

RETHINKING
THE BOUNDARIES



**Cost and Care:
Where Does the Money Come
From?
Where Does It Go?**

Wednesday, March 23rd, 2011

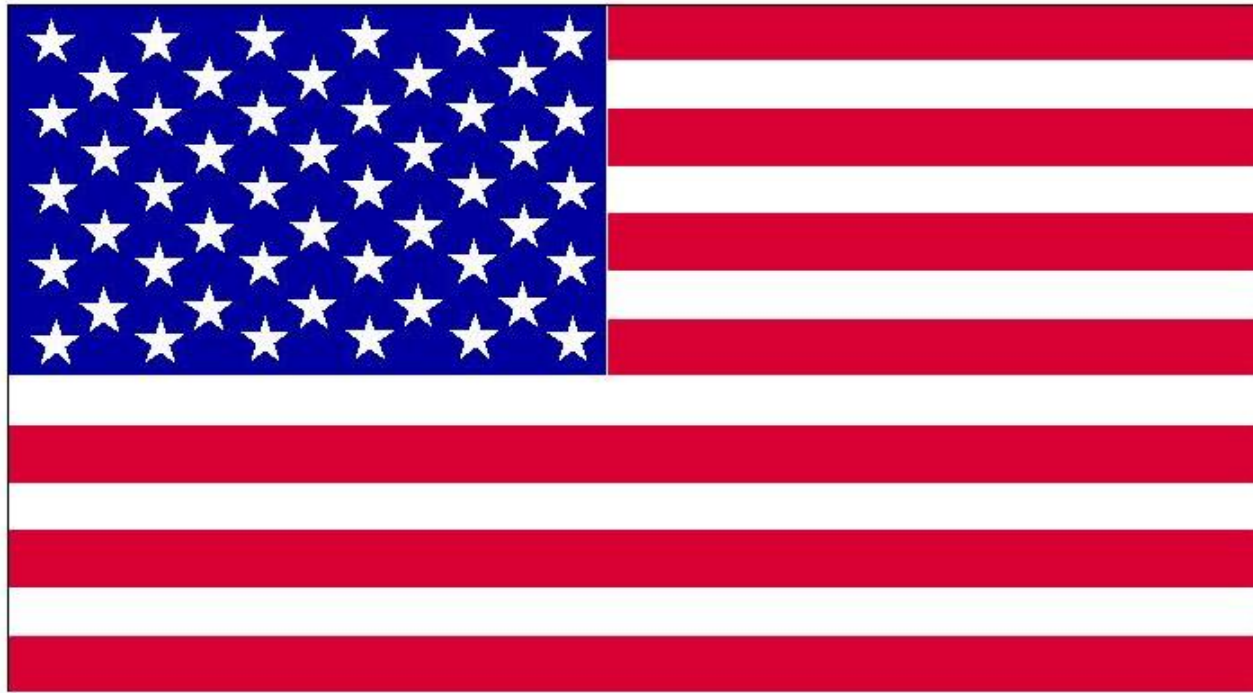
Kevin Schulman MD, MBA

Professor of Medicine and

*Gregory Mario and Jeremy Mario Professor of Business
Administration*

Director, Health Sector Management



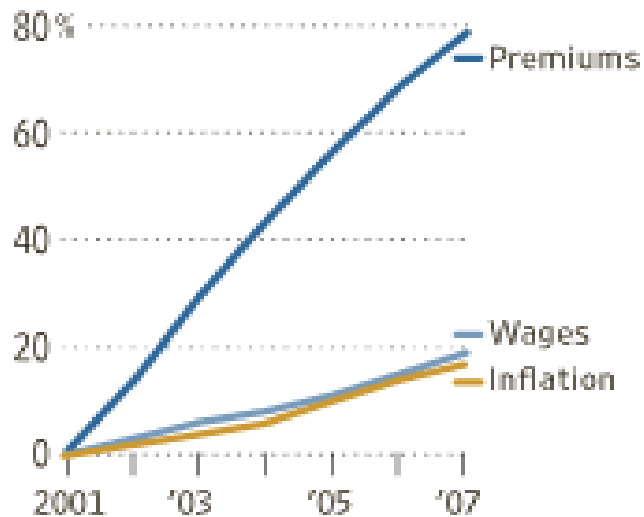


Made in USA

Cost of Health Insurance

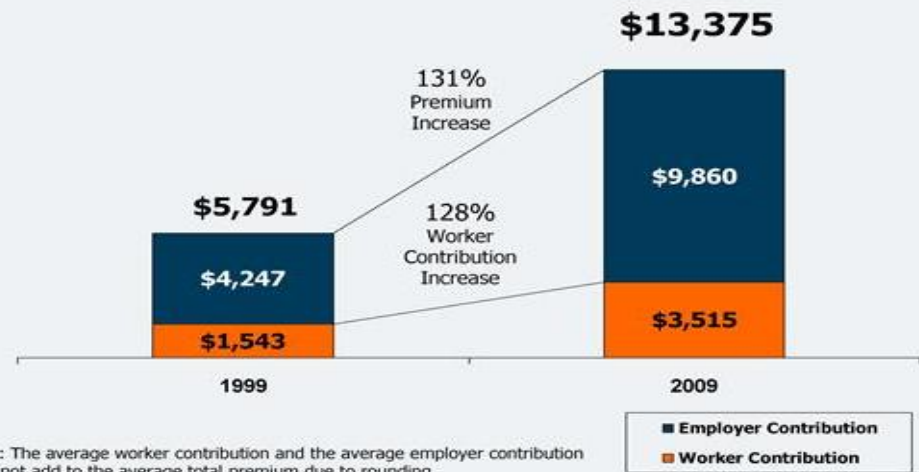
Out of Sync

Health-insurance costs are far outpacing wages and inflation. Cumulative increases in each:



Source: Kaiser Family Foundation

Average Health Insurance Premiums and Worker Contributions for Family Coverage, 1999-2009

