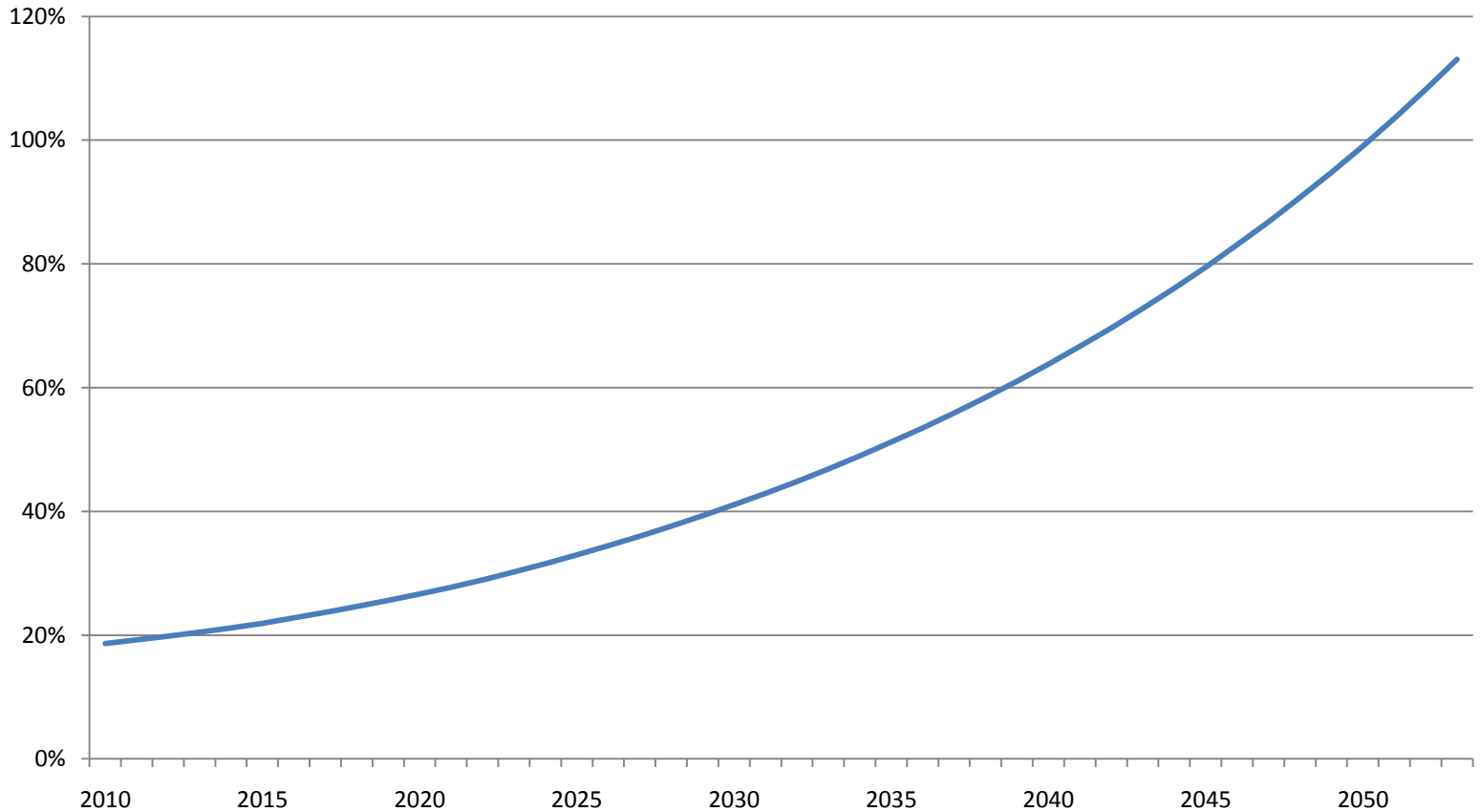
Good idea. But limited because it does not address the underlying problem.

Companies have incentive to shift administrative burden along to providers and clients.



