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HEALTH SOLUTIONS

U.S. HEALTH CARE FINANCING

Ten Key Concepts for an Informed Health Care Conversation

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Ten Key Concepts

1. U.S. spends $4 trillion annually on health care: Where does it go? Who pays?
2. US compares unfavorably in spending and “value” to other OECD countries
3. Health Care Triple Aim: A way to define value
4. Population Health:
   Health ≠ Health Care ≠ Health Insurance
5. Most health care is financed by insurance. Why?
6. Health systems and insurance in the U.S. are complicated and contribute to poor value
7. The way the US pays for the “uninsured” is inefficient and leads to poor outcomes
8. Affordability:
   Cost = Volume x Price (+ admin costs)
9. Pay for Value not Volume
10. A Health Care Policy Home Run: The Four Bases (implications for primary care)

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Ten Key Concepts

1. U.S. spends $4 trillion annually on health care: Where does it go? Who pays?
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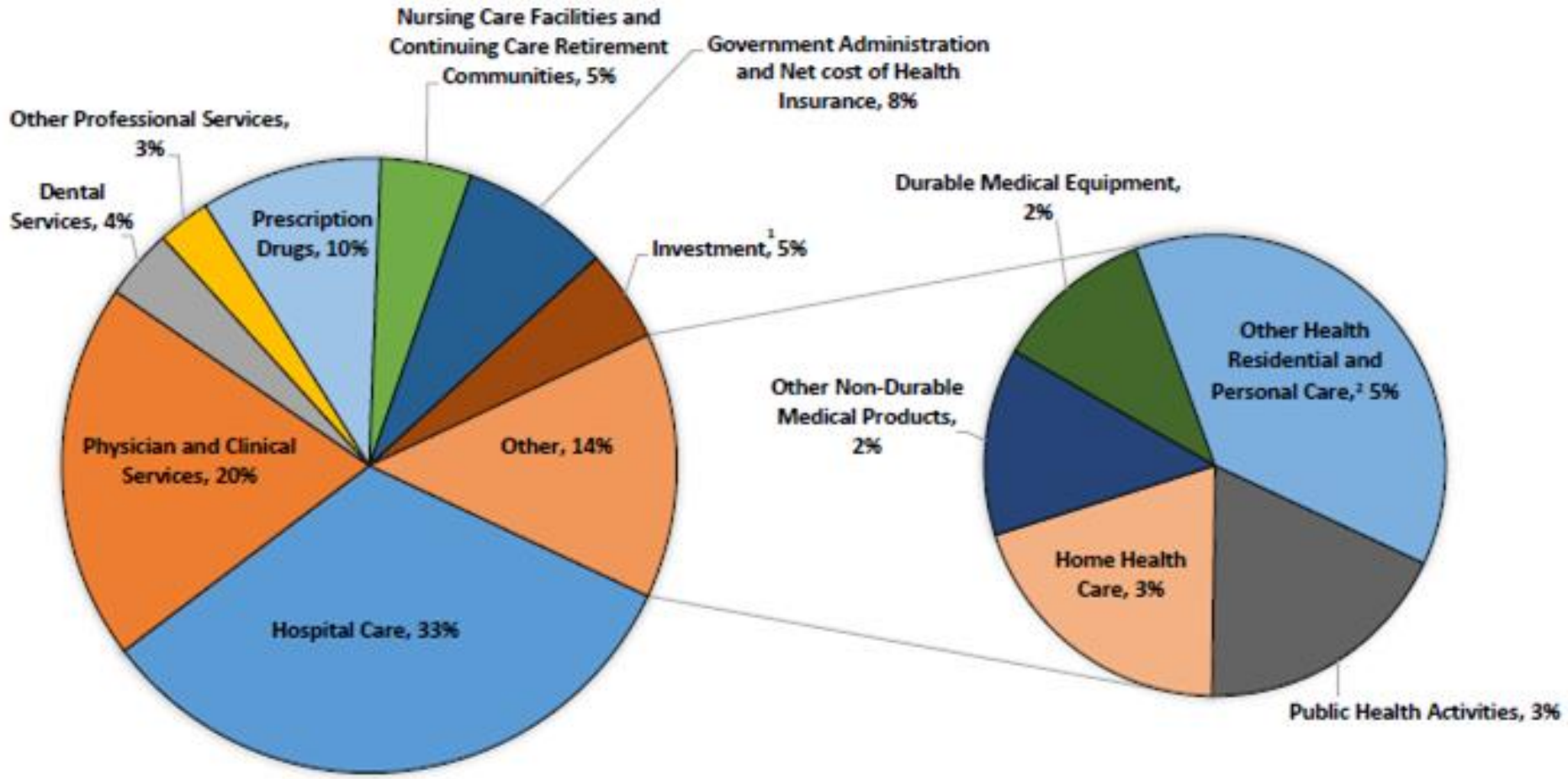
1. U.S. Spends $4 trillion annually on Health Care:
Where does it go?

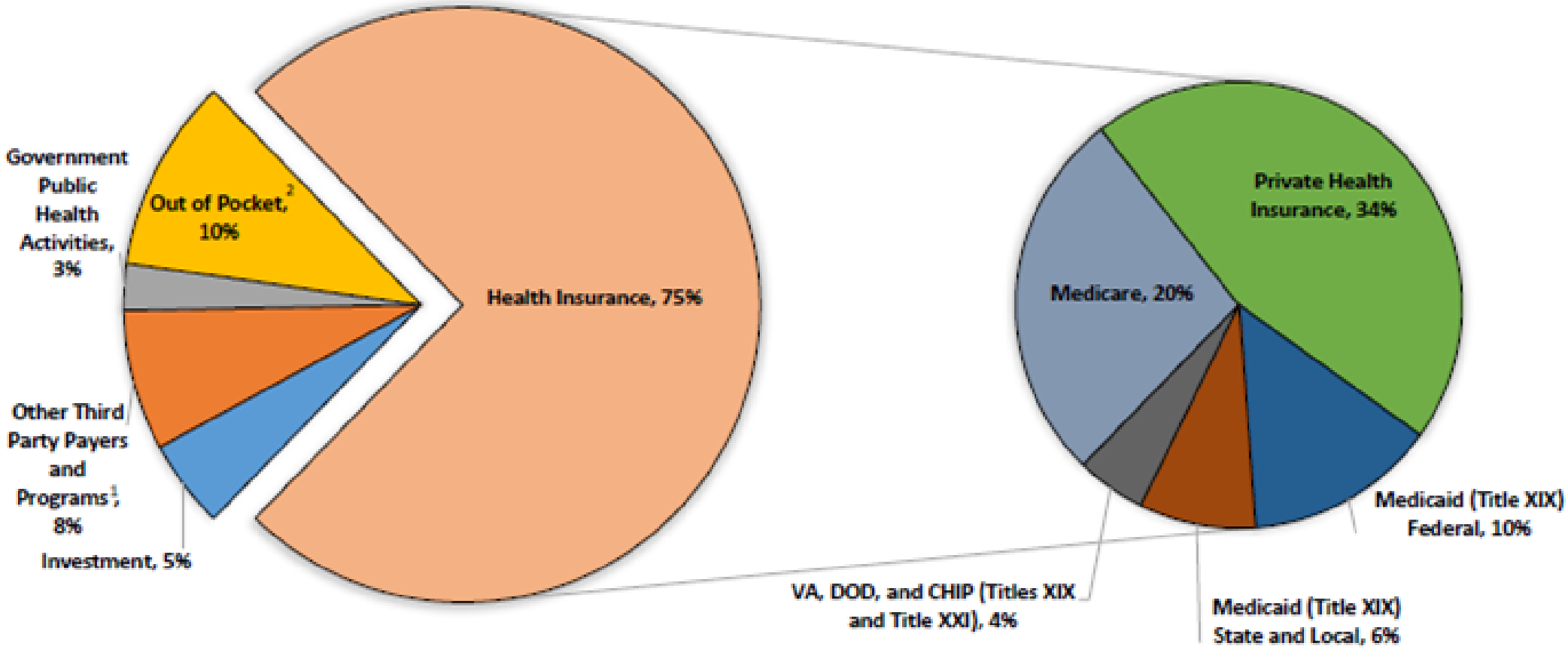


Includes Noncommercial Research and Structures and Equipment.
Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizen centers, schools, and military field stations), and expenditures for home and Community Waiver programs under Medicaid.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, office of the Actuary, National Health Statistics Group

1. U.S. Spends $4 trillion on Health Care:

Where does it comes from?



Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, school health, and other federal and state local programs.
Includes co-payments, deductibles and any amount not covered by health insurance.
Note: Sum of pieces may not equal 100% due to rounding.

SOURCE: Centers for Medicare & Medicaid Services, office of the Actuary, National Health Statistics Group

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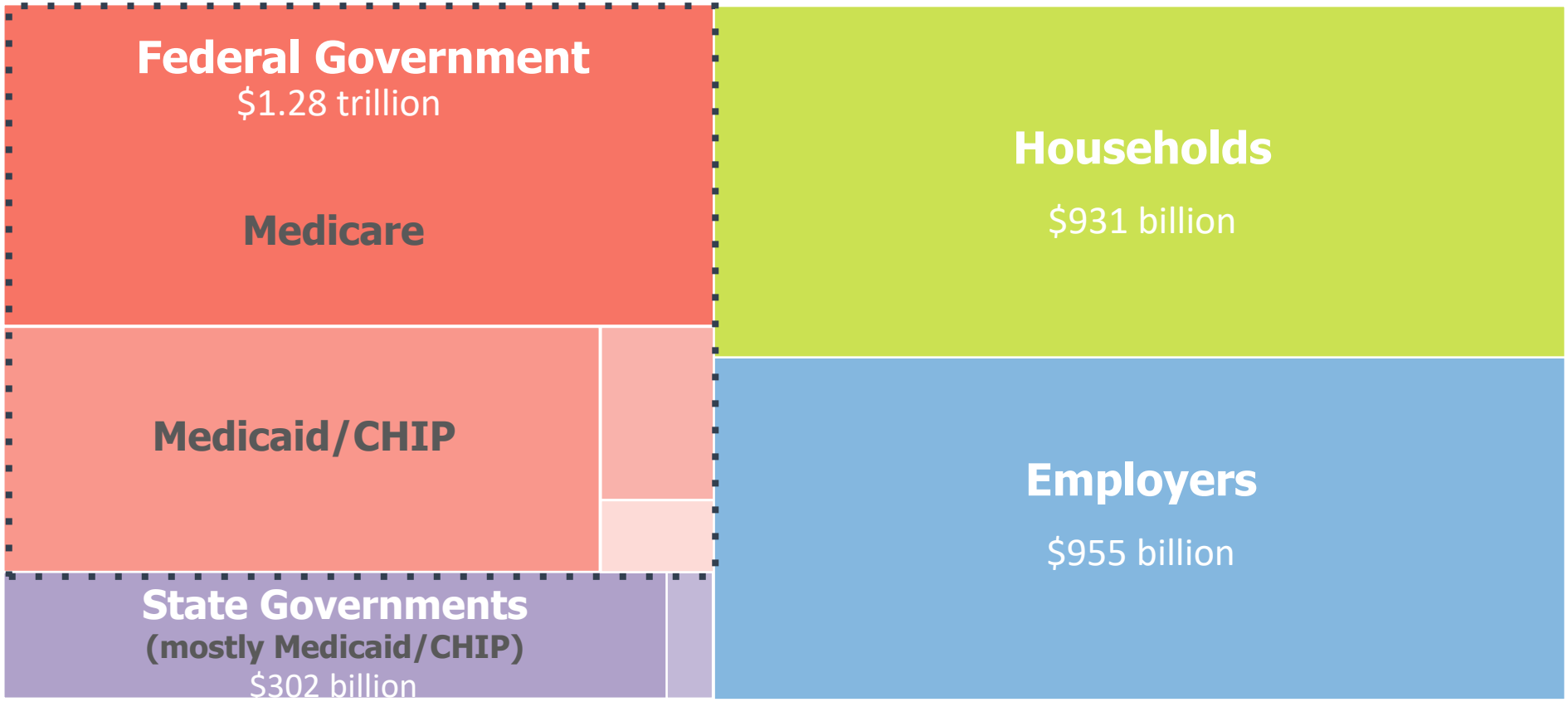
1. Who Pays for Our Health Care?

$3.7 trillion annually under current law



US Health Care Spending in 2020 from NY Times Upshot

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2 US compares unfavorably in spending and “value” to other OECD countries

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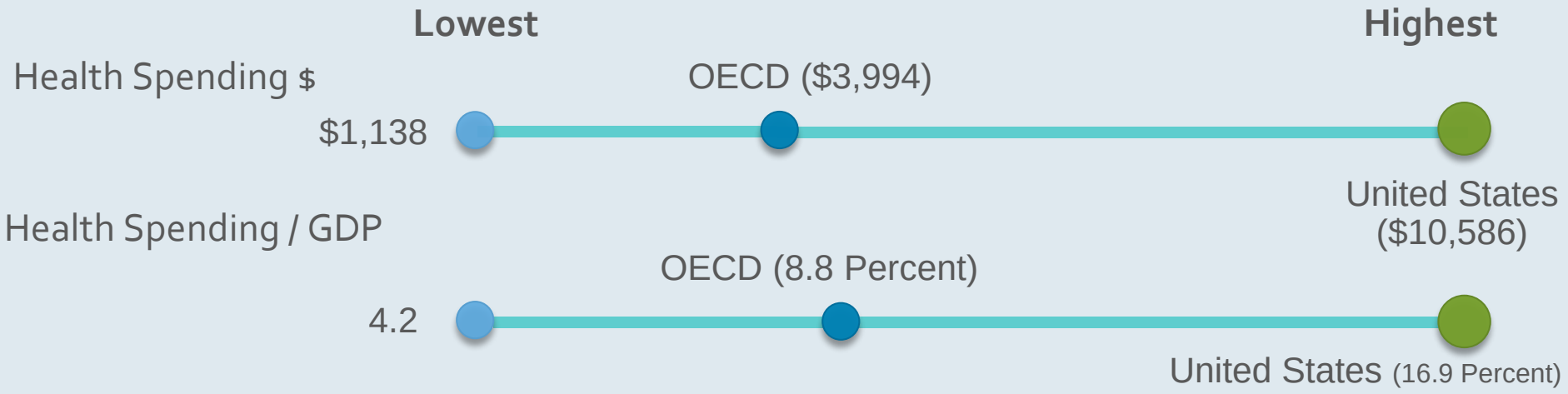
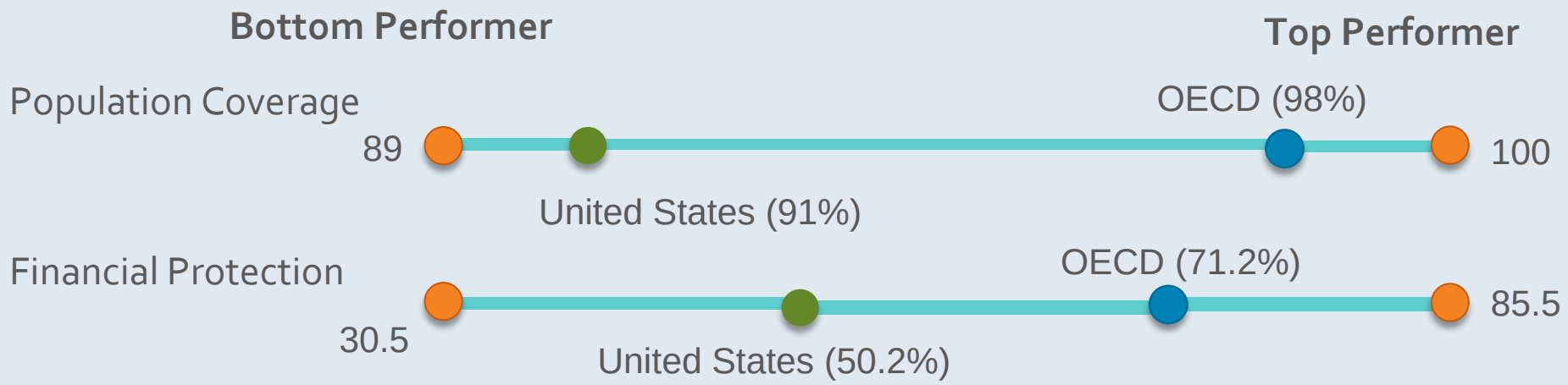
2. US Spends More than Other Countries ….but Gets Less

