

The Future of Health Care Finance and Its Implications for Athletic Trainers

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A Brief History of Health Care Finance in the U.S.

- World War II
 - 16 million men in military service
 - Manpower needed in defense industries
 - Production efficiency adversely affected by higher-pay bidding to change employment
 - Wages capped by law
 - Employers began offering medical insurance as a fringe benefit inducement

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History of Health Care in U.S

- Federal government began subsidizing employment-based health insurance through the tax code:
 - Employer contributions to health insurance coverage tax-deductible
 - Monetary value of health insurance benefit not considered taxable income for employees

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Evolution of American Health Care in the 20th Century

- Era of Expansion
 - End of WWII to late 1960's
 - 100% fee for service reimbursement
 - Expanding role of government financing of medical services for poor & elderly
 - 1960's
 - 90% of population covered by private or public health insurance
 - No limits on Medicare/Medicaid reimbursement

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Funding Source	1960	1999
Out-of-Pocket	55.2%	17.6%
Private Insurance	23.4%	39.1%
Government	21.4%	43.3%

2002: >45%

History of Health Care Finance

- 1965-69: 76% increase in net income of nonprofit hospitals
- 1965-70: Federal share of national health expenditures increased 25%
- 1973: Health Maintenance Organization Act
 - Provided start-up funds for development of HMOs
 - Required large companies to offer an HMO choice
- 1974: Employee Retirement Income Security Act (ERISA)
 - Self-insured employers allowed to design health plans

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Evolution of American Health Care in the 20th Century

- Era of Cost Containment: 1970's to 1990's
 - Legislative initiatives to limit Medicaid expenditures
 - Inpatient Prospective Payment System (1983)
 - Established fixed payments based on discharge diagnosis (DRG: diagnosis-related group)
 - Hospitals raised charges to privately insured patients
 - Outpatient Prospective Payment System (2000)
 - Established fixed payments based on 750 case classifications (APC: ambulatory payment classification)
 - Employer health benefits costs equal to half of pretax profits
 - Growth of managed care in private sector

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Managed Care

- Integration of financing & delivery of a comprehensive set of health care services
- A pre-planned system for delivery of coordinated health care services at lower cost than traditional indemnity plans
 - "In-network" incentive & out-of-network disincentive
 - Negotiation of physician/hospital fee discounts
 - Preauthorization of medical services
 - Gatekeeper physician requirement (POS plans)

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Developing Trends

- U.S. spending on health care
 - 2000: \$1.3 trillion - \$4,637 per person
 - 13.2% of GDP
 - 2002: \$1.6 trillion - \$5,440 per person
 - 14.9% of GDP
 - 2004: \$1.8 trillion - \$6,040 per person
 - 15.4% of GDP
 - 2014: \$3.6 trillion* - \$11,046 per person*
 - 18.7% of GDP* *projected

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Demographic Trends

- U.S. population:
 - 1950: 150 million - 2000: 281 million
 - Number <18 yrs old decreased 31% to 26%
 - Number >65 yrs old now >20%
 - By 2008, median age of work force will be 41 yrs
 - Life expectancy 77 yrs in 2001 (increasing)

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Developing Trends

- Increasing employer involvement in employee health management
 - Increasing costs cannot be recovered through product price increases
- Premiums for a fully-insured health plan
 - 11.2% increase in 2004
 - Average salary increase in 2004: 2.2%
 - 2004 inflation rate: 2.3%
- Premiums cost 13.5% more than the cost of medical services provided for employees

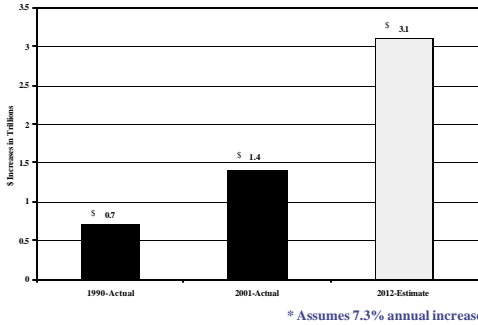
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Evolution of American Health Care in the 20th Century

- Era of Assessment and Accountability
 - Late 1990's to present
 - Documentation of effectiveness & value
 - Problems facing employers:
 - Rising health care costs
 - Rising workers' compensation costs
 - Rising disability-related costs
 - Aging of the American workforce
 - International market competition
 - Decreasing profit margin

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CMS Forecast: Total Medical Expenditures