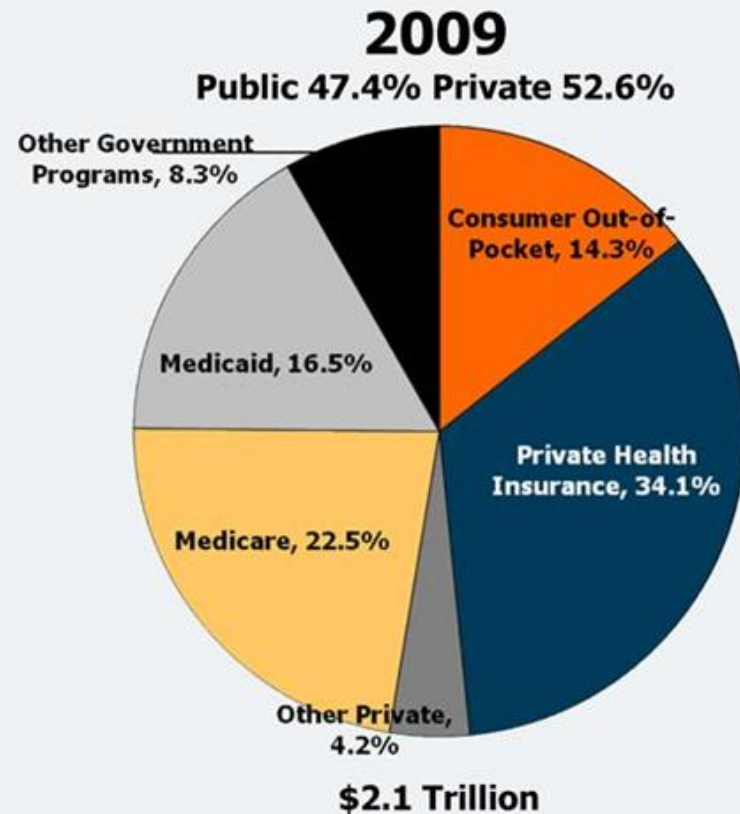
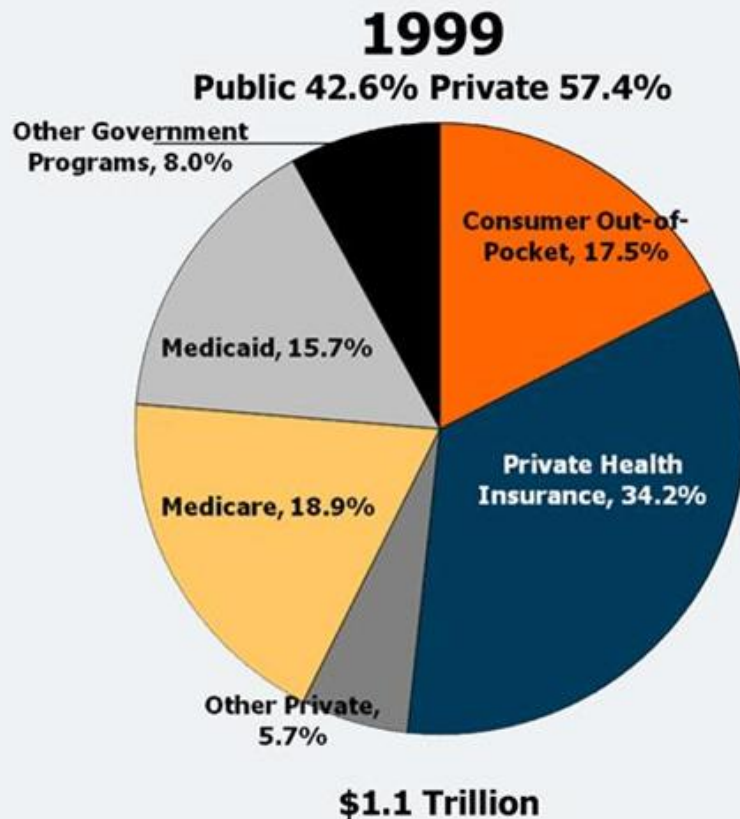


Note: The average worker contribution and the average employer contribution may not add to the average total premium due to rounding.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