Health Care Resources



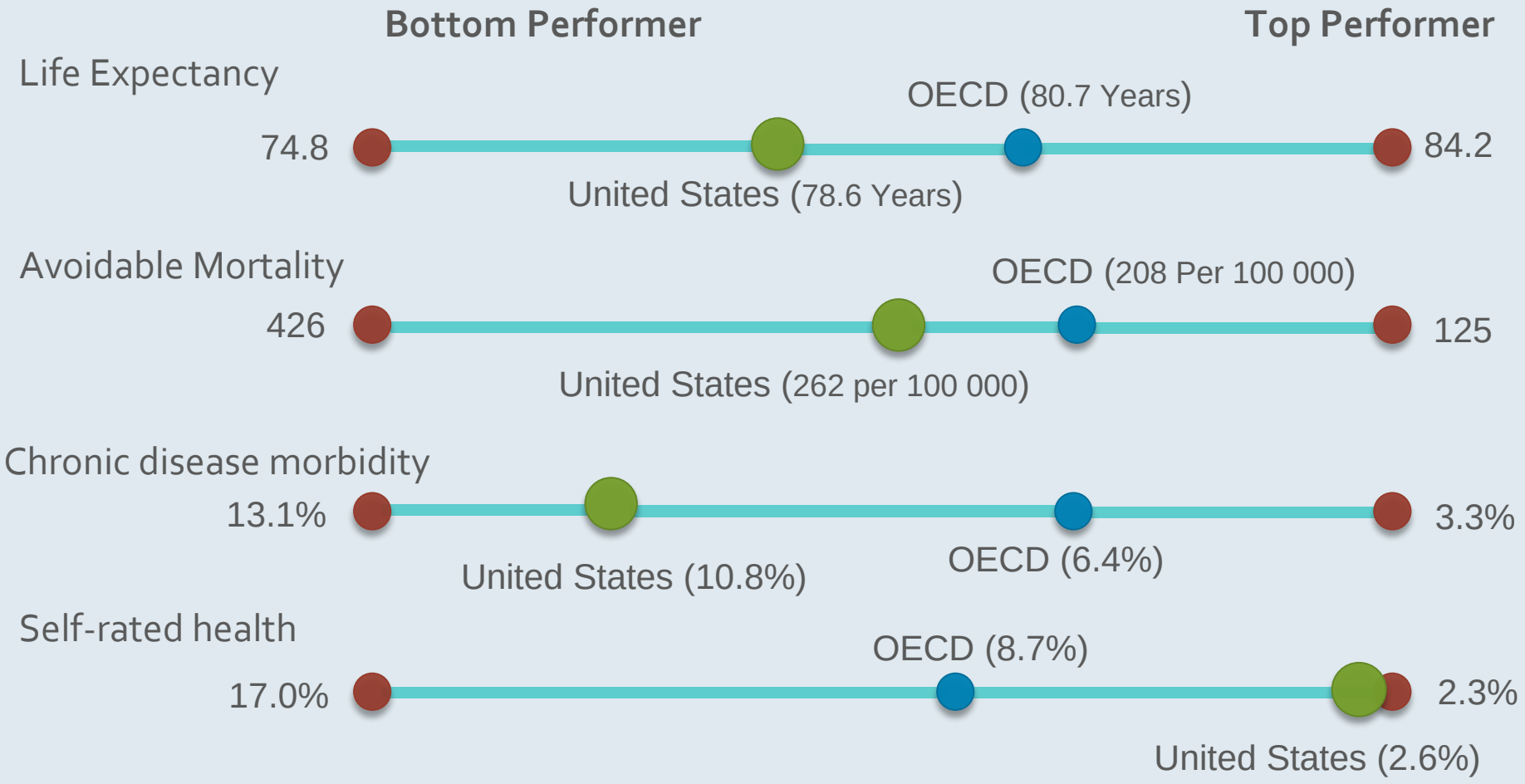
Access to care



Source: OECD Health at a Glance 2019, 36 countries

2. US Spends More than Other Countries ….but Gets Less

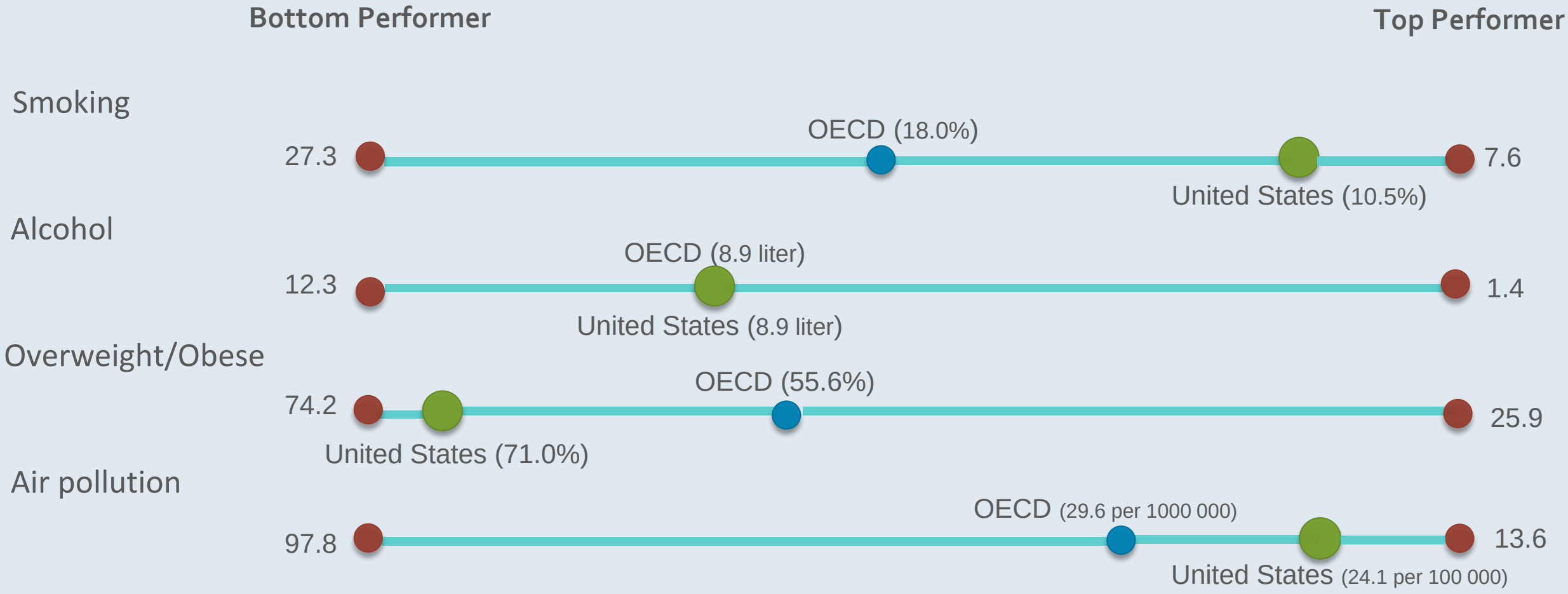
Health Status



Source: OECD Health at a Glance 2019, 36 countries

2. US Spends More than Other Countries ….but Gets Less

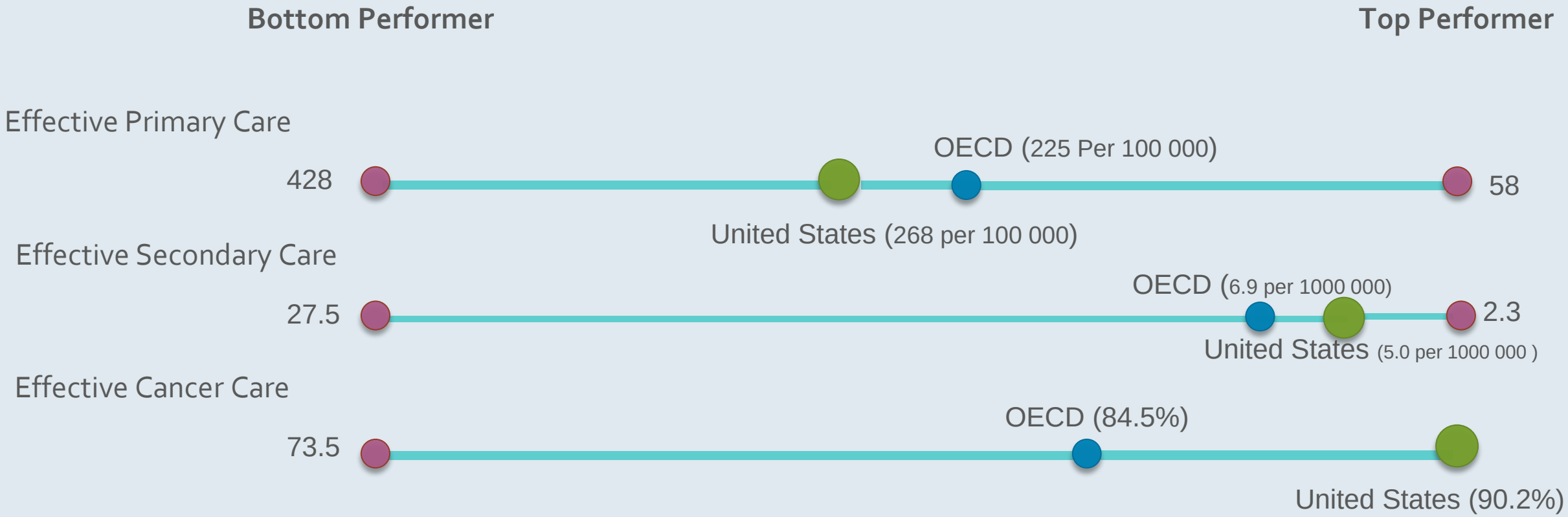
Risk Factors



Source: OECD Health at a Glance 2019, 36 countries

2. US Spends More than Other Countries ….but Gets Less

Quality of Care



Source: OECD Health at a Glance 2019, 36 countries

US has the best "repair shop" but under-invests in prevention and primary care.

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3 **Health Care Triple Aim: A way to define value**

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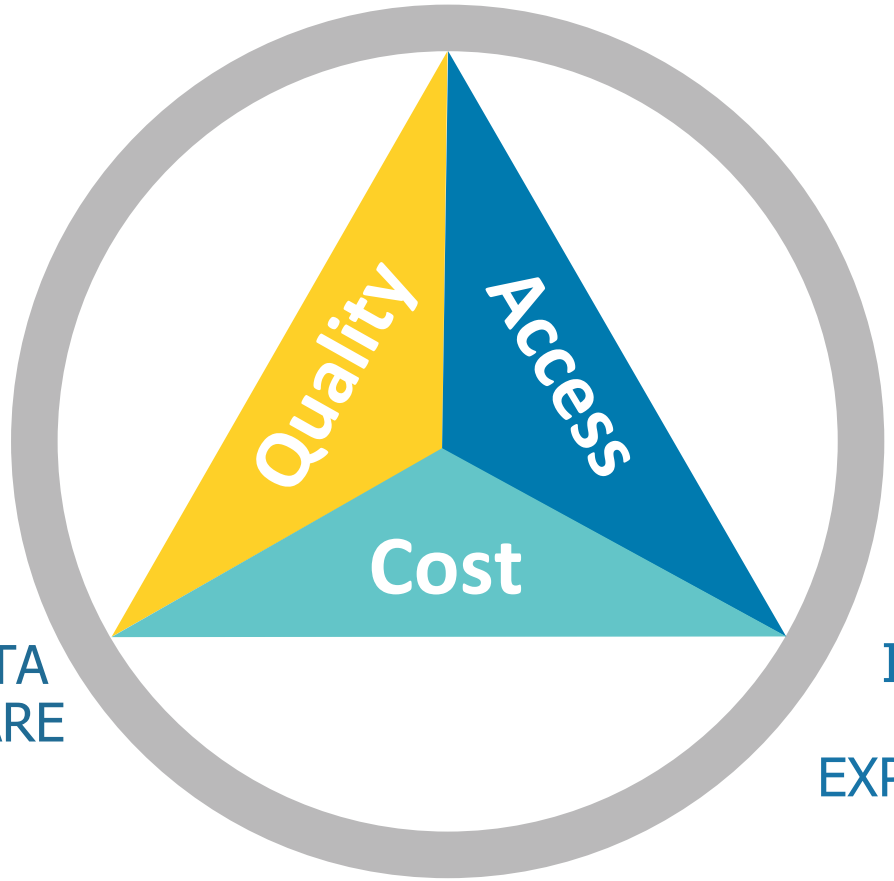
3. The Health Care Triple Aim:
Simultaneous improvements replaces the “iron triangle”

