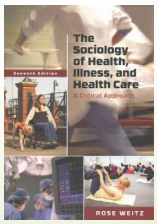
Chapter 8:

Health Care in the U.S.



Sir Michael Marmot: Social Determinants of Health (2014 WORLD.MINDS) (compares U.S. to other countries

(show first 41/2 mins)

https://www.youtube.com/watch?v=h-2bf205upQ

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Having knowledge of the history of the health care system in the U.S. will assist us in understanding the problems we have today with health care in the U.S.

Let's take a look:

The first U.S. health insurance plans were established in the 1930s.

Why were they created?

health costs had gotten so high most Americans could not afford to receive care for any major health problem

Who paid for the health insurance?

Individuals paid for coverage along with companies and businesses that provided their employees with health insurance to attract the best employees and keep their existing employees healthy

What were the first health insurance plans created?

Blue Cross (hospital) and Blue Shield (doctors and other medical expenses) were created

1. Only the healthy were allowed to enroll (why?)

Insurance companies used actuarial risk ratings to determine who was a high risk of needing health services.

Those people considered a high risk were denied health insurance because they would cost the insurance company money.

2. Too expensive: Individuals were eventually having to pay high deductibles (insurance won't pay until the insured person has paid a certain amount out-of-pocket) and co-payments (amount paid each time visit doctor)

3. High cost of Hospital and MD services were caused in part by a "fee-for-service" method for determining how much would be paid to hospitals and MDs.

(very important concept)

Fee-for-service = the hospital and MDs get paid for each service they provide.

What is the problem with this?

What is the alternative?

(more reasons health care became so expensive)

4. doctors made more money by requesting more tests or prescribing drugs that required the patient to have regular doctor visits
5. hospitals made more money by keeping patients in the hospital longer
6. Medicalization of illness means more money for MDs, hospitals, pharmaceutical companies

Review: What were some of the eventual problems with this system of health insurance most of which we still have today?

1. Too expensive
2. Only the healthy were allowed to enroll
3. Fee-for-service encouraged more tests/longer hospital stays
4. Medicalization of illness

**5. MDs and hospitals could charge whatever they wanted and the insurance company would pay it

Why did the U.S. government get involved by offering a health program to the elderly, disabled (Medicare program), and poor (Medicaid program)?

Why the old, disabled, and poor?

- poor Americans could not afford health insurance (as well as many middle income persons)
- retired persons often lacked health insurance; a single major health problem would typically bankrupt an older couple
- the disabled were often uninsured

Why not cover all Americans (like all the other more developed countries in the world, e.g., all of Europe, Japan)?

- "National Health Care" proposals in the U.S. could not get enough votes in Congress (unlike other countries when their national health care was begun) (do you remember when many of the national health programs were started)
- Hospitals and MDs didn't want it. They were afraid they would make less money.
- Health insurance companies thought they would no longer be needed
- Pharmaceutical companies were afraid the government would control costs

While there was not enough support in the U.S. Congress to establish national health care, the "compromise" was to establish Medicaid and Medicare programs passed in 1965.

Medicaid was established to provide health care services to the poor.

What do you know about Medicaid?

(Who pays for it?

What services does it provide?)

Medicaid was established to provide health care services to the poor.

So, where does the money come from to pay for the health services that the poor receive?

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Medicaid—is paid for by a combination of federal and state funding

The percentage that the federal government contributes to a state's total Medicaid cost depends on the wealth of the state—the poorer the state the higher the percentage the federal government will pay of the state's total Medicaid expenditures

For example, for a poor state such as LA, the federal gov't might pay 70% and for a rich state such as NY the federal government might pay only 40% of the state's total Medicaid expenditures.

Medicaid—individual states have the authority to determine the following since each state pays a portion of the Medicaid costs:

--who qualifies (who is considered poor, but must be no lower than Federal Poverty Level),

--what is covered, and

--how much Medicaid will pay for health care services

What do states consider to be poor? (i.e., what income)?

Those in poverty:

In 2024, the Federal Poverty Level (FPL) for a single adult is approximately $14,580 annually (or about $1,215/month). However, at least half the states increase the poverty level so more low income people can qualify.

The FPL increases with family size. For example, the FPL for a family of four in 2024 is about $30,000.

So, states can use the FPL to determine who qualifies or they can increase it.

Where would you guess Texas ranks in terms of its "generosity" for people to qualify and have extensive coverage?

Texas is one of the stingiest states regarding all three (who qualifies, what is covered, how much is paid for a service).

Consequently, (1) patients must be extremely poor in TX to get Medicaid, (2) don't get the best coverage if they do qualify and (3) have difficulty finding an MD who will see them because Medicaid in TX pays MDs relative little (compared to BCBS and other health insurers).

New York, New Hampshire and Wisconsin were found to provide the best Medicaid programs in the country.

States with the best Medicaid programs (e.g., NY) spend 65% more per person than bottom-level states (like Texas).

Cost of living difference between New York and Texas is:

The cost of living in NY city is 39.5% higher than in Dallas, TX.

Is Medicaid considered a charity or a "right" and why?

Medicaid—is considered a gift or charity rather than a "right" unlike most other countries where it is believed all citizens are "entitled" to health care services.

Medicaid in all states covers hospital, medical professionals, and pharmaceuticals. Within each of these, what exactly is covered depends on the state (e.g., specific drugs, dental care, eye exam/glasses)

Lets now learn about Medicare which pays for health services but for a different group of people than Medicaid.

Who can receive Medicare?

Review: Medicaid was established to provide health care services to the poor.

Who qualifies?

Who pays for it?

What services does it provide?

How is Medicaid different from Medicare when considering who qualifies to receive it?