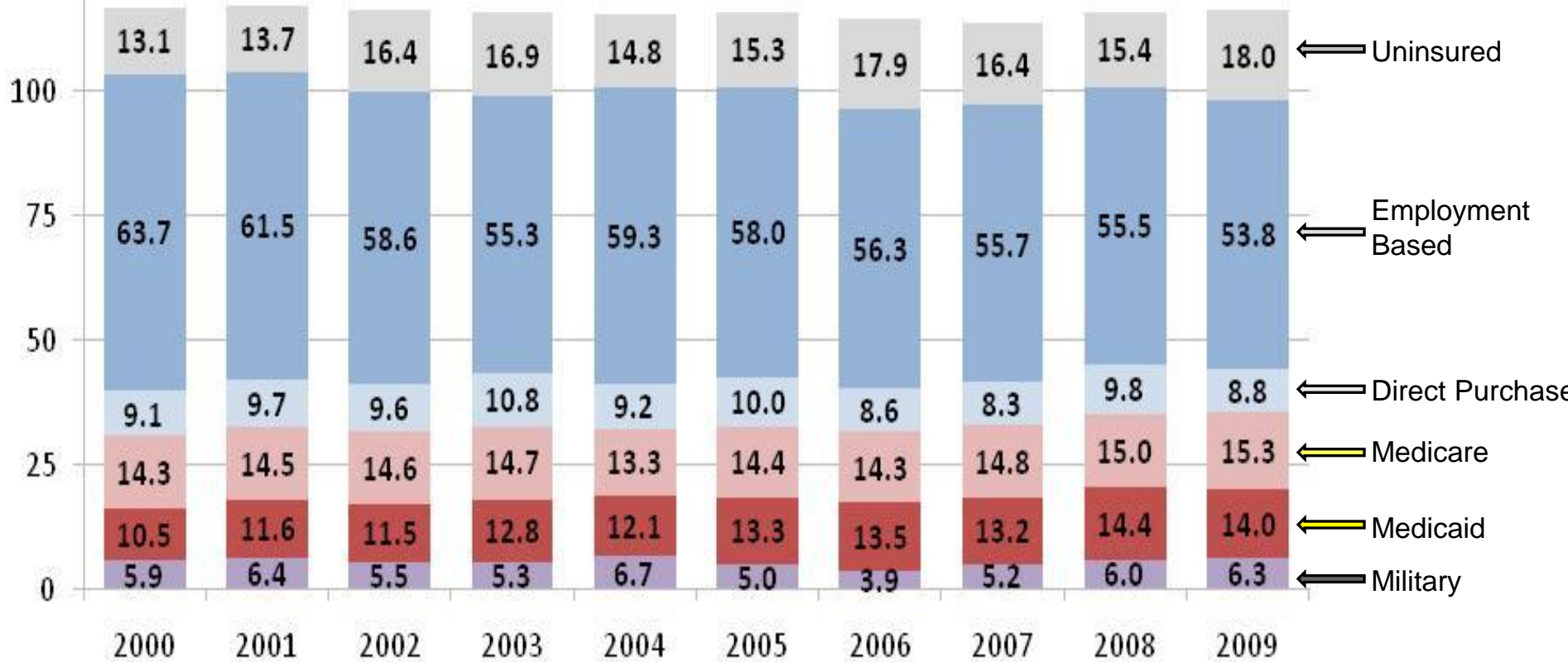
Expenditure by Payment Source

Distribution of Personal Health Care Expenditures by Source of Payment, 1999 and 2009



Insurance Trends NC









Coverage % by funding source



Note: Percentages total to over 100% due to dual coverage

Utilization and Cost Comparisons

2008 2009 2010

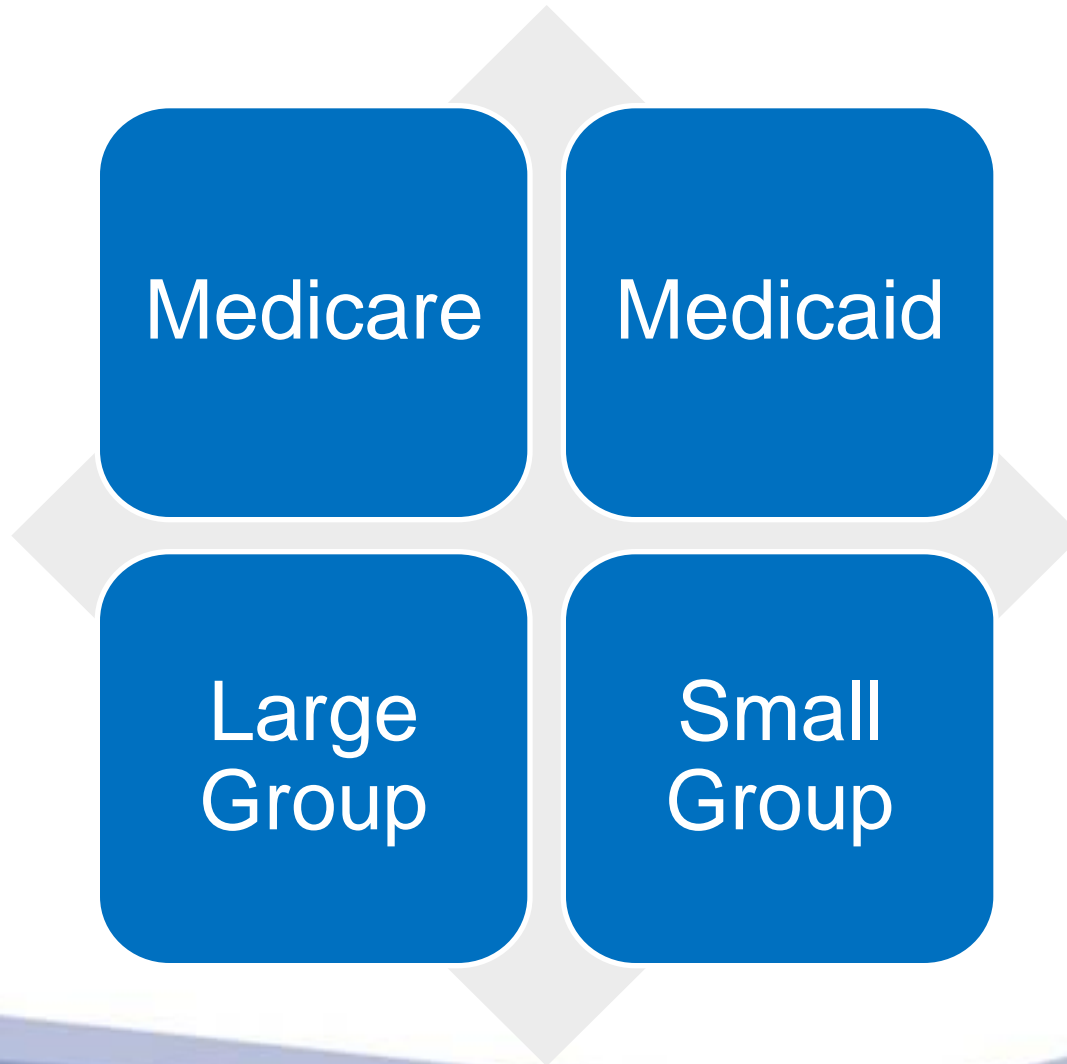
| | | | |
|--|-----------------------|-----------------------|-----------------------|
|  Pair of jeans Gap's Easy Fit, stonewashed, starting price | \$44.50 | \$54.50 | \$54.50 |
|  Internet service Average monthly subscription cost for broadband cable service from Comcast, standard tier | \$42.95 | \$42.95 | \$44.95 |
|  Tax preparation Average cost of federal, state and local tax return preparation by H&R Block | \$174.70 ¹ | \$187.36 ¹ | \$189.21 |
|  Hospital stay Average cost of one day in a semiprivate room, including ancillary services except private physician's fee (Cleveland) | \$5,310 | \$6,838 | \$7,507 |
|  McDonald's Big Mac Average price for company-owned restaurants. Prices vary at independently owned franchised locations | \$2.97 | \$3.20 | \$3.20 |
|  Clearing clogged sink Roto-Rooter drain service, total country cost | \$263.36 ¹ | \$263.82 ¹ | \$271.88 ⁴ |
|  Movie ticket Average price for all tickets sold at all prices at all times | \$7.18 ¹ | \$7.50 ¹ | \$7.85 ⁵ |
|  Birth Average hospital cost for mother and child, excluding private physician's fee (Cleveland) | \$8,906 | \$10,121 | \$10,679 |