IMPROVING THE HEALTH OF POPULATIONS

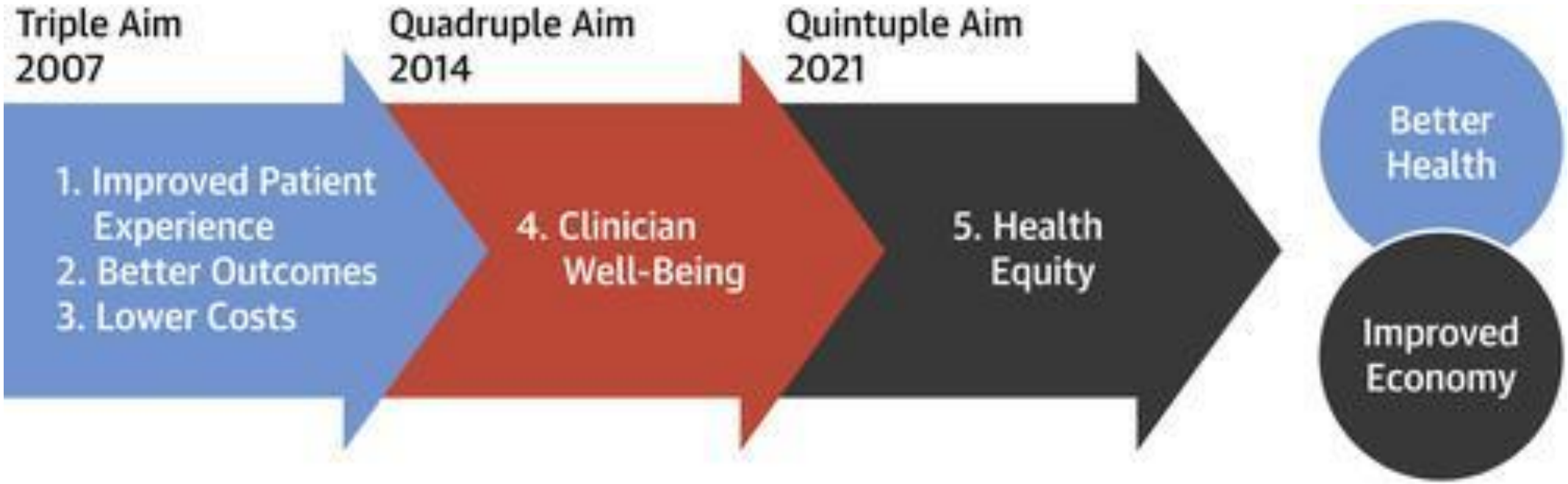


REDUCING PER CAPITA COSTS OF HEALTH CARE FOR POPULATIONS

IMPROVING THE INDIVIDUAL EXPERIENCE OF CARE

http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

3. From Triple to Quintuple Aim



Dipti Itchhaporia et al. *J Am Coll Cardiol* 2021; 78:2262-2264.

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4 **Population Health:**
Health ≠ Health Care ≠ Health Insurance

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4. Health ≠ Health Care ≠ Health Insurance

(based on D. Kindig, "What is Population Health?")

GOAL

HEALTH

Individual and Population, measured by both length and quality of life

CONTRIBUTORS

GENETICS
- Medical Research
- New Therapies

PUBLIC HEALTH
- Water Sanitation
- Environment
- Communicable Diseases
- Immunizations

PERSONAL BEHAVIORS
- Tobacco Use
- Diet and Excercise
- Alcohol/Drug use
- Sexual Activity

SOCIOECONOMIC FACTORS
- Education
- Employment
- Housing
- Community Safety
- Transportation
- Food Security

HEALTH CARE SERVICES
- Access and Quality
- Doctors
- Hospitals
- Pharmacies
- Ancillary Services

SUPPORTED BY MEDICAL EDUCATION AND RESEARCH

FINANCED BY

INDIGENT, UNINSURED BAD DEBT ?

HEALTH INSURANCE 80%

PERSONAL PAYMENT 20%

FUNDED BY

- Government
- Private Philanthropy
- Individuals (e.g. Education)

- Government
- Employers
- Individuals

INSURANCE COMPANIES, PROVIDER SYSTEMS

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5 **Most health care is financed by insurance. Why?**

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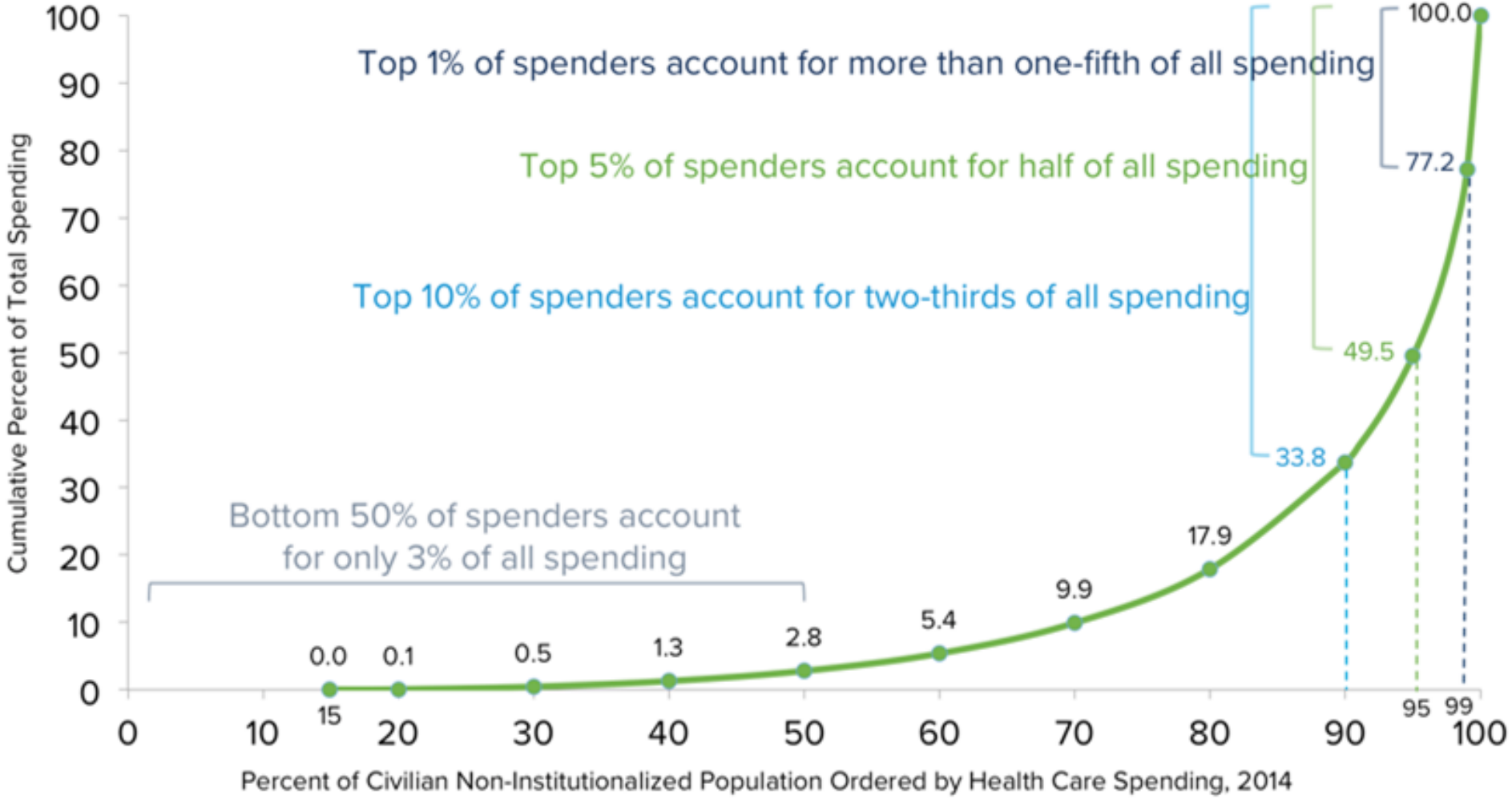
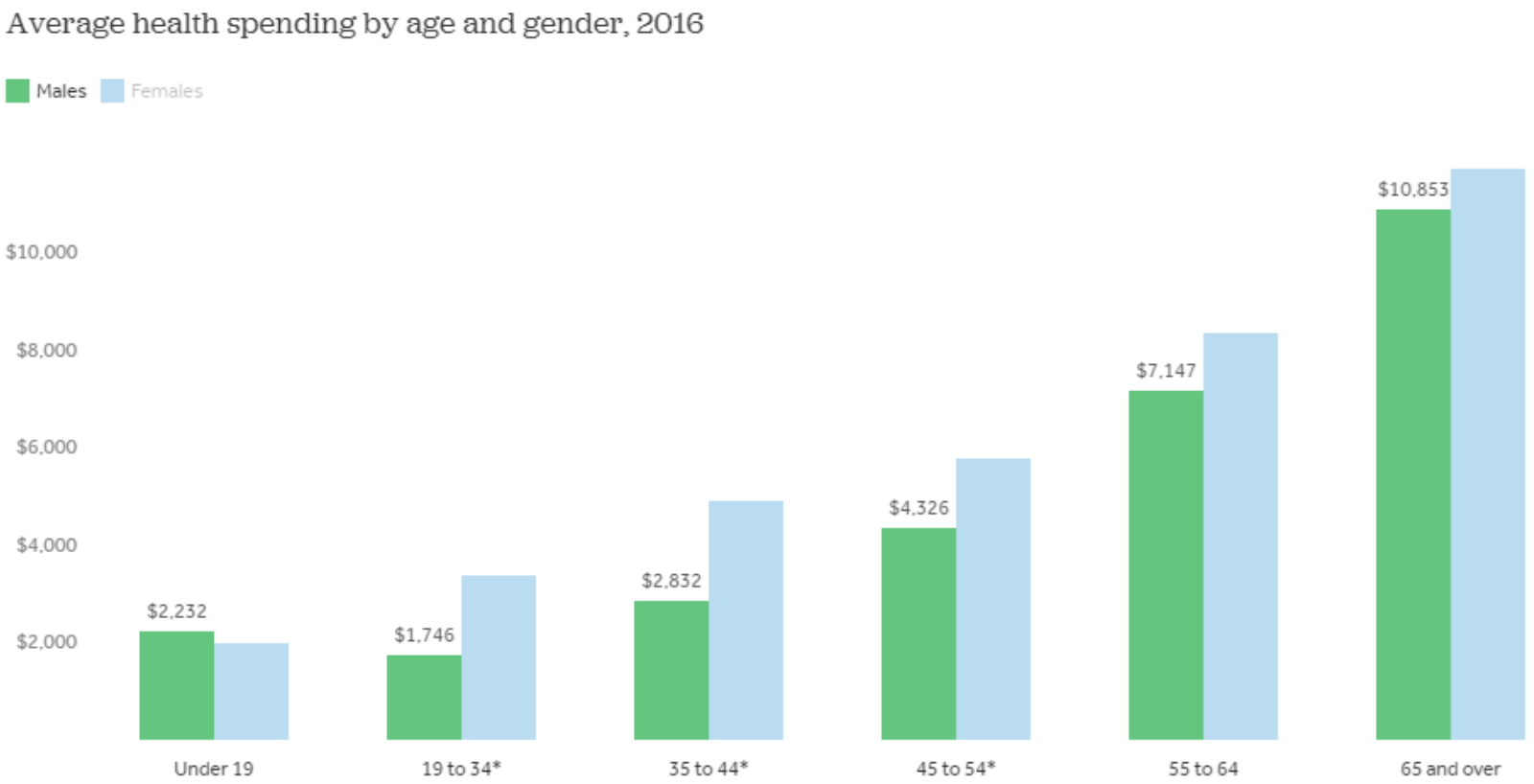
5. Most Health Care is Financed by Insurance
Spending is Highly Concentrated, Hard to Predict



NIHCM Foundation analysis of data from the 2014 Medical Expenditure Panel Survey

5. Most Health Care is Financed by Insurance
Costs by Age and Gender

While health spending increases throughout adulthood for both men and women, differences by gender vary by age



Note: *Indicates that, for the age range, the difference in estimates for males and females is statistically significant (p<.05).

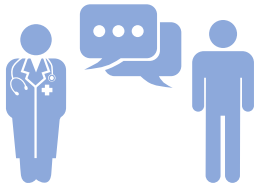
Source: Kaiser Family Foundation analysis of Medical Expenditure Panel Survey • Get the data • PNG

Peterson-KFF Health System Tracker

5. Most Health Care is Financed by Insurance: Health Insurance is Critical

Expensive and you never know when you'll need high-cost care

Protect assets
(if you are lucky enough to have assets to protect)



Insurance is **access** to health care providers and contract prices

Insurance facilitates **care coordination**

Everyone needs coverage!