Rising health care costs will swallow the economy

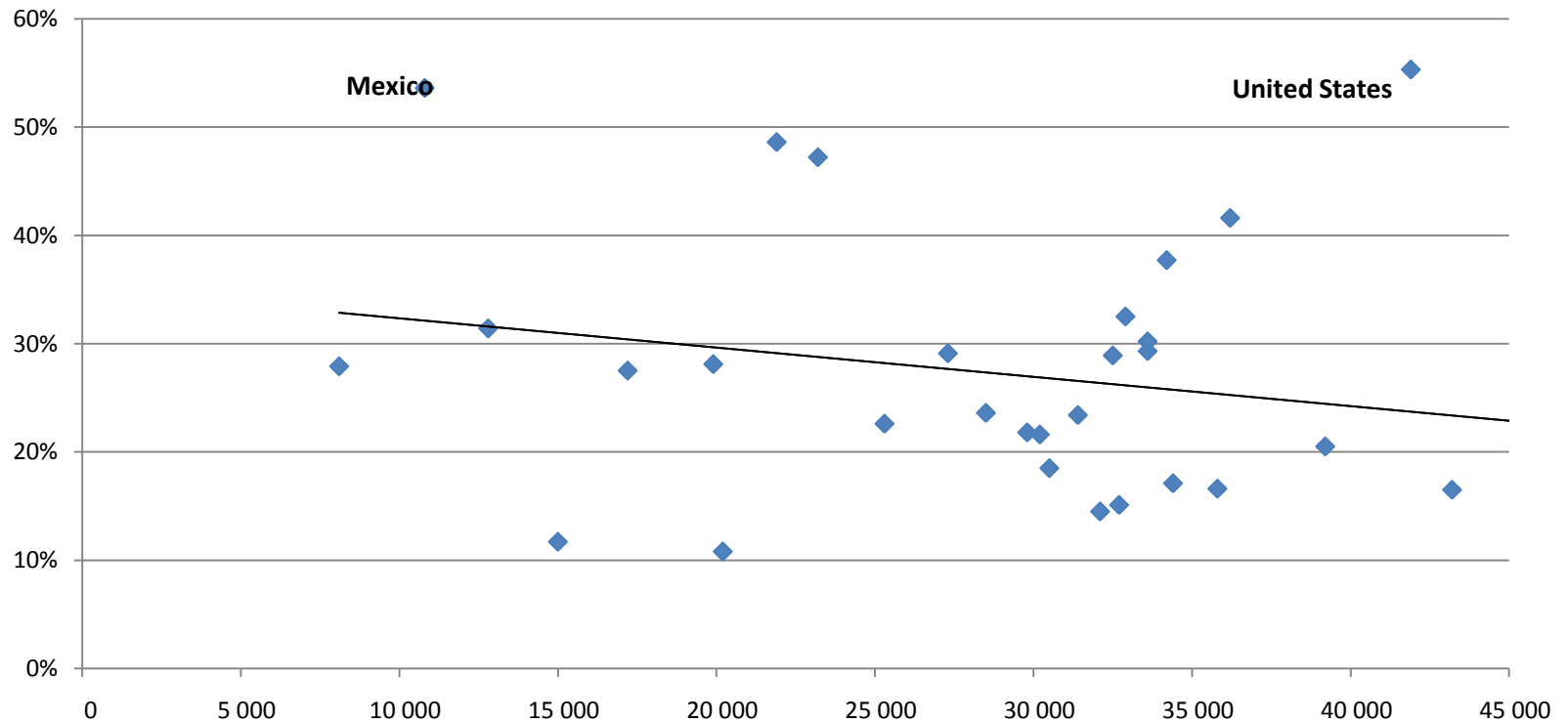
Health Share of GDP: CBO Assumptions



American Exceptionalism?