2007-2010 Change

| | Change in Utilization ¹ | Increase in Cost ² |
|------------|------------------------------------|-------------------------------|
| Individual | -2.3% | 14.4% |
| Group | -3.8% | 39.5% |

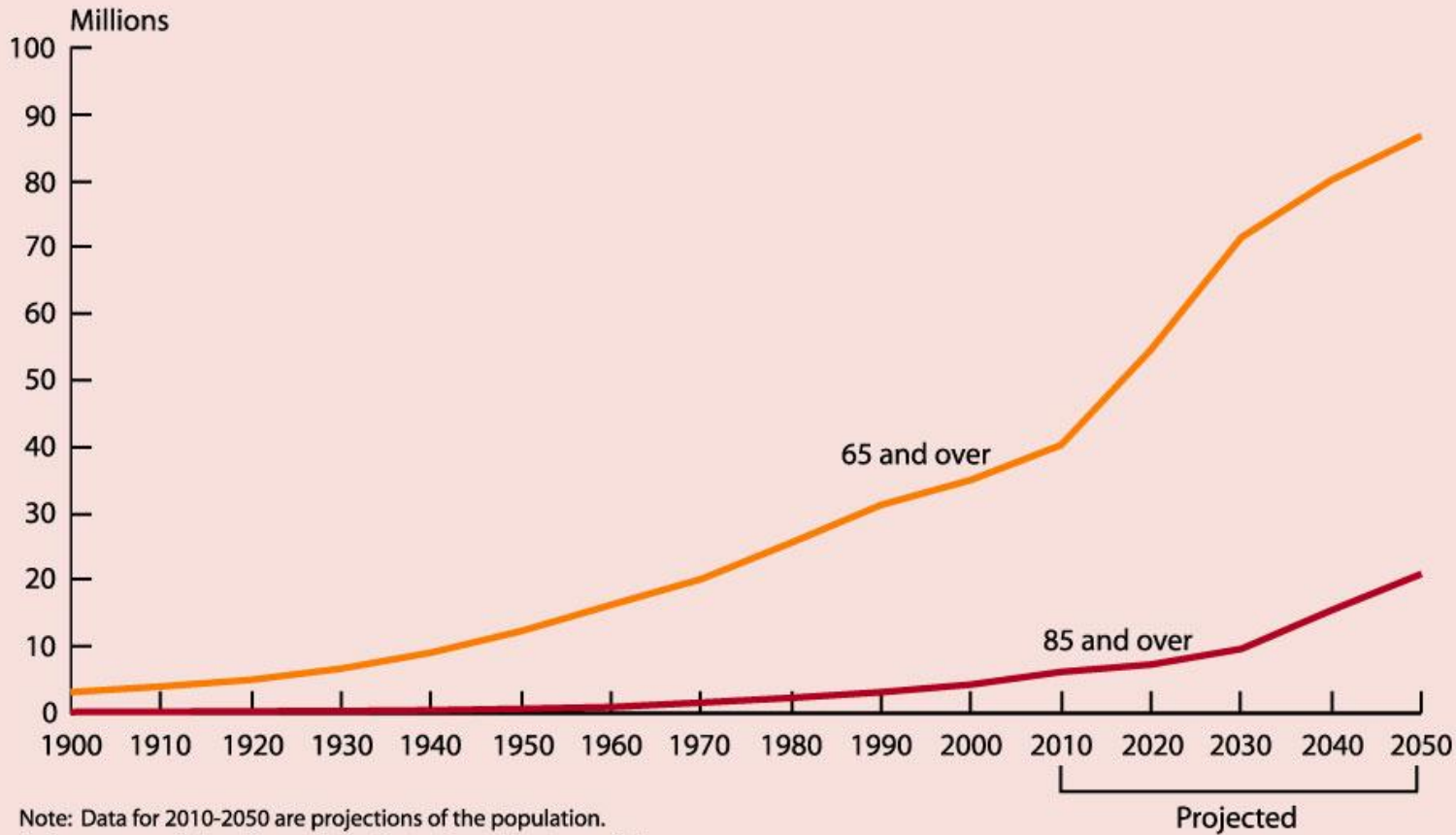
1 Utilization based on inpatient admission per 1000 members
2 Cost based on allowed cost per admission

Health Care Financing in NC



The Future of Medicare

Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050



Note: Data for 2010-2050 are projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census and Projections.

Average Annual Growth in Medicare Spending

| | NC % | US % |
|-----------|------|------|
| 1995-2004 | 8.0% | 6.0% |

Note: Data reflect Medicare spending on personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence. State of residence estimates account for the flow of individuals between states in order to consume health care services and present health spending based on where individuals reside rather than where they receive care.

Average Annual Growth in Medicare Spending per Enrollee

| | NC % | US % |
|-----------|------|------|
| 1995-2004 | 5.7% | 4.8% |

Note: Data reflect Medicare spending on personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence. State of residence estimates account for the flow of individuals between states in order to consume health care services and present health spending based on where individuals reside rather than where they receive care.