Health insurance is important tool, but not the goal…

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6 Health systems and insurance in the U.S. are complicated and contribute to poor value

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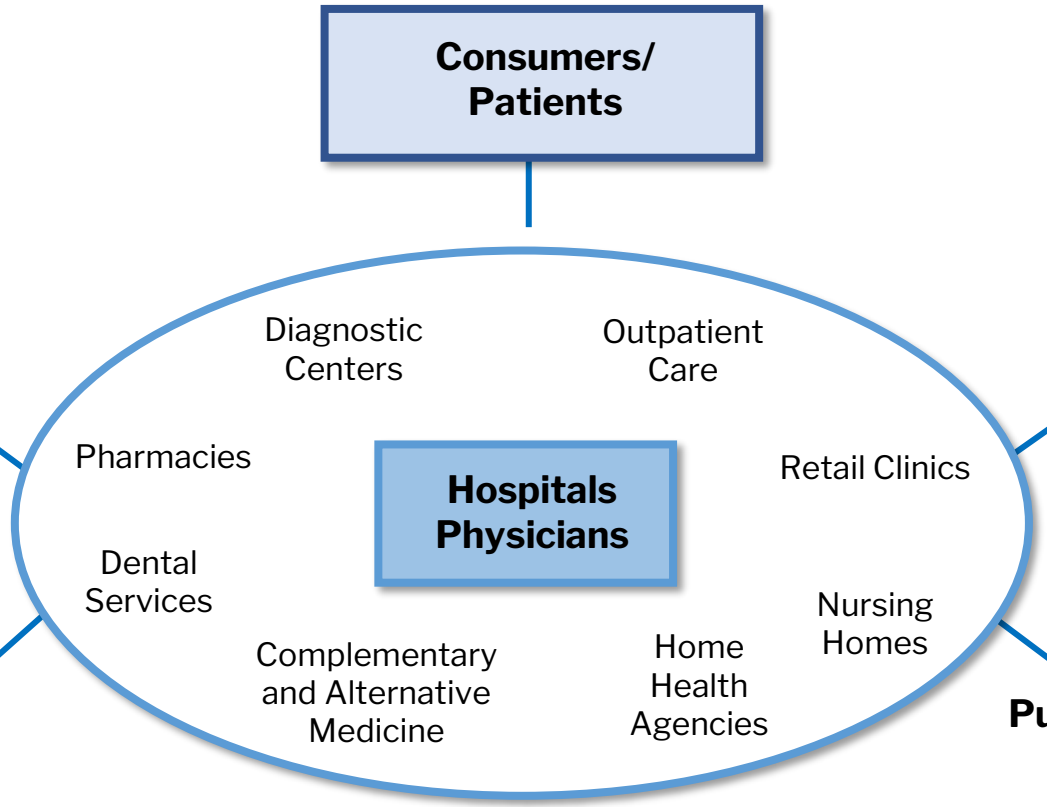
6. System View of the US Healthcare Industry: It's complicated



Pharmaceuticals
Biotechnology
Medical-Surgical Supplies
Medical Devices
Capital Equipment
Information Technology

Group Purchasing Organizations
Wholesalers/Distributors
Medical Professionals/Labor

Suppliers

Government:
Medicare and Medicaid
Veterans Administration
Employers
Individuals/Out of Pocket
Philanthropy

Insurers and Insurance Brokers
Managed Care
High-Deductible Health Plans/HSAs
Pharmacy Benefit Managers

Buyers

Regulators

State Insurance Commissioners
State Licensing Board
Food and Drug Administration
Occupational Safety and Health Administration
Federal Trade Commission
Justice Department
Office of the Inspector General

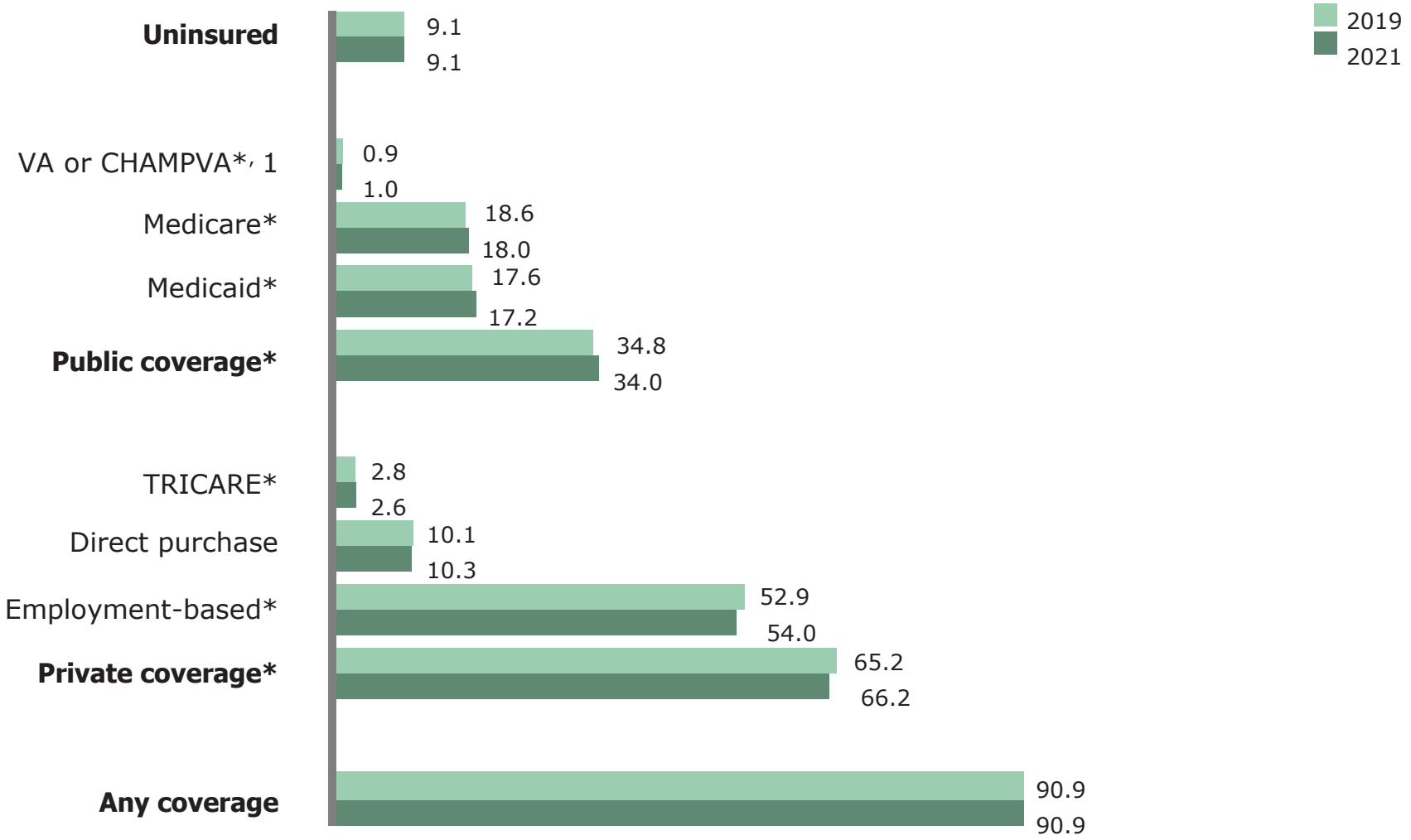
Public Health Agencies

National Institutes of Health
Centers for Disease Control and Prevention
Environmental Protection Agency
Department of Health and Human Services
Health Resources and Services Administration
Public Health Service
Departments of Defense, Homeland Security

Source: Lawton Robert Burns
The U.S. Healthcare Ecosystem

6. US Insurance is Complicated

Percentage of People With Health Insurance Coverage by Type: 2019 and 2021
(Numbers in percent. Population as of March of the calendar year)

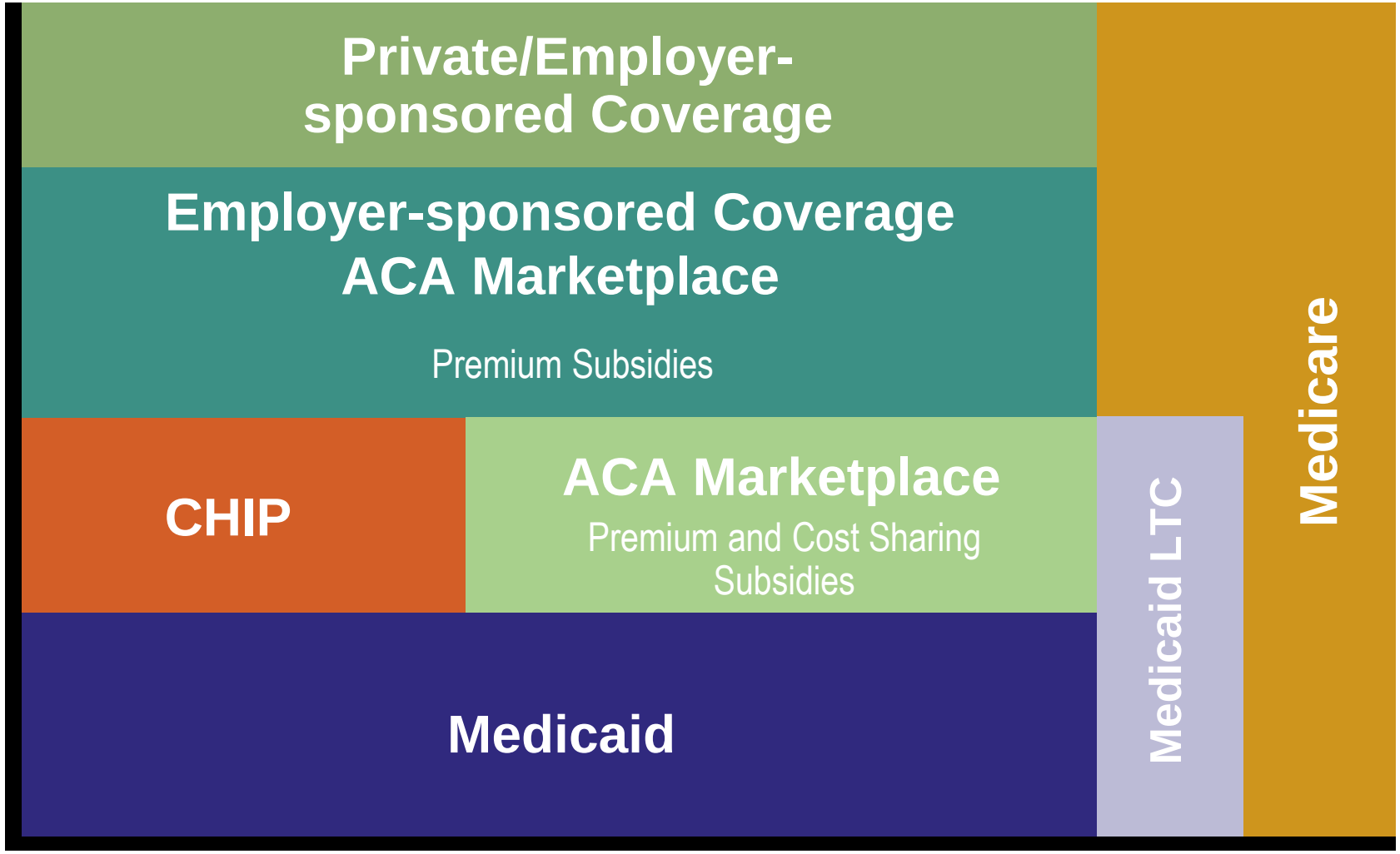


Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

6. U.S. Health Insurance is Complicated

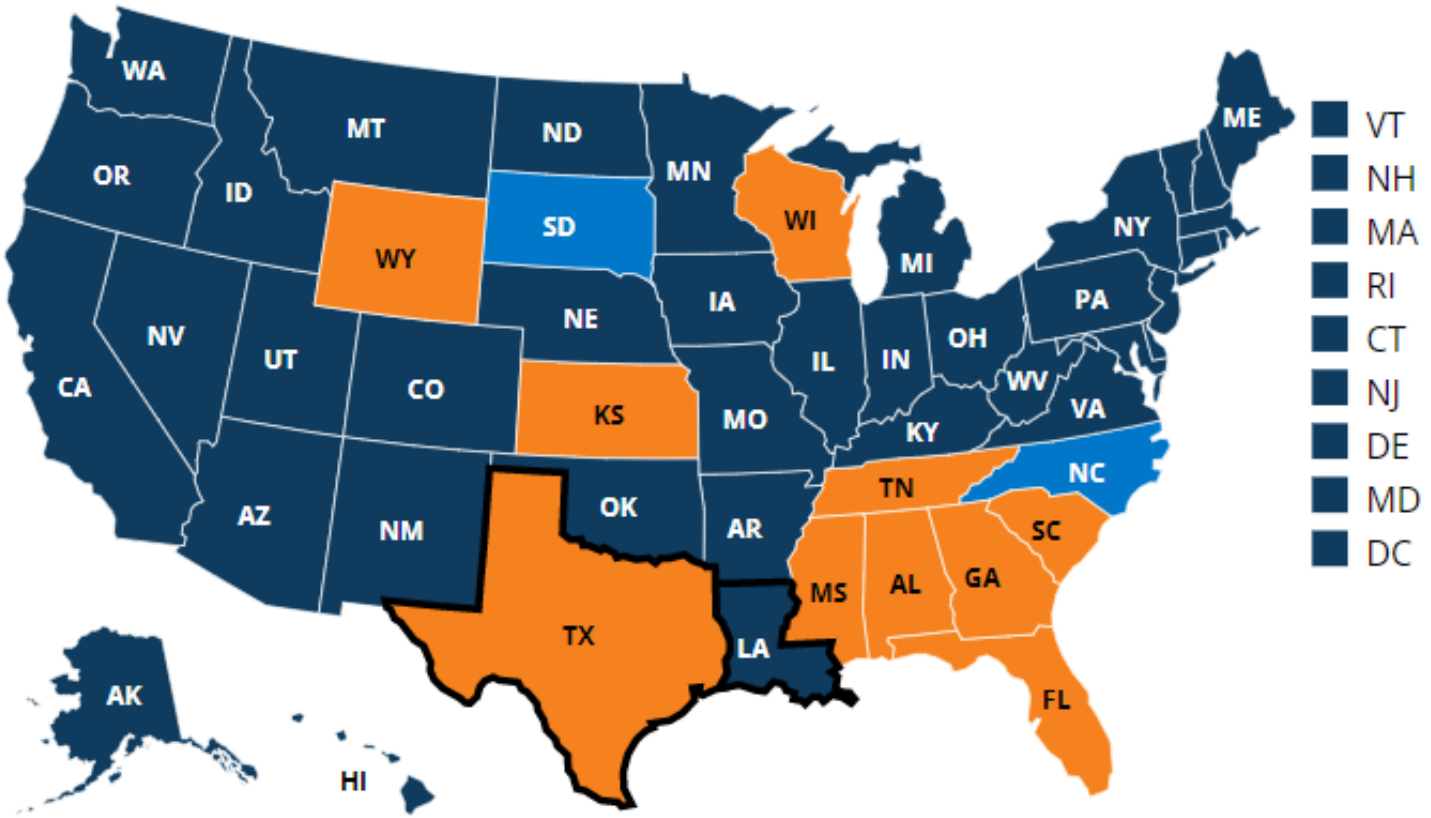
Predominant Coverage by Age and Income - After ACA

Family of 1	Family of 4	FPL
$54,360	$111,000	400%
$41,850	$83,250	300%
$34,875	$69,375	250%
$27,180	$55,500	200%
$18,075	$36,908	133%
$13,950	$27,750	100%
$2,265	$4,625	17%