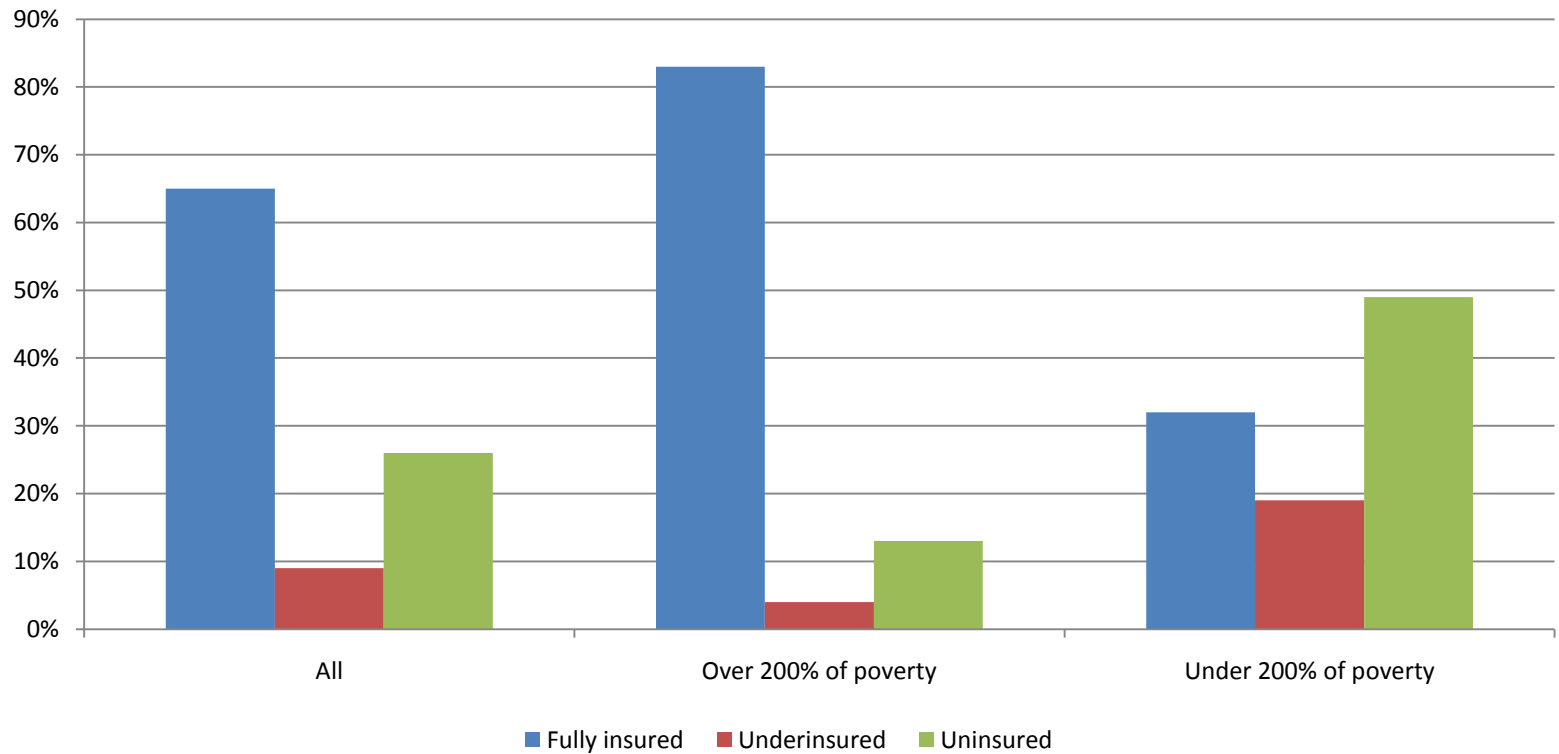
We are the only rich country that leaves health to the private sector