Projected Health Insurance Cost Increase: 2002-2005

Type Coverage	2002 Premium	2003* Premium	2004* Premium	2005* Premium	2002-2005* Increase
PPO (family) (single) 2002: 50%	\$ 8,173 \$ 3,175	\$ 9,399 \$ 3,651	\$ 10,997 \$ 4,272	\$ 12,866 \$ 4,998	\$ 4,693 \$ 1,823
HMO (family) (single) 2002: 29%	\$ 7,541 \$ 2,764	\$ 8,657 \$ 3,179	\$ 10,146 \$ 3,683	\$ 11,871 \$ 4,309	\$ 4,330 \$ 1,545
Indemnity (family) (single) 2002: 7%	\$ 8,479 \$ 3,582	\$ 9,750 \$ 4,119	\$ 11,407 \$ 4,819	\$ 13,347 \$ 5,638	\$ 4,868 \$ 2,056
% Increase	14.7%	15%*	17%*	17%*	57%*

* Source: Kaiser Family Foundation and Health Research and Education Trust

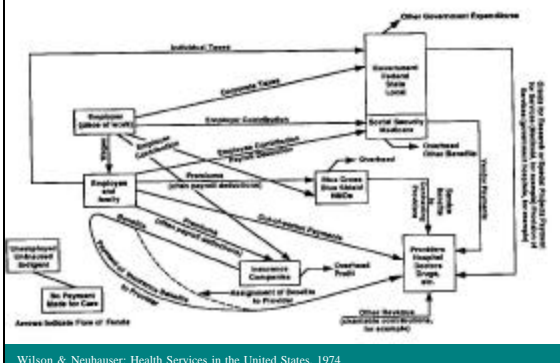
Health Insurance Premium Increase @ 7.3% per year

Type Coverage	2002	2012
PPO (family) (single)	\$ 8,173 \$ 3,175	\$ 17,980 \$ 6,985
HMO (family) (single)	\$ 7,541 \$ 2,764	\$ 16,590 \$ 6,080

2005 Health Care Scenario

- Americans **reluctant to accept responsibility** for health status
 - Overweight, high BP, high cholesterol, smoking
- Providers & insurers **resistant to change**
 - Escalating healthcare costs & insurance premiums
- Employers **unable to absorb increasing costs**
 - Cost-shifting to employees
 - Defined contribution
 - Increased deductibles & coinsurance
- Medicare program **cannot be sustained!**
 - 2002: ~12% of Federal Govt revenue
 - 2030: >25% of Federal Govt revenue

Flow of Healthcare Dollars



Control of Health Care Costs (Millenson: 1997)

- Pay Less**
 - Discounted provider fees
 - Cost-shift to employees
- Do Less**
 - Utilization management
 - Coverage limitations & exclusions
- Do Things Better**
 - Health management
 - Value-based purchasing



The relationship between modifiable health risks and health care expenditures.

- Goetzel RZ et al: J Occup Environ Med, 1998
 - 46,026 employees of 6 employers (ages 18-64)
 - ✦ Followed for up to 3 years (113,963 person-years)
 - Medical expenditures per person-year (statistically adjusted)
 - Gender
 - Race
 - Age
 - Job Category
 - Education
 - Employer
 - High-risk classifications:
 - Sedentary Lifestyle
 - Depression
 - Excessive Alcohol Use
 - Extreme High/Low Body Wt
 - Poor Nutritional Habits
 - High Total Cholesterol
 - Tobacco User
 - High Blood Pressure
 - High Stress
 - High Blood Glucose Level

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Goetzel et al, 1998: Results

- **CHD High-Risk Average: \$3,803**
 - poor nutritional habits
 - smoker
 - sedentary
 - high BP
 - high cholesterol
 - high stress
- **Risk-Free Average: \$1,166**
- **High-Risk >3X more expensive**

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Total Health-Related Costs

Goetzel et al: JOEM, 2001
Health & Productivity Management: Establishing Key Performance Measures, Benchmarks, and Best Practices.