6. Texas Did not Expand Medicaid under the ACA

Status of State Action on the Medicaid Expansion Decision



https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

6. Texas Health Insurance is More Complicated

Predominant Coverage by Age and Income- Texas

Family of 1	Family of 4	FPL
$54,360	$111,000	400%
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$34,875	$69,375	250%
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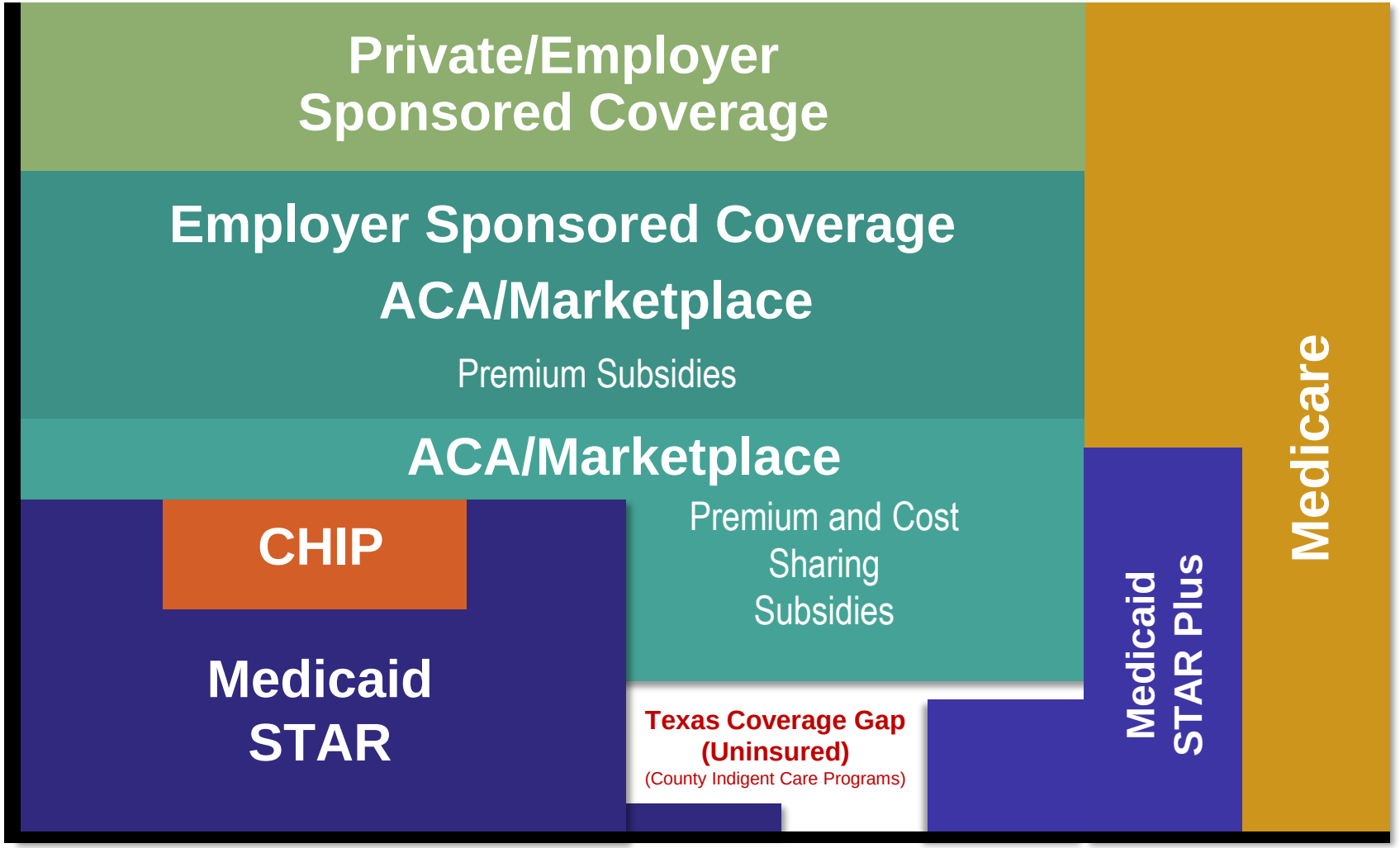
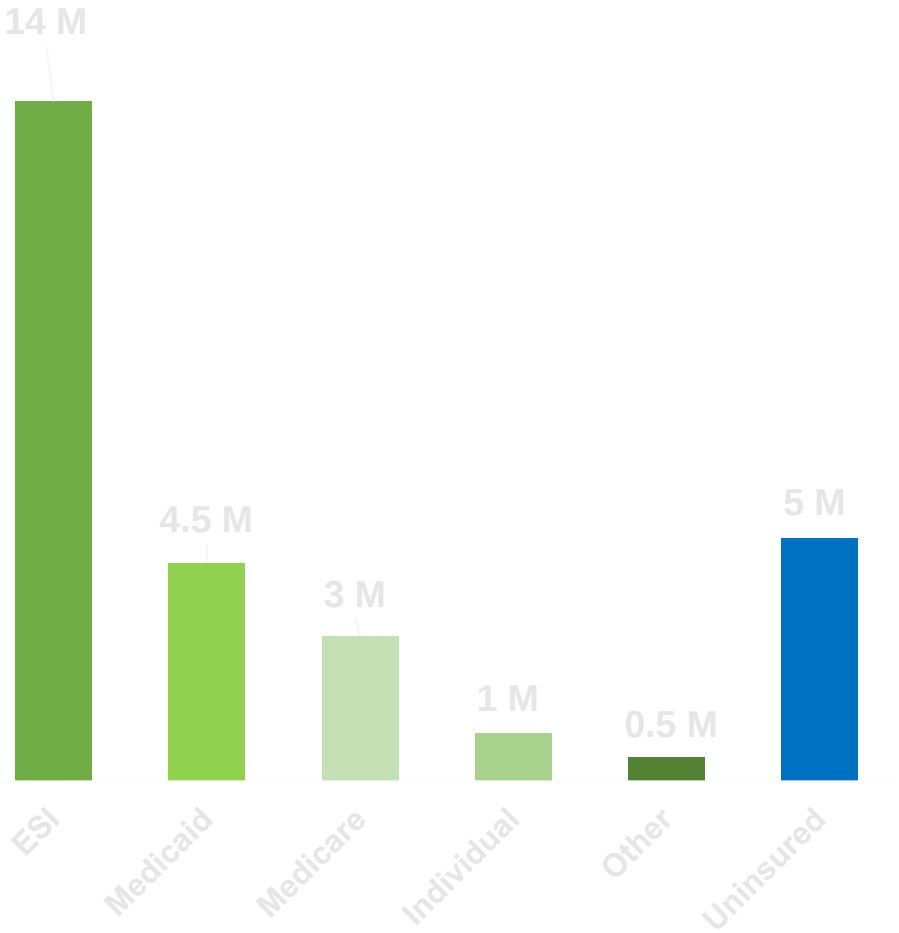
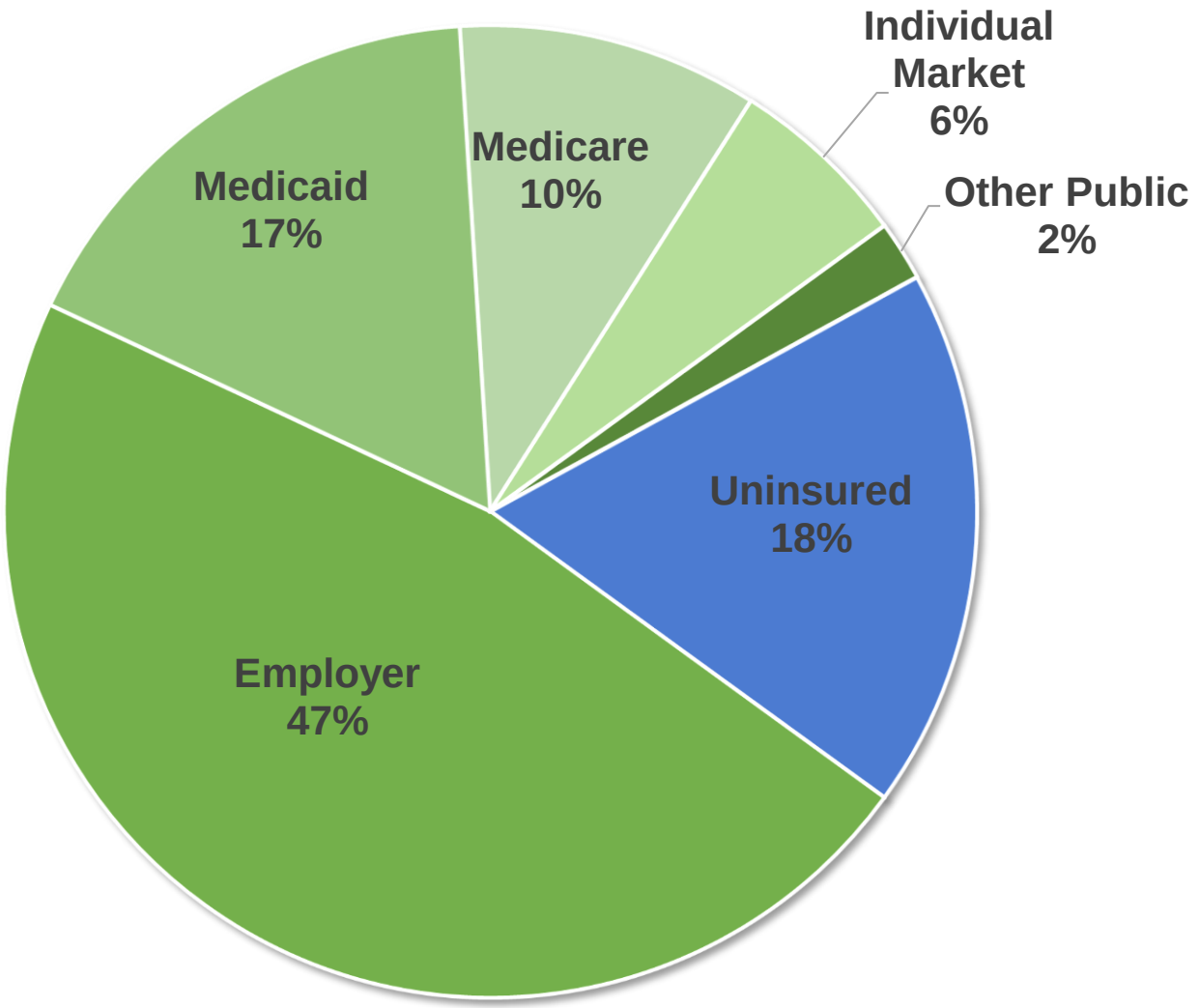


6. Health Insurance is Complicated
The Texas Health Insurance Market - 2018



28 Million Texans



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7 The way the US pays for the “uninsured” is inefficient and leads to poor outcomes

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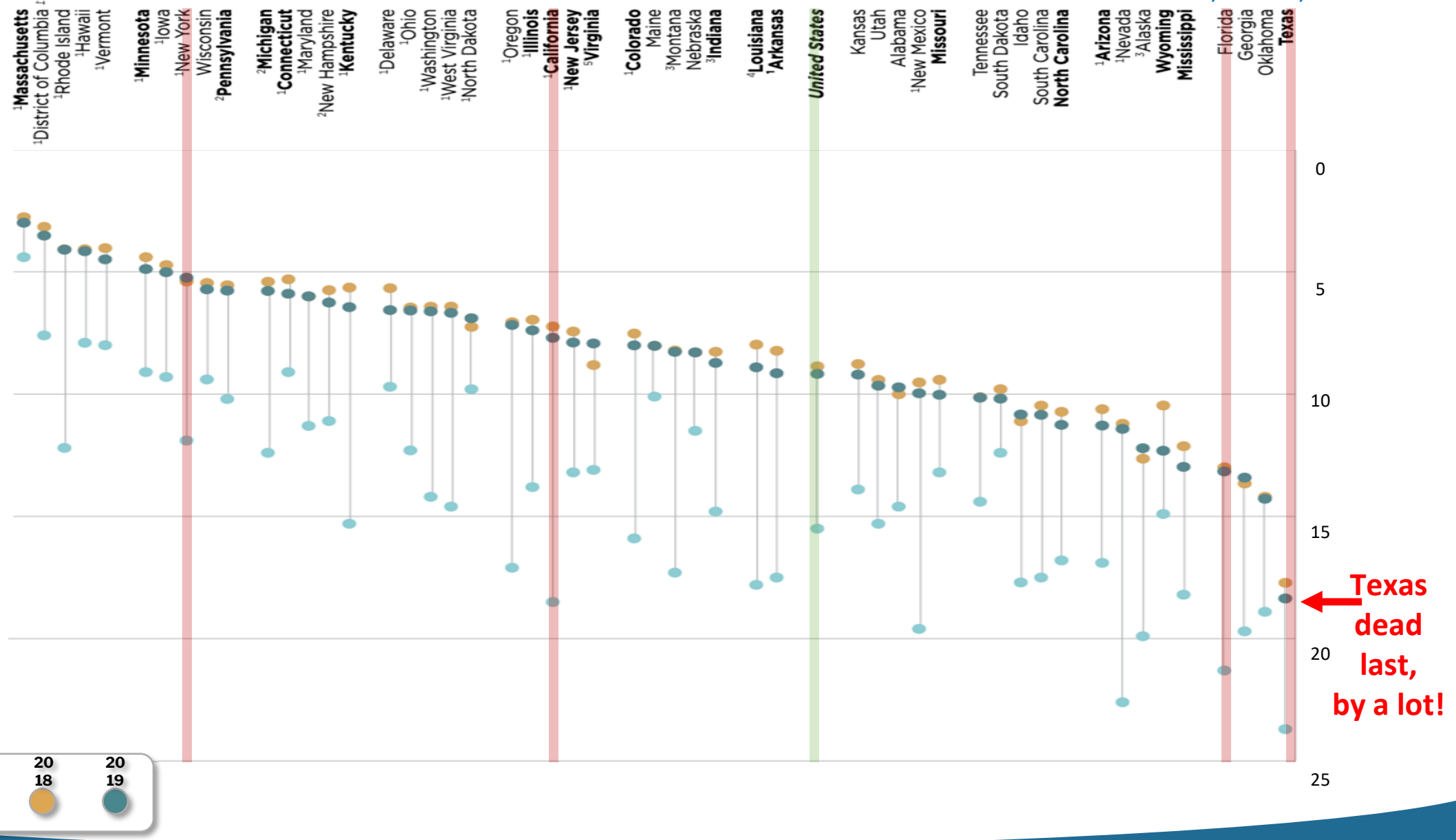
7. Percentage Without Health Insurance Coverage by State:

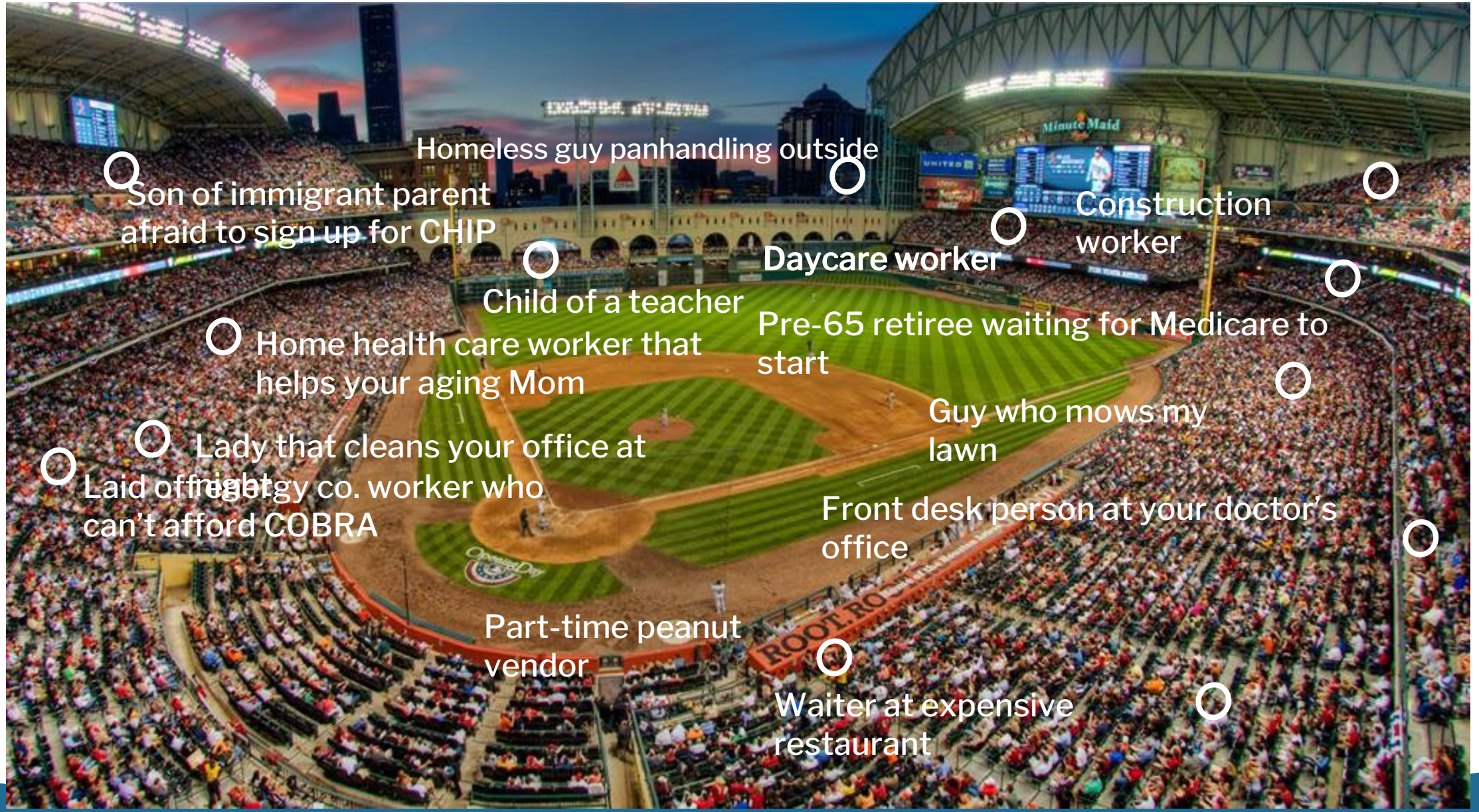
2010, 2018, and 2019



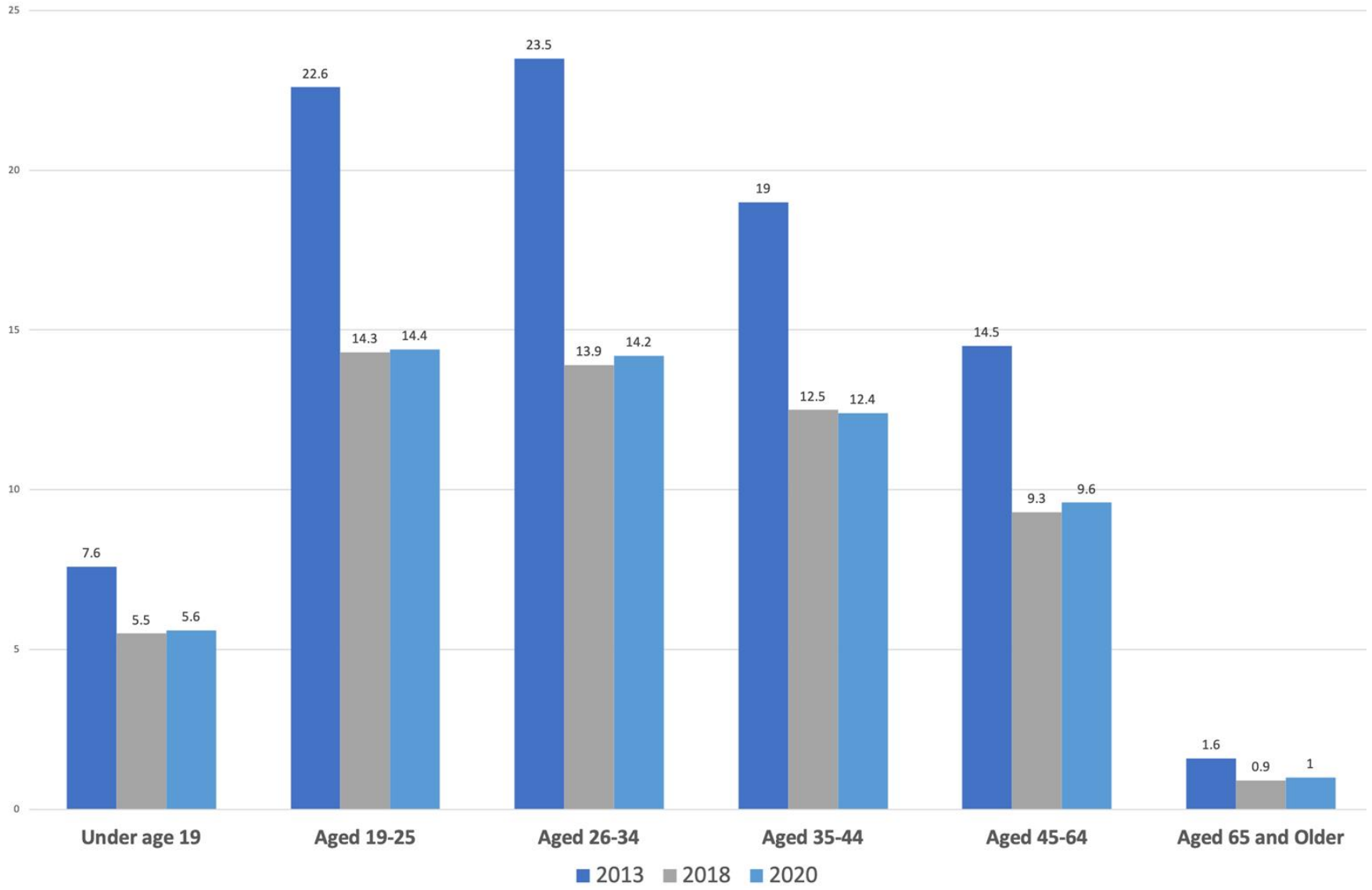
Source: U.S. Census Bureau, 2010, 2018, and 2019 American Community Survey (ACS), 1-Year Estimates

7. The Uninsured: 5 million, 17% of All Texans

7. Who are these uninsured people?

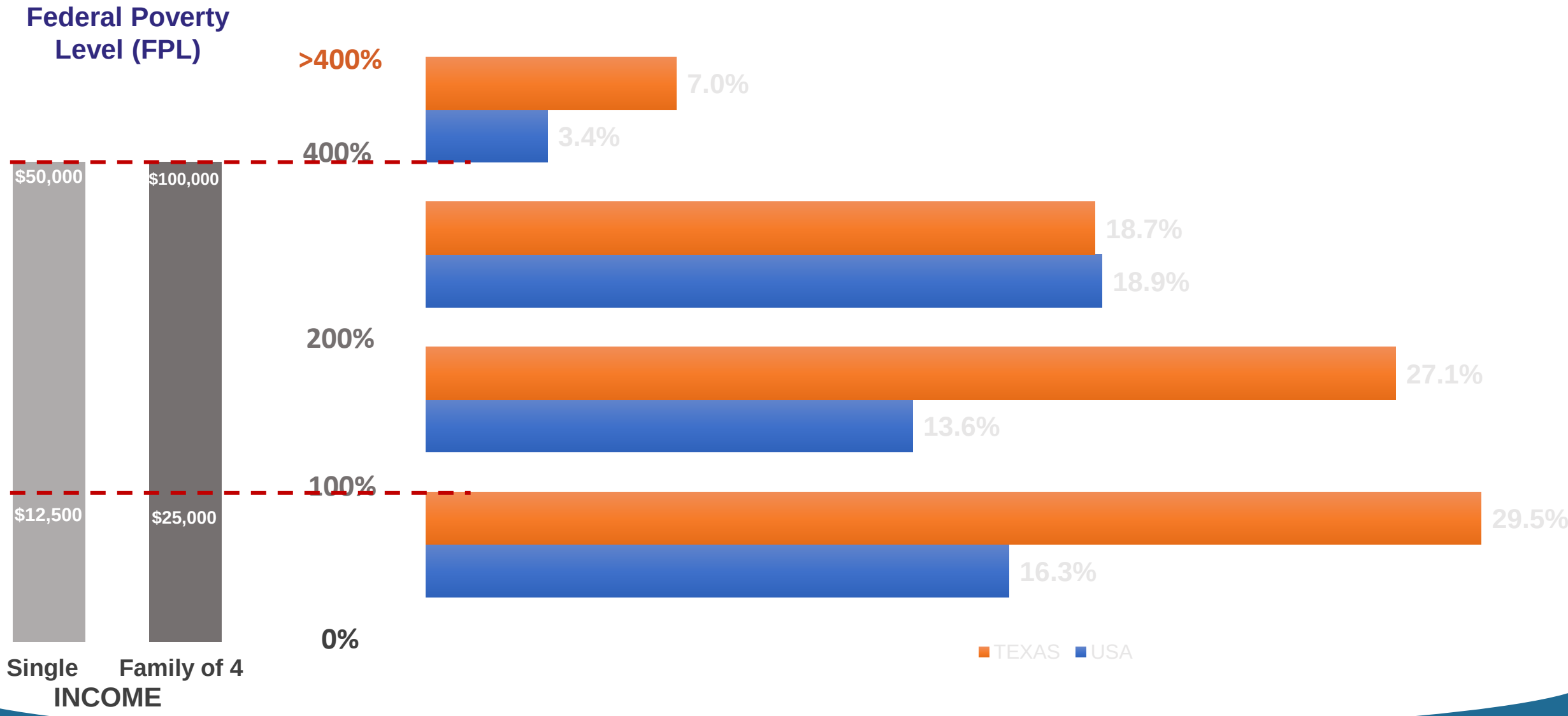


Percentage of People Uninsured by Age Group: 2013, 2018 and 2020



Source: U.S. Census Bureau, Current Population Survey, 2013, 2018, 2020

7. Who are These People?
Uninsured Rates Vary by Income



Source: https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf

7. Why are there so many uninsured Texans?

1. Health care is expensive and therefore health insurance is expensive
2. You don't need it TODAY. Unlike food or housing or transportation…
3. Almost everyone with insurance has someone else that pays most of the cost (employer, state or federal government)
4. Texas employers are the stingiest in the country… anti-union, accustomed to endless supply of immigrant labor. Nationally, about 60% of people have employer-sponsored insurance, only 47% in Texas.
5. Less than 30% of Texas small employers offer a health plan at all.
6. Many large employers exclude part-time workers from health insurance, some intentionally keep people under 30 hours/week to avoid ACA mandate.
7. Texas has the most restrictive eligibility for Medicaid in the country, and did not expand Medicaid under the ACA
8. Texas has the second most undocumented immigrant workers (exploited by employers, lack a voice to complain, don't understand employer-sponsored insurance)
9. Texas leaders have actively worked to kill the ACA without offering any alternative… changing?