Future Liabilities

FIGURE 1
Annual Cash Flow Deficits in
Social Security and Medicare
(Billions of dollars)

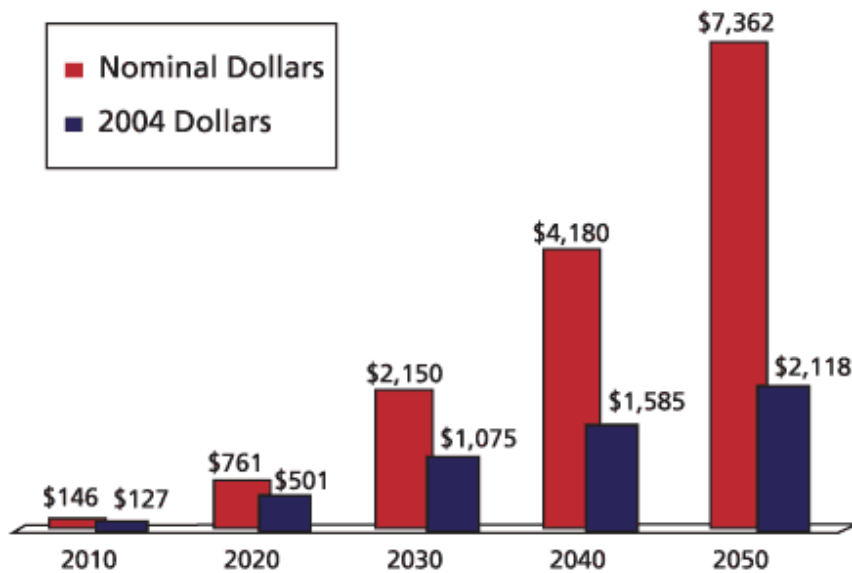
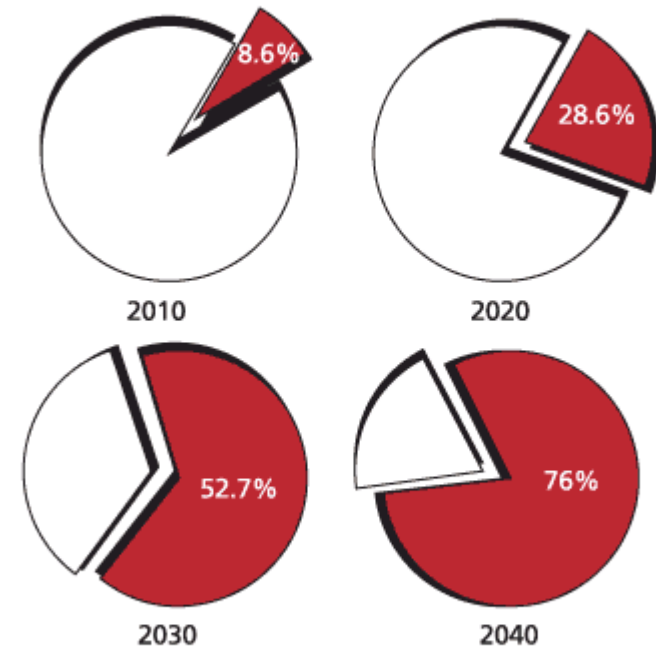


FIGURE 2
Percent of Federal Income
Tax Revenues Needed to Fund
Social Security and Medicare Deficits