Private share of health expenditure

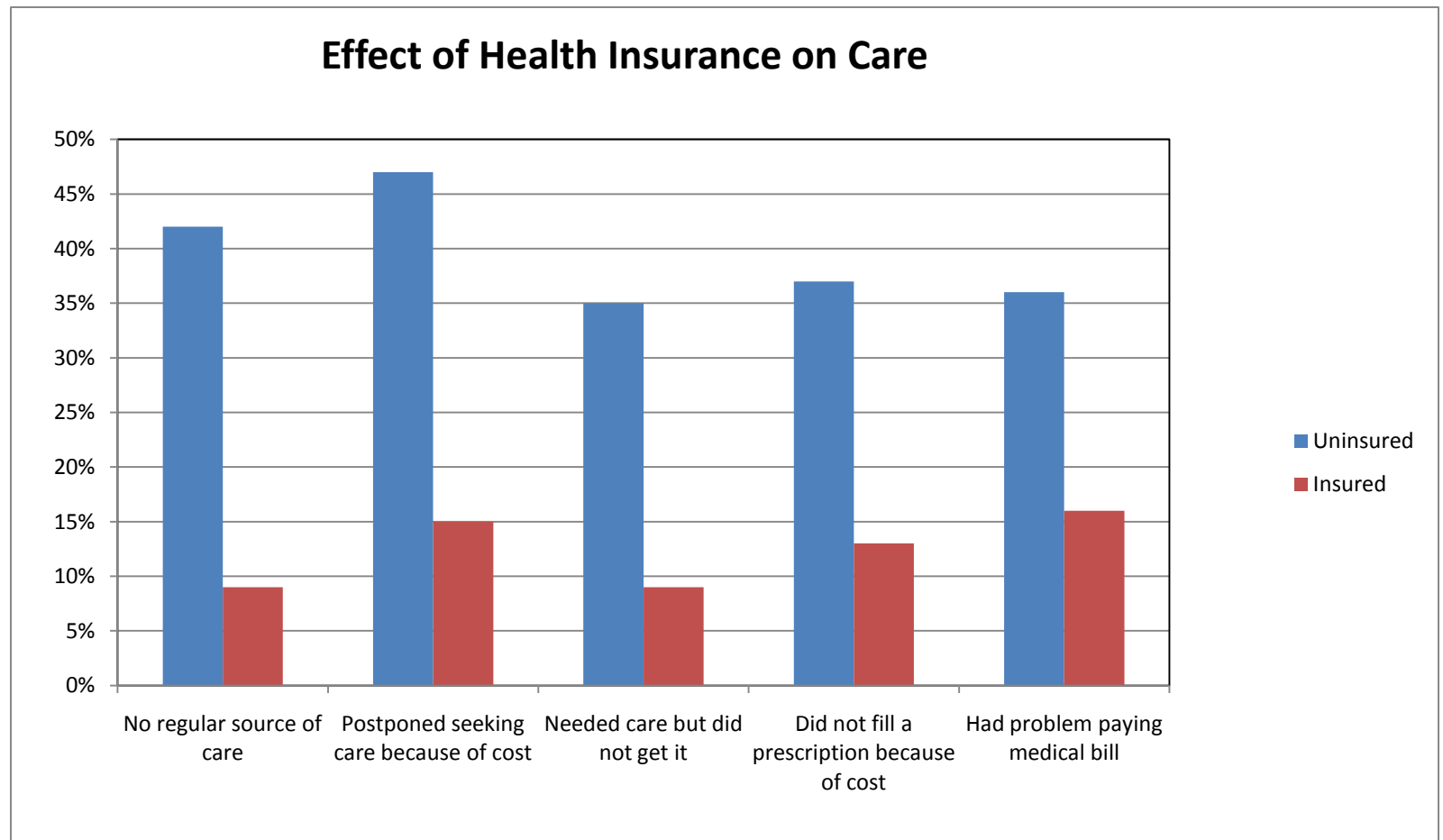


We treat health insurance as a privilege. Growing numbers don't have it.

Uninsured and Underinsured by income



Reliance on private insurance also contributes to health problems



This is one reason why the greatest increases in life expectancy have gone to the well-off



The top half has gained 6 years; the bottom half has gained 1.

Private health care financing treats health as a private good

But it is a public good because:

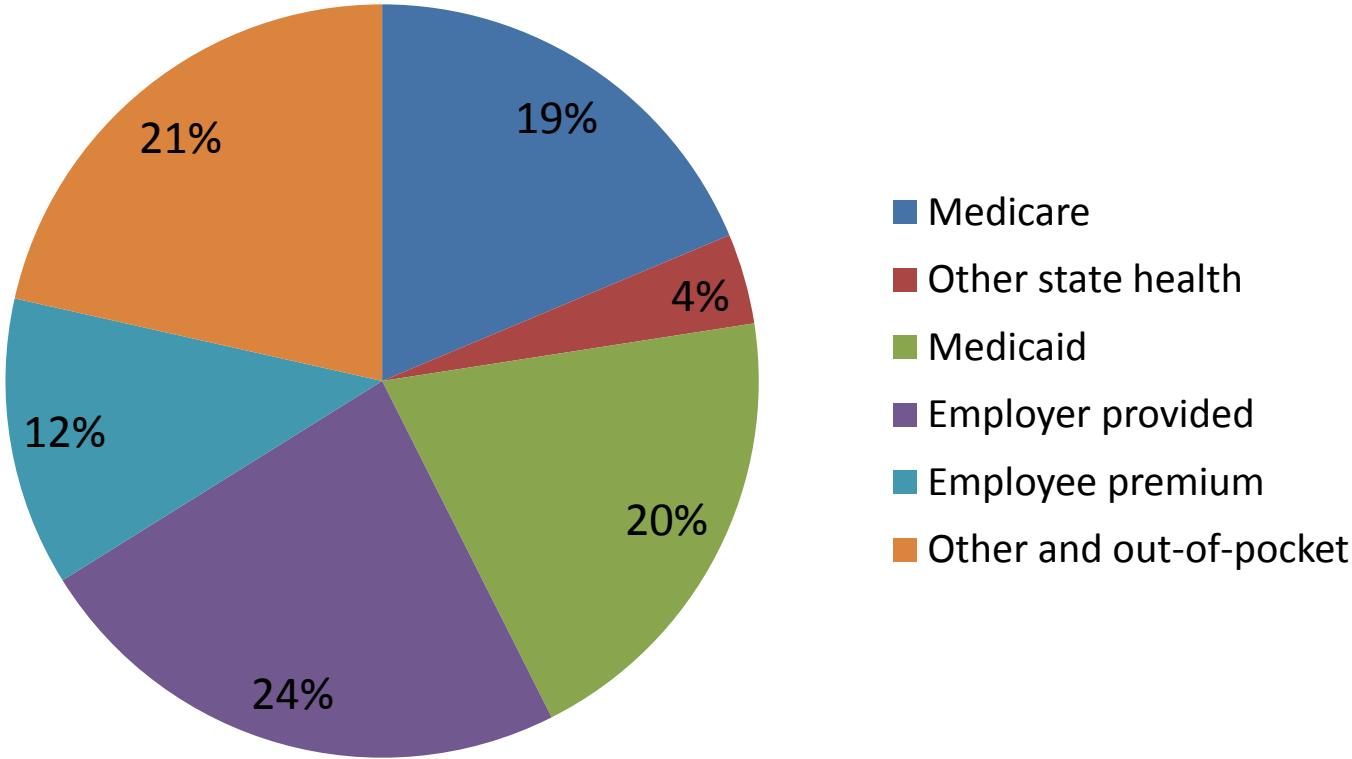
- It effects others through the spread of communicable diseases
- It effects others through changes in productivity.

We are all effected by the health of our neighbors!

How Single Payer will help

- Lower billing costs in doctor's offices
- Eliminate administrative costs (including advertising, selection, and profit) in private insurance
- Extend coverage to everyone.
- Facilitate healthier medical practices.
 - Including lower stress.
 - keep people alive long enough that Medicare will cover their costs

Health Care in Massachusetts



Single payer would lower costs

Change in health-care expenditures	Change of total health-care expenditures
Savings from single-payer system	
Administration costs within health insurance system	-2.0%
Administrative costs within providers' offices	-10.1%
Reduction in provider prices through reducing market leverage for privileged providers	-5.0%
Savings:	-17.1%
Increased costs from single-payer	
Expansion in coverage to the uninsured	+1.35%
Increased utilization because of elimination of copayments, balanced by improvements in preventive care	+/- 0.0%
Total increased costs:	+1.35%
Net change in health-care expenditures:	-15.75%

These savings are over \$5 billion! Almost \$1,000 per person.

Single payer would also have other benefits

- *Universal coverage would lower individual stress reducing medical (and psychiatric) costs.*
- *Better coverage would keep people healthier until they reach Medicare (paid for by the Feds).*
- *Further reductions in Emergency Room use as last resort.*
- *Economies to scale in administration would also facilitate economies in application of new technologies.*
- *Single-payer would allow Massachusetts to reduce excessive profits (and prices) in pharmaceutical industries.*

Private health coverage burdens the working poor

Applying a fixed charge to everyone
disproportionately burdens lower incomes.

This isn't math; simple arithmetic.

Burdens small businesses unable to reap scale
economies in administration.

Single payer would help those who need it

Lower income people now spend more of their income on health care.