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Population Health Measures:
Commonwealth Report Card
(47 indicators)

Access and Affordability

- Uninsured adults
- Uninsured children
- Adults without a usual source of care
- Adults who went without care because of cost
- High out-of-pocket medical spending
- Employee insurance costs as a share of median income
- Adults without a dental visit

Prevention and Treatment

- Adults without all recommended cancer screenings
- Adults without all recommended vaccines
- Diabetic adults without an annual hemoglobin A1c test
- Children without a medical home
- Children without a medical and dental preventive care visit
- Children who did not receive needed mental health care
- Children without all recommended vaccines
- Hospital 30-day mortality
- Central line–associated blood stream infection (CLABSI)
- Home health patients without improved mobility
- Nursing home residents with an antipsychotic medication
- Adults with any mental illness reporting unmet need
- Adults with any mental illness who did not receive treatment

Healthy Lives

- Mortality amenable to health care
- Breast cancer deaths
- Colorectal cancer deaths
- Suicide deaths
- Alcohol deaths
- Drug poisoning deaths
- Infant mortality
- Adults who report fair or poor health
- Adults who smoke
- Adults who are obese
- Children who are overweight or obese
- Adults who have lost six or more teeth

Avoidable Hospital Use and Cost

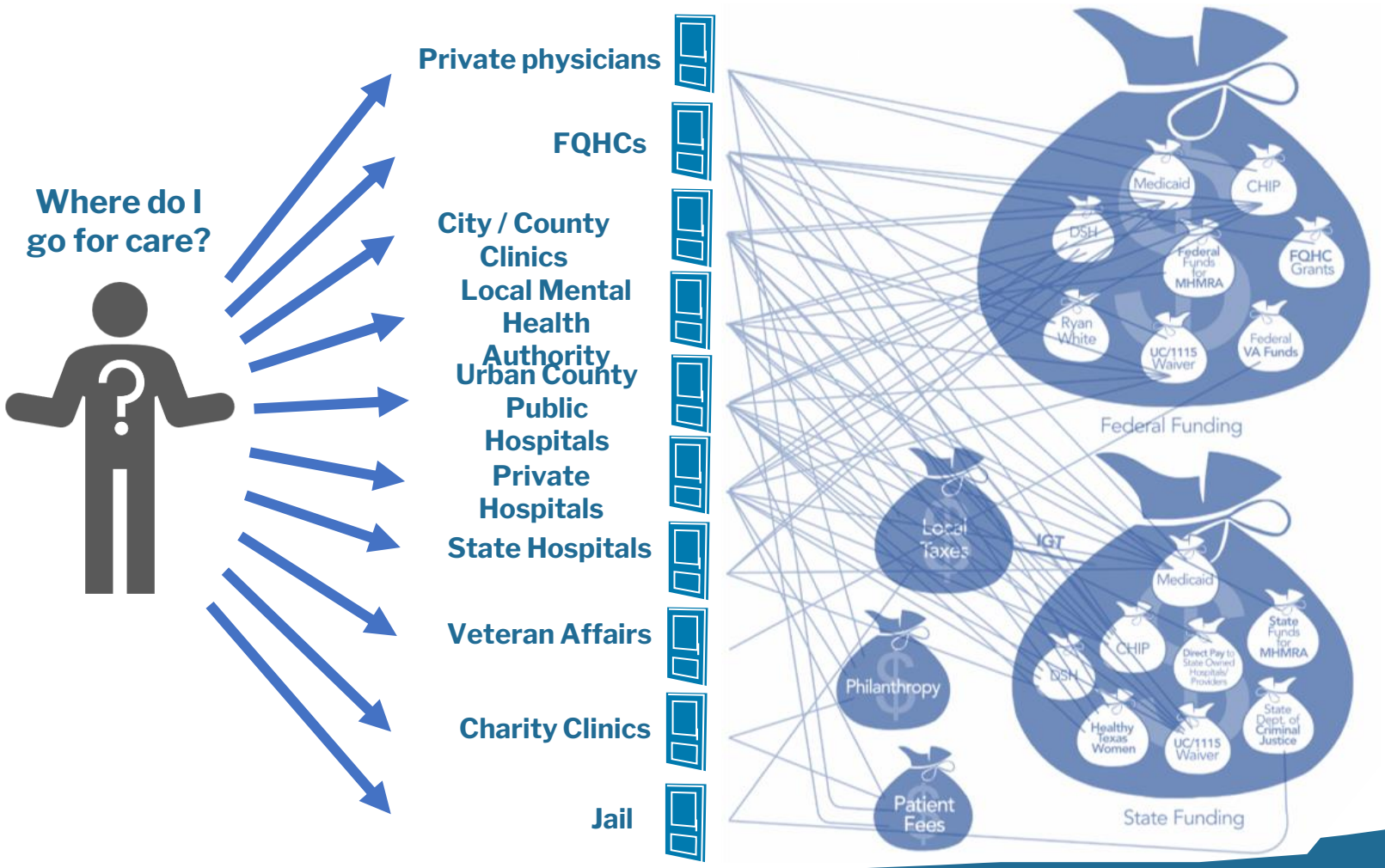
- Hospital admissions for pediatric asthma
- Potentially avoidable emergency department visits ages 18–64
- Potentially avoidable emergency department visits age 65 and older
- Preventable hospitalizations ages 18–64
- Preventable hospitalizations age 65 and older
- Hospital 30-day readmission rate ages 18–64
- Hospital 30-day readmission rate age 65 and older
- Skilled nursing facility patients with a hospital readmission
- Nursing home residents with a hospital admission
- Home health patients with a hospital admission
- Adults with inappropriate lower-back imaging
- Employer-sponsored insurance spending per enrollee
- Medicare spending per beneficiary

7. We Pay for the Uninsured:
Inefficient and Poor Outcomes (Coverage is Better)

CURRENT FRAGMENTED SAFETY NET "SYSTEM"

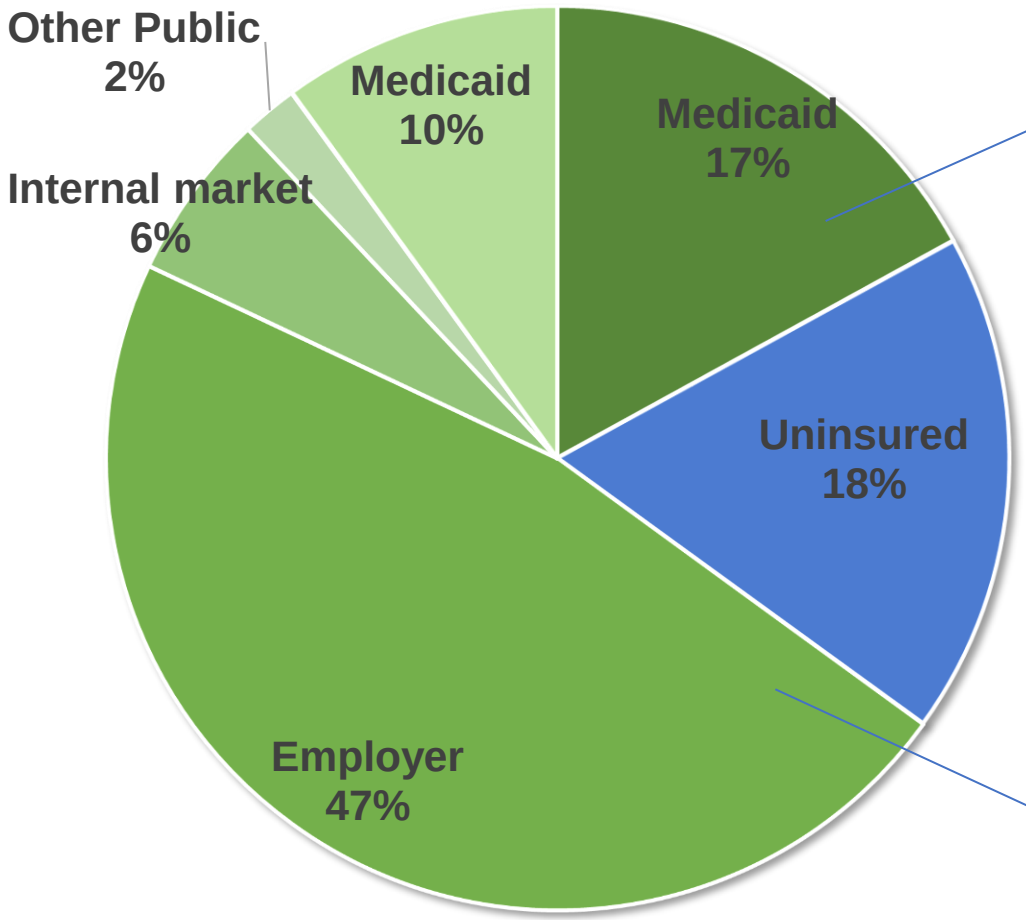
For 1.3 million eligible for Medicaid expansion, coverage would:

- Draw down more federal dollars
- Save the state money (90/10 match)
- Reduce administrative burden
- Produce better health outcomes



*Not exhaustive, other state funding sources currently exist for safety net care

7. Five Million Uninsured Texans



1.3 Million Adults could be covered under a Medicaid expansion

400K are Currently Eligible NOT enrolled in Medicaid

800K Undocumented working immigrants

2.5 Million low-wage Texans and their families

NOT offered
NOT eligible
or cannot
afford
employer
insurance

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8 **Affordability:**
Cost = Volume x Price (+ admin costs)

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8. Affordability: Cost = Volume x Price

Critical Formula of Health Care Financing

- Utilization rate (volume) x Unit cost (price) = Total cost
- Utilization usually expressed as per member per year (PMPY)
- Cost usually expressed as per member per month (PMPM)
- Utilization is highly dependent on who is in the risk pool (mix of old, young, healthy, or sick.)

Prescription Drugs

6 Rxs PMPY (utilization rate)

X $100 per Rx (unit cost)
$600 cost per year / 12 months = $50 PMPM

Inpatient Hospital

75 admissions/1,000 members (utilization rate)
X 4.0 days average length of stay

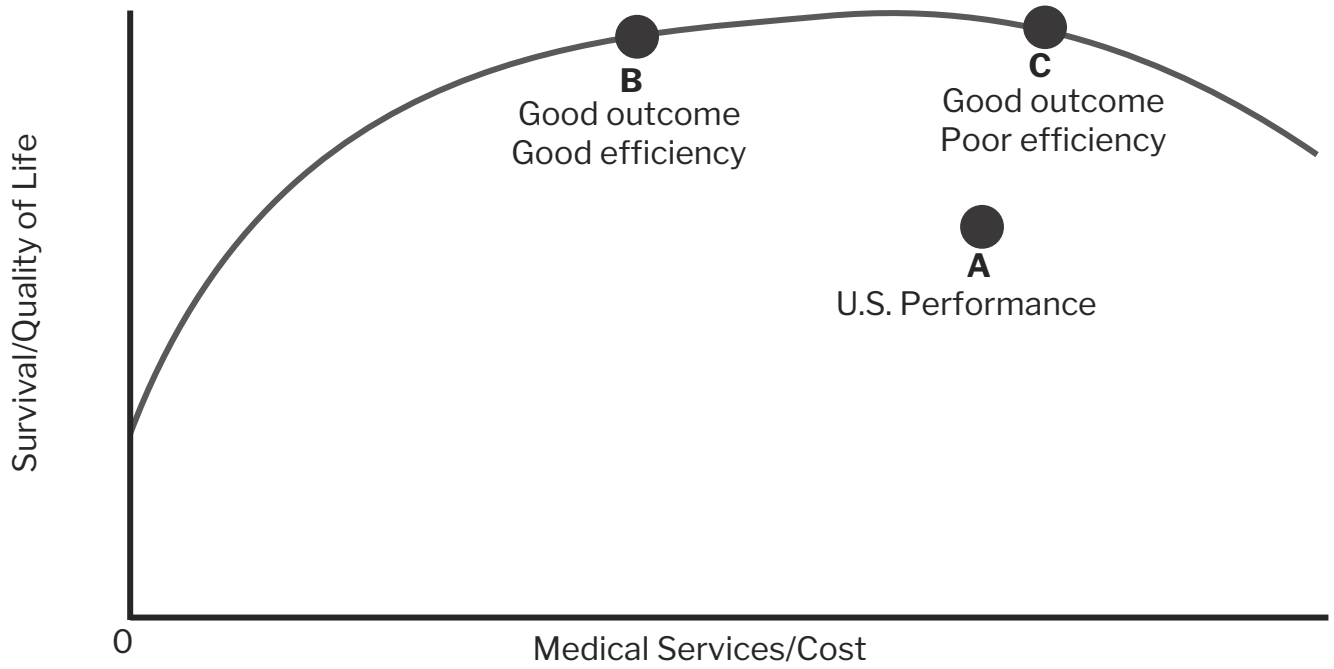
300 days / 1,000 members = 0.3 days per year
X $4,000 average cost/day (unit cost)

$1,200 cost per year / 12 months = $100 PMPM

US healthcare system incentives encourages low value utilization and high prices

8. Affordability: Cost = Volume x Price

Comparative Efficiency in Healthcare
Diminishing Marginal Utility



Controlling Prices

- Discounts, fee schedules
- Generic vs. brand drugs
- Less costly location, level of care

Controlling Utilization

- PCP gatekeepers
- Evidence-based guidelines
- Prior authorizations
- Concurrent reviews
- Complex care management
- Capitation, bundled payments

Increasing cost-effective services for better outcomes

- Immunizations
- Prenatal care
- Wellness/preventive exams
- Condition/disease management programs

Source: Chandra, Amitabh, Anupam B. Jena, and Jonathan S. Skinner. 2011. "The Pragmatist's Guide to Comparative Effectiveness Research." Journal of Economic Perspectives, 25(2): 27–46

8. Affordability: Cost = Volume x Price
The problem of FFS medicine mixed with “insurance”

Moral Hazard

Lack of incentive to guard against risk where one is protected from its consequences

- Insurance compounds moral hazard
- Patient incentives to receive any service that may help with little regard to cost/value
- Provider incentives for overutilization and charging higher prices
- Don’t worry…your insurance will pay for it!
  (But now the horrors of “out of network” charges.)
- Leads to costly administrative reactions to stop fraud, waste and abuse

US healthcare system incentives encourages low value utilization and high prices

8. Affordability: Cost = Price x Volume

Price discrimination

As a general rule…

$ — **Medicaid pays least (.7)** — **Medicare is benchmark (1.0)** — **Employer-sponsored (2.0)** — $$$$

- Physicians and other professionals (1.25)
- Hospitals (1.5 – 3.0)
- Hospital based physicians (3.5 – 8.0)

Low Medicaid payment rates discourage providers from participating. Bad policy.

Certain providers receive supplemental Medicaid payments: hospitals, FQHCs.

Employers are increasingly unhappy with much higher payment rates than Medicare. Tired of subsidizing government programs and/or provider inefficiency/extravagance.

Providers complain about Medicare, but prepare for operation with all patients at or near Medicare.

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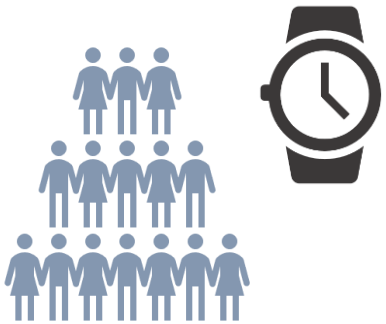
8. Affordability: Cost = Volume x Price

Market Prices or Price Controls?



