

Show Us the Money!

Public Finance Explained

MIND - O P E N E R # 3 :

The Feds – Access, Costs and Quality of Health Care

David Durenberger, National Institute of Health Policy, University of St. Thomas

Tim Penny, Humphrey Institute Policy Forum, University of Minnesota

August 18, 2005

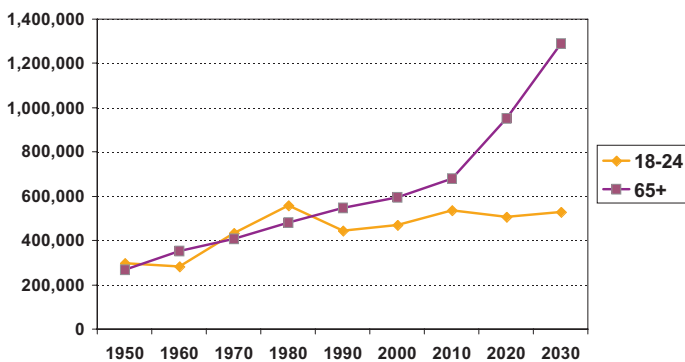
Our problem

The United States spends \$1.7 trillion a year on health care, but our health care system faces significant challenges:

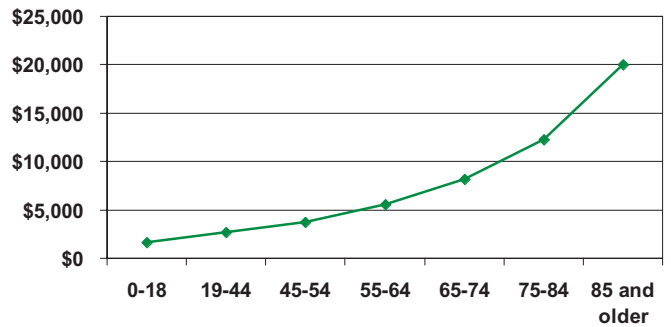
- Patient & employee safety
- Disparities in quality & access
- It takes 17 years from discovery of a new technology to implementing it in practice
- Medical liability costs increasing
- Professional shortages
- 44 million uninsured

In Minnesota, the costs of health care will shoot up in the coming decade: the Baby Boom generation starts to turn 65 in just 2011 – and health care costs increase dramatically after age 65.

MN Boom Generation Begins Turning 65 in 2011



Personal Health Expenditures

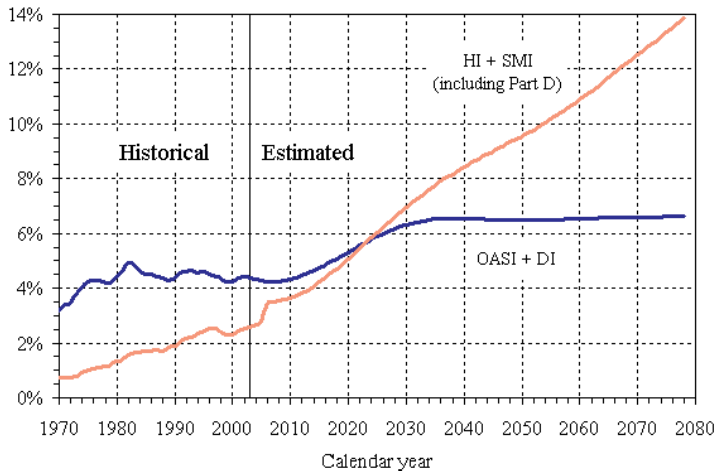


Medicare

Medicare, which provides health insurance for the elderly and disabled, was established in 1965. Medicare is managed and funded by the federal government. Medicare Part A covers hospital insurance; Part B covers medical insurance. Coverage for prescription drugs will begin in 2006.

Medicare costs are rapidly increasing: by the 2020s, Medicare will cost the country more than Social Security. On the graph below, the lighter line (labeled HI + SMI” for “hospital insurance and supplementary medical insurance”) represents Medicare; the darker line (“OASI + DI,” which stands for Old Age and Survivors Benefits and Disability Insurance) represents Social Security.

Social Security and Medicare Cost as a % of GDP



Previous attempts to control costs have been unsuccessful: supply and price regulation in the 1970s and managed behavior modification (by health maintenance organizations) in the 1990s. Today, reforms are focused on creating a consumer-driven healthcare system. The Medicare Modernization Act of 2003 calls for privatization, shifting costs to beneficiaries, focusing on defined-contribution rather than defined-benefit plans and a movement away from entitlement to “personal responsibility.”

Medicaid

Medicaid, a state and federal program to provide health insurance for low-income families and individuals, was established in 1965 as a result of a successful lobbying effort by the National Association of Counties. Before that time, counties were responsible for maintaining public health programs; they argued that public health was a national concern and should be covered by federal legislation. Today, Medicaid is managed by the states and funded jointly by federal and state governments. Medicaid covers 52 million enrollees; 7 million have dual eligibility (that is, they are both elderly and disabled). Those 7 million consume over 40% of Medicaid dollars. Medicaid actually spends more money on elderly Americans than Medicare – 50% of Medicaid participants are elderly; 90% of their costs are in long-term care.