- **Best-practice organizations:**
3M, Applied Materials, Chevron, Coors Brewing, GE, Navistar Int., Steelcase, Texas Instruments, Union Pacific Railroad
- **Comparison group:**
43 employers (950,000 workers: 52% hourly, 48% salaried)
- **Cost categories:**
 - Group health
 - Non-occupational disability
 - Turnover
 - Workers' compensation
 - Unscheduled absence
- Median annual cost per employee: \$9992
- Potential annual cost savings per employee: \$2562

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Health Promotion (Fitness/Wellness)

- Enhancement & maintenance of health through **emphasis on a healthy lifestyle.**
 - worksite exercise facilities/programs
 - health risk appraisals
 - disease screening
 - health education
 - individualized lifestyle counseling
 - targeted behavior modification efforts
 - ✦ e.g., weight loss, smoking cessation

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Health Promotion ROI

Study	Focus	Dependent Variable	Benefit/Cost ROI
Osminkowski et al, 1999 (Citibank N.A.)	Fitness + HRA Education Self-Care Material*	Total Health Care Costs	6.47*
Goetzel et al, 1998 (Proctor & Gamble)	Fitness + HRA Education Disease Screening	Hospital Inpatient Costs	1.49
MEDSTAT Group, 1997 (Pacific Bell)	Fitness + HRA Disease Screening Health Info Service	Health Care Costs (minus drug costs)	1.73
Fries et al, 1994 (State of CA Retirees)	Fitness + HRA Correspondence Self-Care Material*	Total Health Care Costs	5.97*
Fries et al, 1993 (Bank of America)	Fitness + HRA Correspondence Self-Care Material*	Total Health Care Costs	5.47*
Aldana et al, 1993 (City of Mesa, AZ)	Fitness + HRA Disease Screening Education	Total Health Care Costs	3.60
Breslow et al, 1990 By et al, 1986 (Johnson & Johnson)	Fitness + HRA Disease Screening Education	Hospital Inpatient Costs	1.70

Demand Management

- The use of **decision support** and **self-mgmt** support to enable and encourage individuals to make **appropriate use of medical care.**
 - Health risk appraisal
 - Info about illness symptoms & treatment options
 - General **self-care** education
 - ✦ Books
 - ✦ Newsletters
 - ✦ Seminars
 - ✦ Websites

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Demand Management

Self-Care + Medical Consumerism

- Symptom identification & interpretation
- Administration of self-care options
- Optimal utilization of the healthcare system
- ❖ 85% will experience at least one symptom each month
- ❖ Most are practicing some self-care with limited information
- ❖ A significant portion of utilization is for self-limiting conditions

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Demand Management ROI

Study	Focus	Dependent Variable	Benefit/Cost ROI
Fries et al, 1997	Arthritis Self-Care	Outpatient Medical Costs	2.70 – 10.70
Lorig et al, 1993	Arthritis Self-Care	Outpatient Medical Costs	4.50
Vickery et al, 1988	General Self-Care	Total Health Care Costs	2.19
Lorig et al, 1985	General Self-Care	Outpatient Medical Costs	9.20
Vickery et al, 1983	General Self-Care	Outpatient Medical Costs	3.50

Disease Management

- A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant (Disease Mgmt Assoc of America).

- Disease screening
- Disease-specific self-care education
- Coordination of medical services (case management)
- Health behavior modification counseling
- Surveillance of physiologic indicators of disease status
- Provision of evidence-based treatment guidelines
- Physician or nurse consultation through telephone or email
- Regular reminders of the importance of compliance with a prescribed treatment plan

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Disease Management ROI

Study	Focus	Dependent Variable	Benefit/Cost ROI
Sidorov et al, 2002	Diabetes	Total Health Care Costs	2.23
Barnwell, 1998	Diabetes	Total Health Care Costs	8.88
MEDSTAT Group, 1997	Mental Health	Mental Health Care Costs	10.38
Bolton et al, 1991	Asthma	Emergency Room Costs	7.33

Paradigm Shift in Health Care

- Paradigm:
 - An accepted framework that governs practice within a field
 - context in which problems are addressed
 - strongly influenced by traditions & dogma
- Allopathic medicine:
 - System of medical practice, which aims to combat disease by the use of remedies that produce effects different from those produced by the disease treated

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Allopathic Medicine Paradigm

- Focus on diagnosis & treatment of existing disease/injury for relief of symptoms
- Emphasis on complete restriction of activity during healing
- Heavy reliance on prescription of pharmaceuticals & surgical procedures
- Emphasis on the "process" by which care is provided

Sports Medicine Paradigm

- Emphasis on **injury prevention** through enhancement of performance capabilities
- Emphasis on **exercise** for restoration of optimum performance
- Maintenance of **protected function** during healing
- Emphasis on the **"functional outcome"** of care

Contrasting Definitions of Health

- Allopathic Medicine:
 - Health = **The absence of disease.**
- Sports Medicine:
 - Health = **Optimized human function.**

❖ Presentation available (PDF download):
www.utc.edu/gatp → "Program News"

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