Market prices work when large supply and time to shop

Market failures in monopolies, patent protections, or lack of consumer opportunity

Examples of Market Failures

- *Emergency room services, ambulance*
- *Hospital consolidations/monopolies*
- *Hospital based physicians*
- *Drugs on patent, without therapeutic substitution*

US healthcare system incentives encourages low value utilization and high prices

WildBlue
HEALTH SOLUTIONS

Ten Key Concepts

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9 Pay for Value not Volume

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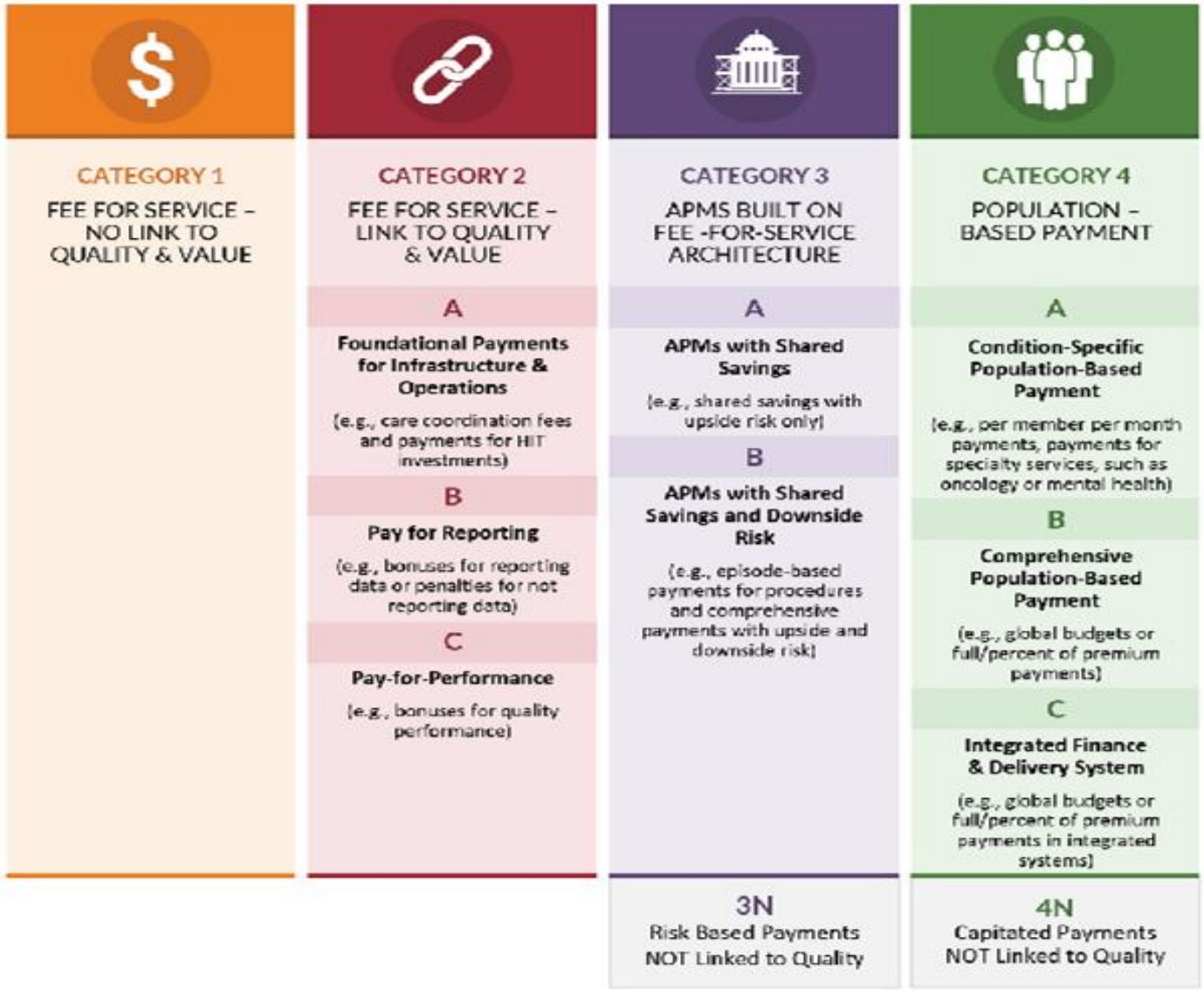
9. Pay for Value, not Volume

Moving to Value-Based Care and Contracting

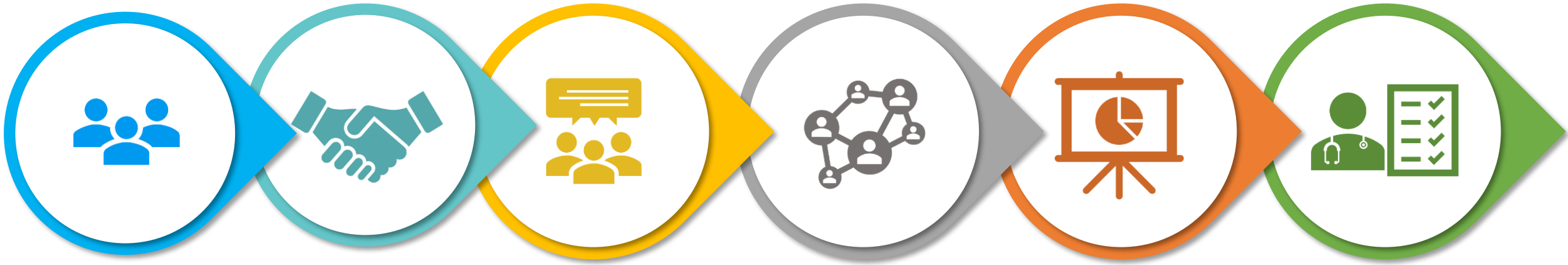
Most health care services in the US still paid FFS



Moving to value-based payments has been slower than expected

https://hcp-lan.org/workproducts/apm-refresh-whitepaper-

9. Implications of Value-Based Care



Population

Care Team

Care management

Social determinants of health

Data: Coding, analytics

New compensation models for doctors

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10 A Health Care Policy Home Run: The Four Bases (implications for primary care)

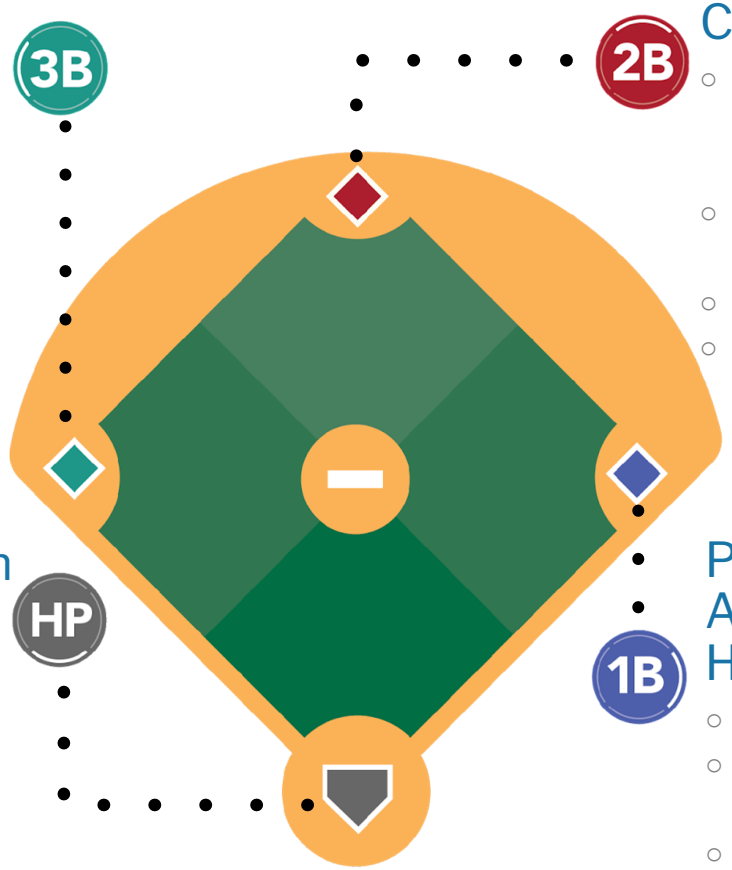
10. Our Goals: A Health Policy Home Run

Simplify Funding and Administration of Programs

- Reduce administrative burden through consistent program administration across Medicare, Medicaid, and private plans
- Reduce complex supplemental provider funding in government programs
- Integration/interoperability of systems

Slow Cost Increases through Provider Payment Reform

- Encourage coordinated, less fragmented care (medical homes, ACOs, etc.)
- Restructure provider payments to reward efficiency and quality (value-based payments)
- Assure fair payment rates across programs and providers, incl Rx



Coverage for Everyone

- A basic benefit plan for all based on age, income, disability
- Choices and ability to "buy up" for additional services
- Everyone in the pool
- Subsidies based on age and income

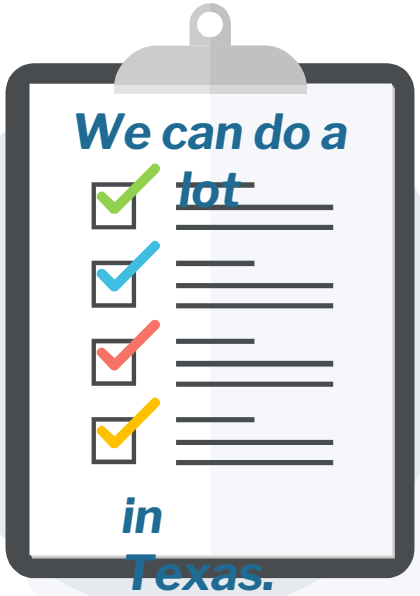
Personal & Community Accountability for Health

- Healthy behaviors
- Choices, transparency and consumerism
- Everyone pays something: based on income
- Community/social influences

10. Ken Sees the Future for Health Insurance

Short-term there will continue to be gridlock in Washington, DC.

- Texas will continue and eventually expand Medicaid Managed Care, but still high uninsured
- Medicare Advantage will grow
- Small group market will disappear, replaced by QSEHRAs/ICHRAs
- Many large employer will move to defined contribution



- A Texas health insurance exchange to make it easier for individuals and employers to buy
- Medicare and Medicaid will continue move to VBC*
- Large employers will demand reduced price discrimination
- Looks like Medicare Advantage for All

*(**QSEHRA**)Qualified Small Employer Health Reimbursement Arrangement

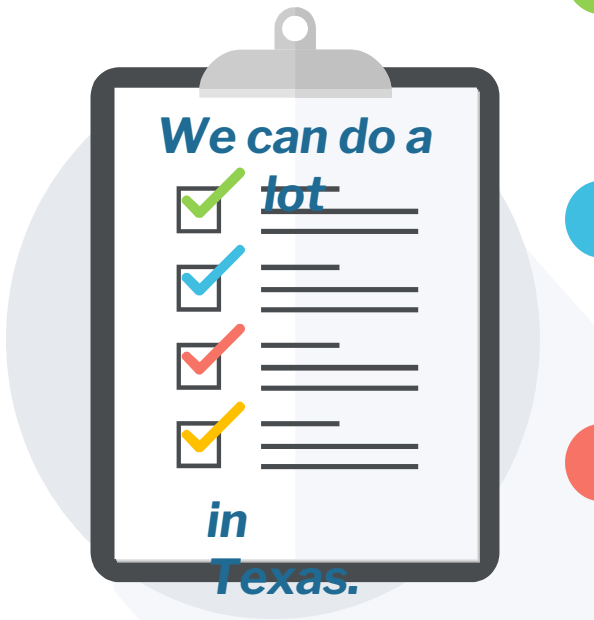
*(**ICHRA**) Individual coverage health reimbursement arrangement

*(**VBC**) Value based Contract

10. Ken Sees the Future: Health Consumers

Short-term there will continue to be gridlock in Washington, DC.

- Focus on price of insurance
- Are bigger deductibles, more cost-sharing a good or bad thing?
- Obamacare, HSAs, HRAs, STLDI… I'm confused
- Is my doctor in the network? But access is more than "Is my doctor in the network?"



- On demand care: urgent care centers, telemedicine
- Picking a system rather than just a PCP (e.g. Kelsey Seybold, Memorial Hermann, etc.)
- Consumer experience trumps clinical quality. Are health plan quality measures aligned with consumer needs?
- Make it easier: mobile devices, personal health records and other consumer expectations

10. Ken Sees the Future: Health Insurers

Short-term there will continue to be gridlock in Washington, DC.

- Texas will continue and expand Medicaid Managed Care, but still high uninsured
- Medicare Advantage will grow
- Small group market will disappear, replaced by QSEHRAs/ICHRAs
- Many employers will move to defined contribution

- Need to understand and improve SDoH*, behavioral issues and other non-medical ways to improve health
- Customer service will matter
- Narrow networks will thrive
- Transition to VBC will happen: implications for data sharing, provider relationships
- Lines between market segments will blur, disappear
- Regional plans can compete with the nationals (at 500K+ members?)

*(**VBC**) Value based Contract
(**SDoH**) Social determinants of Health

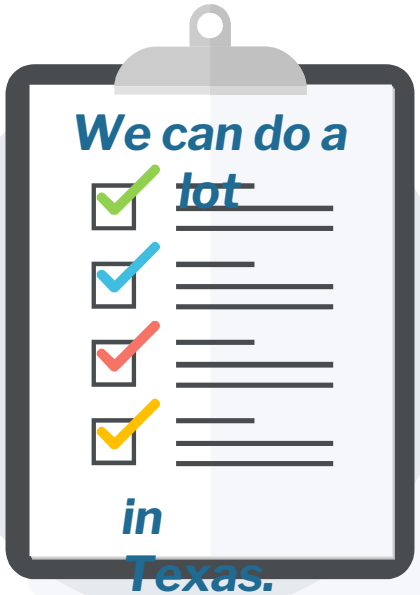
*(**QSEHRA**)Qualified Small Employer Health Reimbursement Arrangement

*(**ICHRA**) Individual coverage health reimbursement

10. Ken Sees the Future: Health Care Providers

Short-term there will continue to be gridlock in Washington, DC.

- Narrower networks: pick your payer partners (payment rates, administrative hassles)
- Provider Payment Reform: Value based, transparent and reduced price variation
- Sharing of data with insurers and patients (EHRs, PHRs, claim systems)
- Improved consumer experience required



- Care coordination/Clinically integrated networks
- Medicaid growth in specialties serving adult population
- Population health (disease registries, not just EMRs)
- Social determinants of health

*(**QSEHRA**)Qualified Small Employer Health Reimbursement Arrangement

*(**ICHRA**) Individual coverage health reimbursement

10. Ken Sees the Future: Primary Care Providers

Who will you work for?

Big health systems vertically integrating	Memorial Hermann, Baylor Scott & White, Houston Methodist
Academic groups	UT Physicians, Baylor College of Medicine, UTMB
FQHCs	Legacy, Lone Star, HealthPoint
Private equity/venture capital backed or publicly traded groups	Village MD, One Medical (Amazon), Walmart
Health Insurers	Kelsey Seybold (Optum), Oak Street (Aetna), Centerwell (Humana)

10. Ken Sees the Future: Primary Care Providers

How will you be paid?

- Straight Salary: 0 – 100%
- Salary (e.g. 50% of total comp) with strong incentives for productivity (RVUs)
- Salary with value-based incentives for quality, customer satisfaction
- Mixed salary and incentives with profit sharing
- Pure FFS/RVUs (not likely to continue)

It's rapidly changing, murky now, but as value-based payments to organizations grow, physician compensation will follow.