Long-Term Care

It costs \$50,000 each year that an individual spends in a long-term care facility. Minnesotans need to decide: how much of that cost should be financed with public money, and what portion should individuals and families shoulder?

The current system encourages families to hide assets, in order to appear needier and therefore qualify for more assistance in paying for long-term care. Hiding assets is easy – elderly parents can place their assets in their children’s names – and most states do not aggressively enforce a thorough review of assets.

Medicine is Not a Market Product

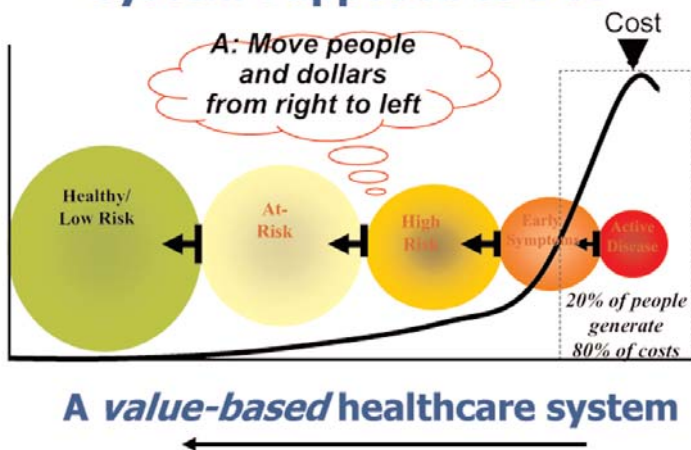
- Demand for the health care (the “product”) is irregular and unpredictable.
- Supply of the product is not responsive to buyer demand but to provider judgment.
- There is limited provider entry, as a result of high costs, and professional, educational and licensure limits.
- Pricing is difficult: consumers are insulated from costs, providers are cross-subsidized and there is little-to-no real price competition.
- There is an asymmetry of information between the provider and the buyer concerning the need for, and the probable consequences of, a medical service or course of action.

So, what are the solutions?

Our health care system is the result of “evolution.” What might it look like if we engaged in some “intelligent design?”

The first question should be: what is the health care system supposed to do?

Q: What is the Health Care System Supposed to Do?



To accomplish this, we need *national rules*, a *local health care market* and *private contracts*.

The public needs to believe that Medicaid and Medicare are not health care programs, but instead are programs that provide financial access to health care treatment.

Minnesota Citizens Forum on Health Care Costs

The Minnesota Citizens Forum on Health Care Costs (MCF) sought to ascertain Minnesotans' views on health care costs and recommend strategies for controlling costs that reflect those views. MCF developed seven principles for health care cost reform:

1. Put Minnesotans in the driver's seat.
2. Fully disclose costs and quality.
3. Reduce costs through better quality.
4. Change incentives to encourage health.
5. Assure universal participation.
6. Support new models of healthcare education.
7. Reduce the cost of overhead and administration.

Charging fees for service injects competition into health care (when consumers can choose their providers), but have been shown to increase overall costs and lead to overtreatment and overmedication.

Limiting treatments and medication: Minnesotans believe that they are overtreated and overmedicated, but when it comes down to it nobody wants to limit their ability to receive treatments.

Increasing co-payments and deductibles shifts costs from the government to individual health care consumers, and forces consumers to make health care choices using their own money.

Means testing. The majority of social security programs are not means-tested (that is, eligibility is not based on income). Why not base Medicare eligibility on income?

Disease management & prevention. 80% of people 65 or older have at least one chronic condition; 50% of people 65 or older have at least two chronic conditions. We should invest in public health programs to prevent chronic illness and best practices for disease management

Subsidizing health care premiums, rather than providing a health care system. The Medicare Advantage program already does this.

Make long-term care coverage an insurance program, financed through a payroll tax.

Mind-Opener Schedule

Wednesday, August 31

The 800-Pound Gorilla in Minnesota: Health Care

Dan McElroy

Chief of Staff to Governor Tim Pawlenty

Jan Malcolm

Chief Executive Officer, Courage Center

Lynn Blewett

Director, Public Health Administration Program
University of Minnesota

How can the state address the demographic time bomb of providing our aging population high-quality health care at a price we all can afford?

Wednesday, September 14

The 800-Pound Gorilla in Our Backyards

Karen Anderson

Mayor of the City of Minnetonka

Matt Smith

Director of Financial Services, City of Saint Paul

How do we meet post-9/11 homeland security demands facing local governments? How can we provide greater public safety with limited resources?

Wednesday, September 28

Wrap-up Mind-Blower (evening)

Join the Citizens League and a number of reform-minded policymakers to review what we learned in the previous sessions and discuss ideas for how we can most effectively serve the common good. We'll take the most compelling facts and key policy questions that have emerged from the five previous sessions and use them to frame small group discussions with citizens and policymakers.

Networking & registration at 5:30 p.m.

Program at 6:00 p.m.

Dorsey & Whitney, 50 South Sixth Street in Downtown Minneapolis.

Citizens League

555 North Wabasha St., Suite 240

St. Paul, MN 55102

ph#: 651/293-0575

fax#: 651/293-0576

www.citizensleague.net

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