1. This lecture reviews the financing health services. It is a timely topic. In 2010, Congress passed the Patient Protection and Affordable Care Act. Futurist Jeff Goldsmith said the following about this US health reform. It represents: “the most significant change in the US health system in 50 years, will fundamentally change how healthcare is financed in the US, both broadening access and restructuring public and private insurance. It will not only expose the federal government to significant spending increases, but also change incentives to hospital, physicians, pharmaceutical companies, medical technology firms, and everyone who supplies or supports the health system.” To understand the need for the law, it is necessary to understand how health care financing evolved and how it worked prior to health reform.

2. As such, the session objective is to understand the main components and issues in financing personal health services. This will include a discussion of US health expenditures, and the development of private health insurance in the US, Medicare and Medicaid, as well as issues pertinent to the health reform law.

3. First, let’s review health expenditures. In 2013, U.S. health expenditures totaled $2.9 trillion, averaging $9,255 per person. However, while expenditures are significant, a 2012 IOM report concluded that about one-third of medical care provided was wasted expense. It was wasted since the health care was unnecessary, inefficiently delivered, too pricey, or fraudulent.

4. In the US, health spending accounted for 17.9% of the GDP in 2010. In contrast, health spending constituted 11.6% of the GDP in Germany, 11.3% in Canada, and 9.6% in the United Kingdom. If the US could eliminate the one-third of health expenditures that represent waste, the GDP on health spending would be reduced to 11.9%, which is a GDP that is more consistent with other developed nations. Hence, health reform is not only needed to assure access to health services, but also to reduce waste and cost.

5. As depicted, U.S. health expenditures have increased substantially, in both private and public sectors. The annual increase in expense occurs from both increasing prices for health services and from increasing utilization of health services. This means, we are paying more for services received, as well as receiving more services.

6. This graphs the percent of personal health expenditures paid by private versus public sources over time. In 1980, 60% were paid by private sources, such as private health insurance, whereas 40% were paid by public sources, such as Medicare, Medicaid, and the Veteran’s health system. The percent paid by private sources has been declining over time and the public sources have been increasing. By 2009, the split between private and public sources was nearly a 50-50 split.

7. While the previous slide provided the private-public split in funding health expenditures, it is important to note that expenditures for both public and private sources have steadily increased and are projected to increase further.

8. The next slides discuss the development of private health insurance in the U.S.

9. In the 1800s, health insurance did not exist. Physicians were paid on the basis of cash and collected directly from their patients. Hospitals relied on donations as they tended to serve the poor. The first health-related insurance products were developed in the early 1900s. They did not pay for medical bills, such as hospitals or doctors. Instead they replaced lost wages – the wages that were not earned due to an illness.

10. In the early 1900s, hospitals were emerging as centers of care and technology as the science of medicine advanced. However, hospitals had a weakened financial position
following the Great Depression. Average hospital receipts per patient admission fell from $236 before the Depression to $59 after the Depression. Consequently, hospitals had a very serious financial situation and health insurance was developed to help support hospitals and avoid financial ruin.

11. Baylor University Hospital developed the first health insurance product for hospitals. The Baylor insurance plan was offered to 1,500 local school teachers. The benefits provided up to 21 days of hospital care annually at an annual cost of $6 per person. This health plan eventually led to the first Blue Cross health insurance plans.

12. It is important to understand why the Baylor insurance plan was sold through an employer – the school system, and not sold to individuals. Today, most private health insurance follows this model and is sold as employer-sponsored health insurance. This is an important concept. It is assumed that employed persons are a reasonably healthy population. If unhealthy, they would be unable to work. As such, health insurance sold to individuals is likely to attract people with illnesses or who expect to need costly services. Covering such individuals could be expensive for health insurers.

13. Employer-sponsored health insurance grew during World War II. A freeze existed on wages and salaries, so employers could not give salary increases to employees. Consequently, benefit packages were enhanced and included pensions, disability programs and private health insurance. Following World War II, enrollment in private health insurance plans continued to grow.

14. All insurance is based on the concept of risk. Risk recognizes that there is a potential for an adverse deviation from a desired outcome and a probability that this deviation will occur. For example, there is a probability that any driver can a major car accident, which any homeowner can have their house burn down. Similarly, anyone can develop a disease that is expensive to diagnosis and treat.