1.25% 3.5% 5% 6.25% 7%

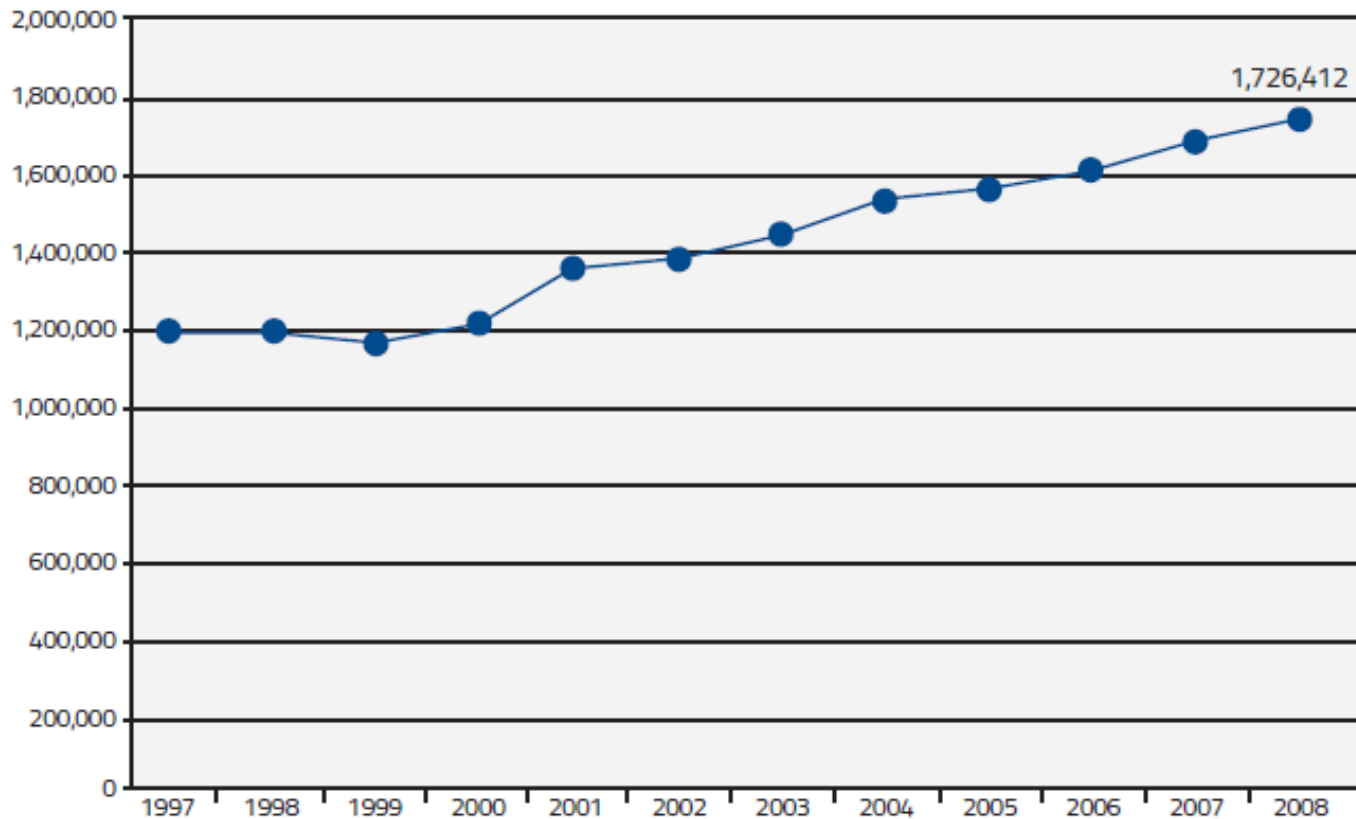
% GDP income shortfalls*

Sources: Andrew J. Rettenmaier and Thomas R. Saving Ph.D., "The 2004 Medicare and Social Security Trustees Reports," National Center for Policy Analysis, Policy Report No. 266, June 2004; and the 2004 Annual Reports of the Board of Trustees of Social Security and Medicare.

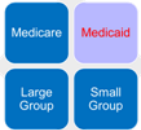
NC Medicaid Eligible Residents

Exhibit 3

Medicaid Eligible North Carolina Residents SFYs 1997 - 2008

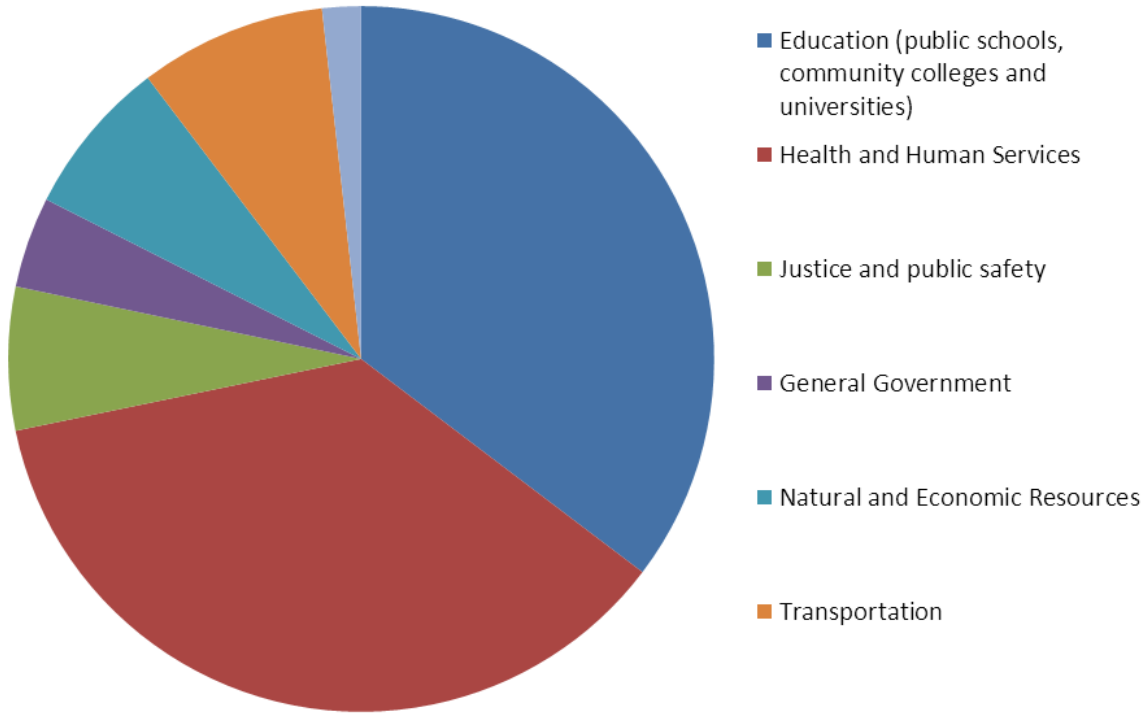


Source: Annual Unduplicated Count: Unduplicated Medicaid Eligibles Report, EJA 752



NC Budget 2009-2011

**NC Budget Appropriations 2009-2011
(Percentage)**



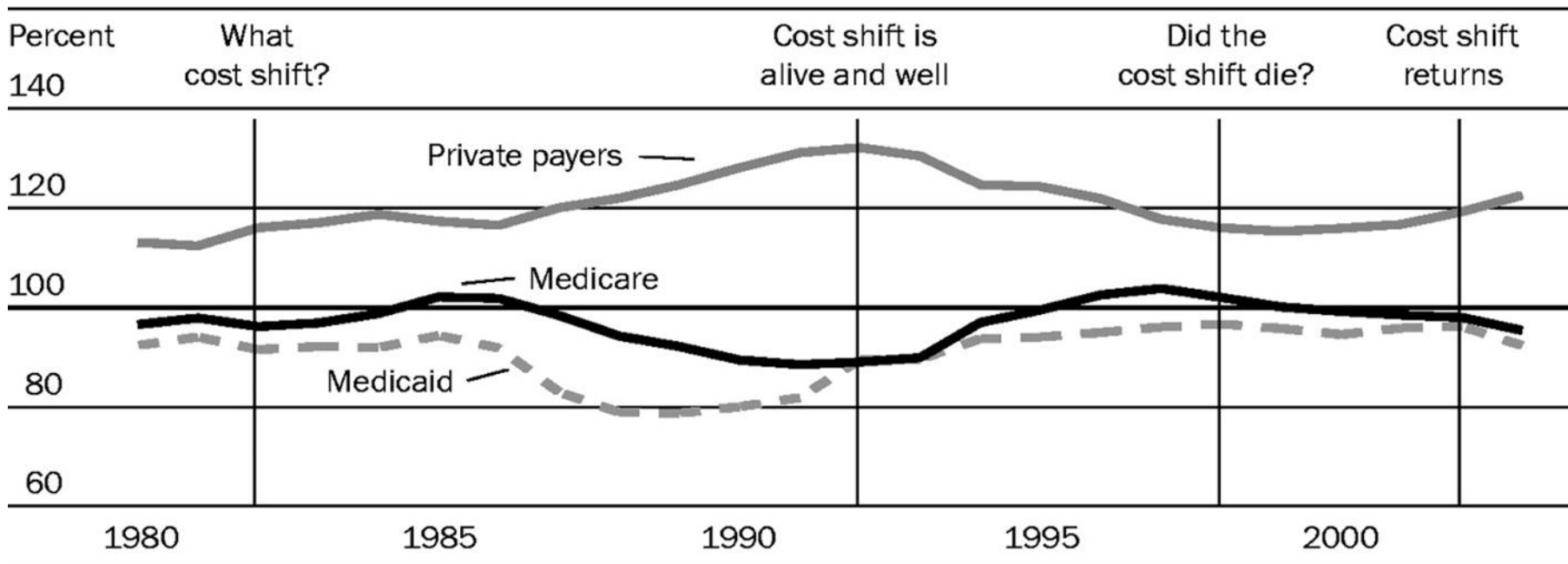
| Fund Appropriations Category | Value (\$) |
|---|----------------|
| Education (public schools, community colleges and universities) | 15,017,181,900 |
| Health and Human Services* | 15,478,997,904 |
| Justice and public safety | 2,790,101,218 |
| General Government | 1,772,215,127 |
| Natural and Economic Resources | 3,061,208,895 |
| Transportation | 3,638,838,732 |
| Debt Services | 753,813,184 |