Massachusetts family income quintile, 2006	Median household income in quintile	Estimated spending on health care as share of household income: out of pocket and private insurance
1	\$ 19,964	22%
2	\$ 47,599	19%
3	\$ 74,043	18%
4	\$ 105,935	19%
5	\$ 175,722	15%

We could afford universal coverage with a single-payer system

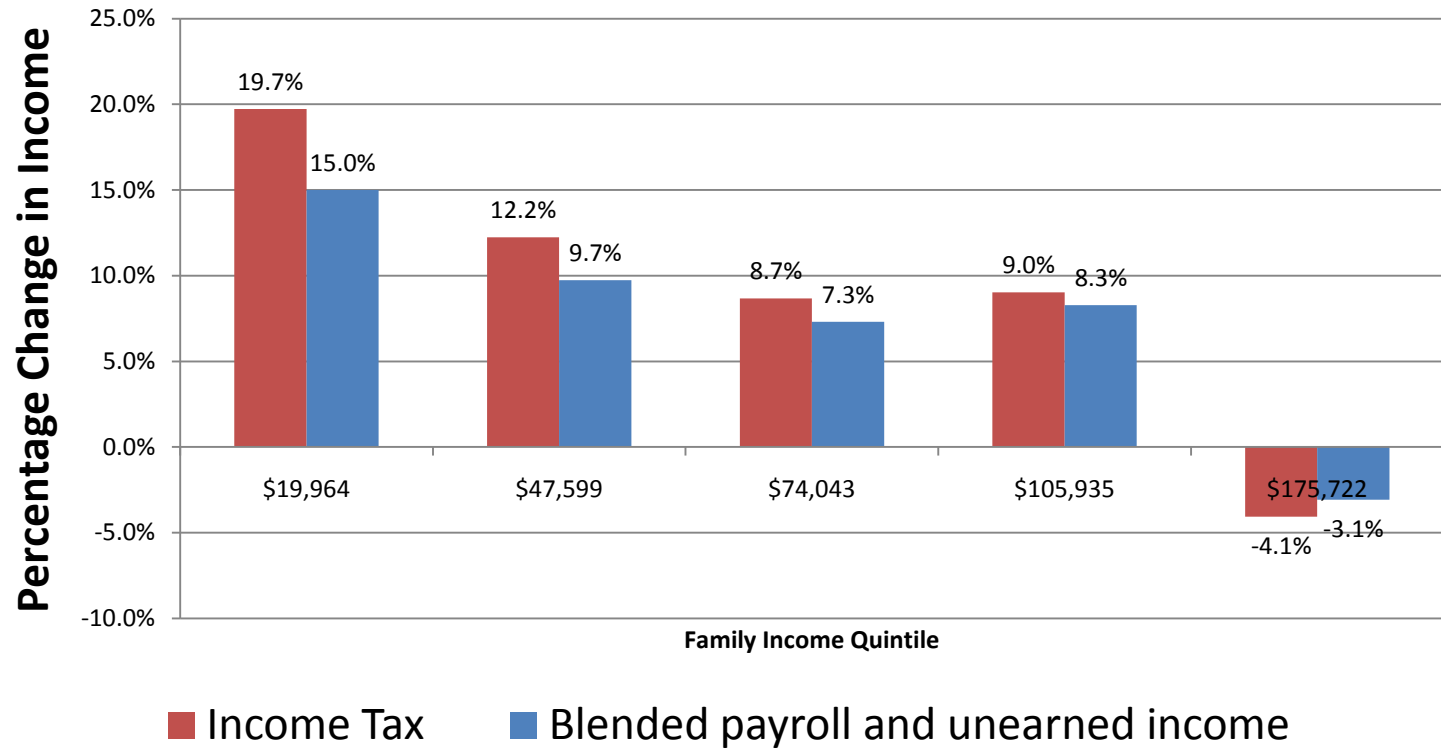
It would be cheaper than what we do now!

We could pay for it with a combination of:

- Income tax (with a high deductible to avoid burdening the poor).
- Restoring the surtax on unearned income.
- A payroll levy (replacing insurance premiums).