15. Individuals who experience a major illness would incur a large and often unaffordable expense. Insurance shifts the risk for this expense from the individual to the group that is the group that is insured. Hence, insurance pools risk and is based on the law of large numbers, such that the risk for an adverse illness or injury is spread over a large population of insured people.

16. The original health insurance plans were similar to automobile and property insurance in that they provided coverage against an expensive loss only. The original plans did not include general medical visits and prescription drugs. However, by not providing access to primary services and medications to manage chronic diseases, the probability of needing expensive services can be increased. Today, health insurance is different from other types of insurance since it does cover normal, expected events, such as doctor office visits and prescription medicines.

17. The ACA health reform law of 2010 pertains to health insurance coverage. Some employers have not funded health insurance plans for employees. Some individuals cannot afford to purchase individual health insurance coverage. Small businesses can see the price of their insurance premiums rise if a single worker incurs significant health care costs, causing some small businesses to discontinue their coverage. At the time the ACA law was passed, about 15% of full-time workers and 30% of part-time workers lacked health insurance, which creates access barriers to needed health services. The goal is to increase the number of people who are covered by a health plan.

18. Moral hazard is a consequence of insurance. The concept of moral hazard was derived from the fire insurance industry, where it was concluded that insured buildings were more likely to burn. Likewise, patients utilize more healthcare services when services are paid for through insurance. There is no incentive to contain cost if insurance pays for all health care
sick. Controlling utilization of services is compounded by the fact that sickness is not always a well-defined condition. Further, doctors typically determine which services patients utilize while often profiting from higher levels of utilization. Finally, prices tend to increase when the ability to pay increases. Therefore when health insurance is provided, utilization and prices increase.

19. To control cost and utilization, health insurance plans used cost sharing methods, so that patients are more prudent because they will share some of the expense. The three prevalent types of health care cost sharing methods are deductibles, co-insurance and co-payments. A deductible requires an individual to pay a certain amount out-of-pocket before health insurance provides any coverage, such as paying the first $1,000. Co-insurance is used as a percent of expenses due, such as the patient paying 20% of the bill. In contrast, co-payments are a set fixed amount, such as the patient being responsible for $25 for any physician visit, regardless of the rate paid by the insurance company.

20. The cost of an insurance premium depends on many factors, including the amount and type of insurance provided. For example, when health plans cover expensive services or prescription drugs, the premiums will be higher relative to not covering these benefits. Also, insurance premiums are based on the likelihood that the covered service will be needed. As diseases become more prevalent in a community, health insurance premiums will increase. Finally, insurance premiums are based on the price that the health plan expects to pay for health services. As hospital and physicians increase prices, insurance premiums will likewise increase.

21. This slide depicts the significant increase in total health care costs for a family of four covered by private health insurance, which includes premium and cost sharing expenses.

22. Most employers do not pay for 100% of an employee’s health insurance premium. As such, insured patients not only pay their cost sharing amounts, in most cases they pay part of their premium as well, which is listed here as the Deduction from Payroll. As health care costs increase, the amount spent by both employers and employees has increased. In 2009, total health care costs for a family of four, including health insurance and cost sharing, approaches $17,000, with families paying $7,000 and employers paying about $10,000.

23. The majority of U.S. health expenditures, 84%, funds personal health services. In addition, 5% funds administrative costs for government and private health insurance, and a mere 3% percent is expended on government public health activities.

24. This illustrates how the funds for personal health services were spent. Hospitals comprise the largest category with 38% of spending. Physicians and clinical services are the second highest category at 27%. Prescription drugs have grown to account for 11% of expenditures. Nursing home expenditures are 6%, dental is 4%, and home health care is 3%, which are all relatively small percentages of the total.

25. This illustrates the sources of funds for personal health care services. While we think of private health insurance as a major funding source, it funds only about one-third of personal health care. Please note that 15% of expenditures are paid out-of-pocket, meaning by the patient or their family. Thus, out-of-pocket payments are approaching half of that which is paid by private health insurance companies.

26. At the conclusion of Part 1, students should be able to answer the following questions.