*Federal spending accounts for 55% of Medicaid budget in North Carolina

Cost Shifting and Private Insurance

EXHIBIT 3

Aggregate Hospital Payment-To-Cost Ratios, By Payer, 1980-2003



SOURCE: Lewin Group analysis of data presented in Lewin Group, *Trendwatch Chartbook 2005: Trends Affecting Hospitals and Health Systems* (Washington: American Hospital Association, May 2005).

NOTE: Medicaid includes disproportionate-share hospital (DSH) payments.

Private Sector Trends



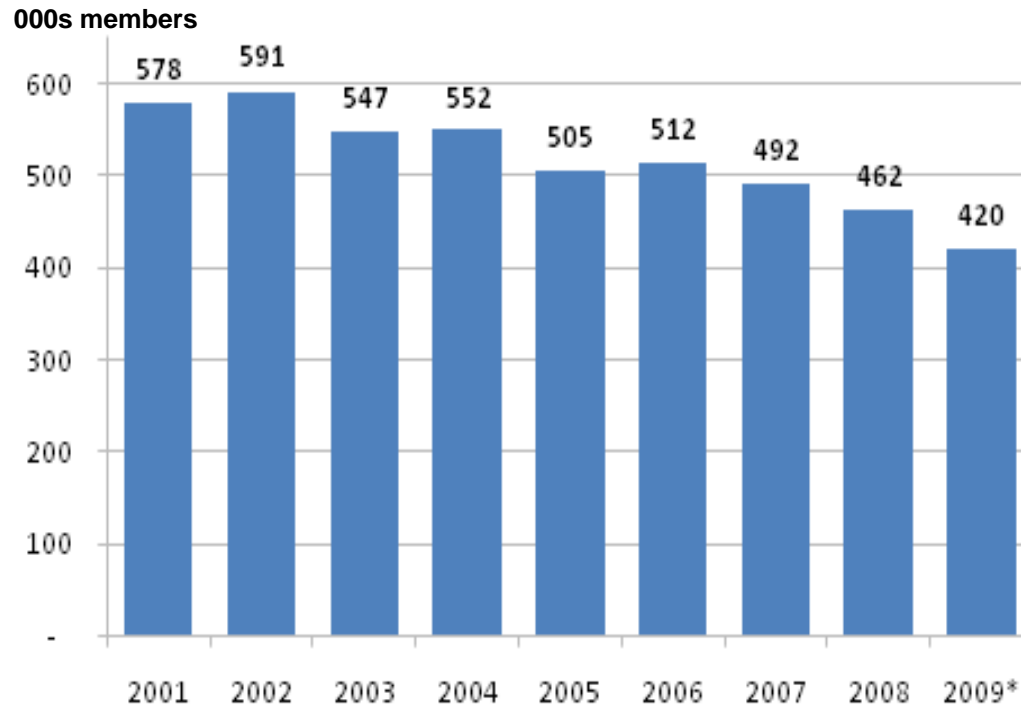
| | 2000-2009 trend | |
|---|-------------------------------|--------------------------------------|
| | Increase in cost ¹ | Increase in utilization ² |
| Medical expense per member per month ³ | 113% | n/a |
| Typical office visit cost (excludes lab costs) | 71% | n/a |
| Emergency room ³ | 211% | 12% |
| Obesity surgery (bariatric and lap band) | 112% | 738% |
| Knee replacement surgery | 60% | 94% |
| Hip replacement surgery | 72% | 38% |
| MRI utilization | n/a | 77% |
| CT scan utilization | n/a | 104% |

¹ Based on allowed charge; includes member cost sharing

² Based on cases per 10,000 members

³ Group underwritten business only

Insurance Trends for NC Population



| | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|-----------------------|-------------|--------------|-------------|--------------|-------------|--------------|--------------|--------------|
| Year over year change | 2.3% | -7.4% | 0.8% | -8.5% | 1.5% | -4.1% | -6.1% | -9.1% |

*2009 estimate based off MEPS data trends

A Cautious Path Forward on Accountable Care Organizations

Barak D. Richman, JD, PhD

Kevin A. Schulman, MD

SPURRING THE CREATION OF ACCOUNTABLE CARE ORGANIZATIONS (ACOs) was a signature initiative in the Patient Protection and Affordable Care Act of 2010 (PPACA). To achieve potential efficiencies by having health care delivery coordinated by multiple health care entities (eg, hospitals, physician groups, clinics, health care systems), the act invites such entities to integrate in ACOs and instructs the Medicare program to share with an ACO any cost savings it can demonstrate.¹ Observers are expressing concern, however, that newly established ACOs are joining health care organizations that otherwise would compete with each other, thus creating networks with dangerous market power.² It appears that the main purpose of health care entities in forming ACOs may not be to achieve cost savings to be shared with Medicare but to strengthen negotiating power over purchasers in the private sector.