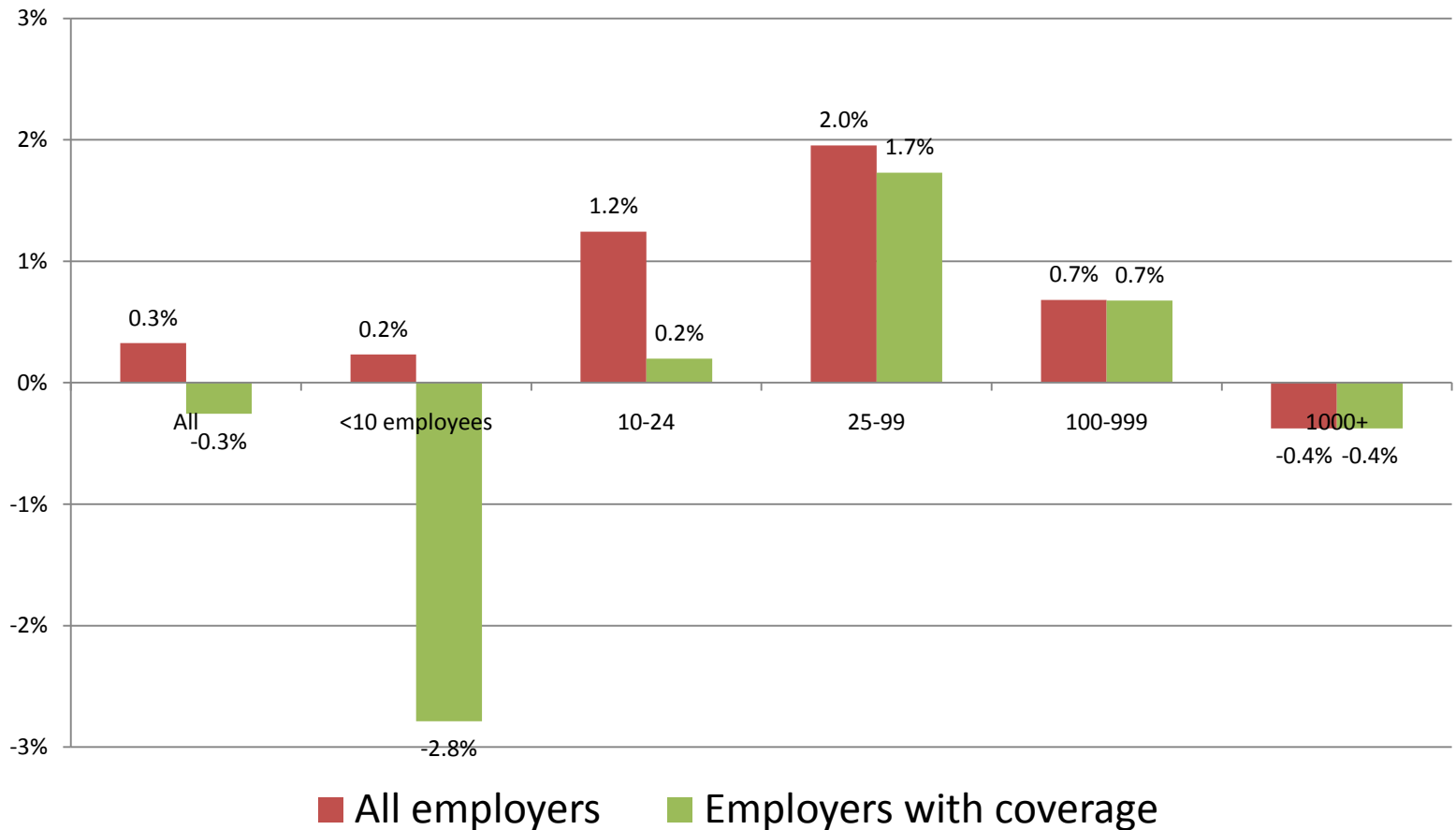
The distributional impact would depend on the exact blend of these.

Single payer would benefit lower income households



Everyone gains because of cost savings. Lower income households gain more because they now spend more. Only the wealthiest will pay more net of savings on premiums and copay/deductibles/out-of-pocket.

A 10% payroll tax would have little effect on employer costs



No group of employer would pay more than 2% in additional payroll costs. Small employers currently providing insurance would have large savings.

Healthy Profits Inc.



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M. WINTERS