This may be the latest chapter in the steady accumulation of market power by hospitals, health care systems, and physician groups, a sequel to the waves of mergers in the 1990s when health care entities sought to counter market pressure from managed care organizations. The possibility

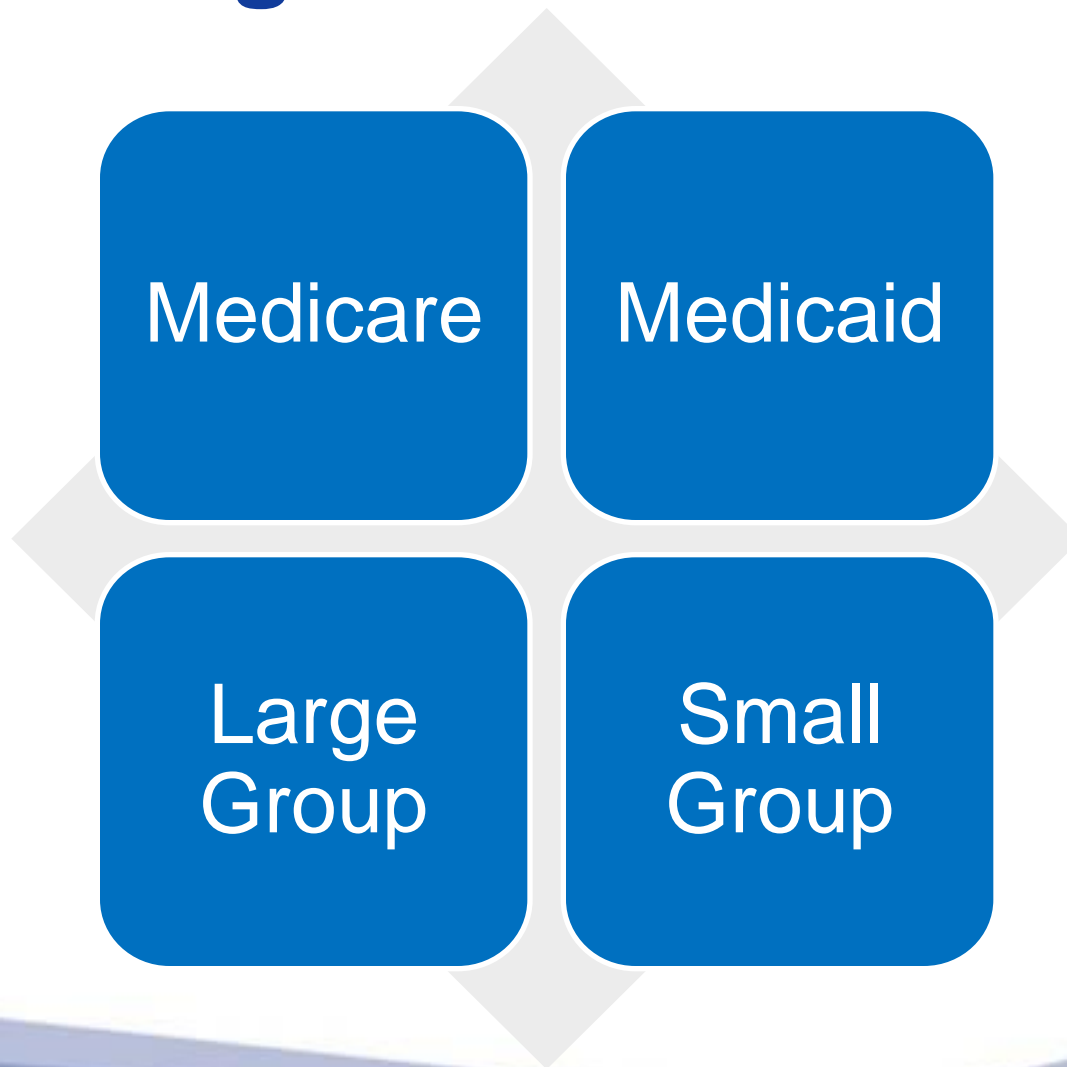
For legal, regulatory, and other reasons, health insurers in the United States cannot refuse to pay the high prices imposed by health care organizations, even when the price exceeds the likely value of the service to the patient. Instead, insurers are expected to cover any desired service deemed “medically necessary” by professional standards, whatever the cost. Health insurance, therefore, enables monopolists of health services to charge more than the textbook “monopoly price,” earn more than the typical “monopoly profit,” and capture more consumer dollars than monopolists in other industries.

Policy makers have been slow to recognize the dangers of market power in health care. In what has properly been called a failure of antitrust policy,^{4,5} policy makers did little to stem the accumulation of health care market power throughout the 1980s and 1990s. But the implications have been huge. For example, hospital mergers have led to estimated price increases of 40% in local markets.⁶ Dominant providers of insured services pose a severe challenge to health care affordability for individuals and for the nation as a whole.⁷

ACOs in Theory and Practice

Still a roughly defined policy concept, ACOs are in theory an attractive solution to problems stemming from the complexity and fragmentation of the health care delivery sys-

Health Care Financing in NC: Challenges in Each Sector



Looking Forward

- While much of the health care reform debate has focused on the public health plans, the cost of health care for the private health plans may make them the most vulnerable.
- Given the high fixed costs of the system, it will be very vulnerable to changes in the financing structure over the next few years.
- Individual participation in the market after 2014 will be key to sustainability of the system.
- Stakeholder engagement across all sectors is required to protect the health care and non-health care economy in the state.

Discussion