Medicaid: why it's worse to be sick in some states than others (11:30 minutes)

https://www.youtube.com/watch?v=sOo_aw-xgHQ

Medicare was established to provide health care services to the disabled and persons 65+.

Its part of a larger program called:
Old Age, Survivors, Disability Insurance (OASDI)

also referred to as Social Security although SS is only a part of OASDI)

What do you know about Medicare?

Who qualifies for Medicare?

- A person 65+ (or individual's spouse) must have paid into Social Security (that is OASDI) for 40 quarters (10 years total) to qualify for Medicare (this is also a requirement to receive Social Security payments)
- If a person has paid into Social Security for 20 quarters (5 years total) and becomes disabled, they qualify for monthly disability payments (the exact # of quarters is based on a complex formula, but generally it is 5 years)

- In addition, to these funds, those who receive Medicare pay a monthly fee to receive "Part B" health services (e.g., MD, tests done outside hospital)

How is this different from Medicaid?

A person can "buy into" Medicare (similar to purchasing a health insurance policy). The cost is $479/month for Part A and roughly $200/month for Part B (dollar amounts for 2021).

The cost will be adjusted down for those who have paid into Social Security but have not met the 10 year (40 quarter) requirement.

Where does the money come from to pay for the health services that Medicare covers for the elderly and disabled?

- The money comes from a portion of the OASDI funds collected each month.
- Workers pay 6.2% of their income to OASDI each month (unless they make more than $168K/year, anything above that is not taxed) and their employers also pay 6.2% each month up to $168K (total paid each month 12.4% of employee's income assuming income is less that $168K)
- 2.9% of the employee+employer monthly payments goes to pay for Medicare health services.

What health services does Medicare pay for?

- Part A covers hospital expenses and is totally covered by federal funds (Medicare participants don't have to pay a monthly fee to obtain Part A)
- Part B covers doctor/medical expenses and can only be obtained if the individual pays a monthly fee (much like paying for health insurance but less expensive)
- Other Parts (C, D, E) are optional (typically person receiving Medicare has to pay for them). They cover pharmaceuticals, "Medicare Advantage", Medicare secondary insurance. (Why secondary insurance?)

- Medicare is considered an "entitlement"

—that is, earned (anyone who gets Medicare has earned it by them or their spouse paying into Social Security for at least 10 yrs)

How about Medicaid?
What is it considered?

One Solution Introduced to Replace "fee-for-service (we'll discuss this more later)

- Capitation is a system that pays the doctor a set amount for each patient that has her/him as their doctor; What is the MDs incentive with capitation?

3. Health Maintenance Organizations (HMOs) were given some federal financial support

What are HMOs, what are their goals, and how are their goals accomplished?

- goal has been to make health care more affordable

What are their advantages?

- includes large numbers of people providing preventive care—services to keep them healthy; reducing "unnecessary" care (surgeries, hospitalizations)
- HMOs have their own doctors who are paid a salary and required to implement HMO policies designed to avoid unnecessary tests/care
- What are disadvantages of HMO's?

- limits coverage to care from those doctors who work for or contract with the HMO.
- It generally won't cover out-of-network care except in an emergency.
- An HMO may require you to live or work in its service area to be eligible for coverage.

- HMO premiums have become very expensive as HMOs attempt to serve a larger population and medical costs have risen
- HMOs are criticized for difficulty getting access to medical specialists, problems with emergency care, and excessive red tape when trying to file grievances or appeals

Americans pay more for health care (17% of their incomes) than people of any other more advanced country (10-11%), yet they get less health care.

What is meant by "Americans receive less health care?"

First, there are millions of people in the U.S. just above poverty without health insurance and so they often don't get health care when needed.

All people living in countries with national health care can obtain health care coverage (all the citizens pay a single fee each month that together covers all health expenses for all people).

On the other hand, Americans get billed in a variety of ways in order to get health coverage.

There's at least five, what are they?

(1) Part of one's monthly Social Security payment goes to pay for Medicare services (1.45% of employee's check and goes to Medicare and the employer matches this—total 2.9%)

(2) purchasing health insurance,

(3) paying co-payments every time they visit a doctor they pay a small fee, e.g., $25 for family practitioner $35 for dermatologist. This fee is in addition to what the doctor charges for the visit.

4. paying the deductible that must be paid before the insurance will pay,
5. Insurance only pays 80% of the non-hospital costs (e.g., doctor bills, medical tests) and Americans pay the remaining 20% out-of-pocket. (some purchase a second health insurance policy to cover the 20% (referred to as secondary health insurance).

What factors have contributed to the high cost of health care in the U.S.? (think historically—what caused health insurance costs to rise?)

1. Initially (1930s), health care insurance was willing to pay for what every hospitals and MDs charged and to pay as much as they charged—no questions asked.

2. In the 1960s, health care costs rose dramatically when the U.S. government started offering coverage to the poor, elderly, and disabled. MDs and hospitals realized the government could pay even more than they were charging the insurance companies so they raised their prices even more.

Thus, medical professionals charged even more for their services and charged for more services (did more tests) since there was more money available due to government spending on Medicare and Medicaid.

(factors contributing to high health care costs continued:)

3. The Medicare and Medicaid programs do not attempt to negotiate prices for medicines and health care. This is unlike other more developed countries.

Consequently, medical professionals in the U.S. get paid much more than those in other countries for the same health service.

4. high administrative costs due to a fragmented health care system

What does this mean? Examples?

- health providers advertise, sell insurance, hire collection agencies, etc. (they increase their charges to patients in order to pay for these)
- doctors and hospitals spend time negotiating with pharmaceutical firms and with health insurance companies
- each insurer has its own forms to be completed forcing doctors and hospitals to hire personnel who spend all their time completing and submit forms for each patient

- in a universal health system, such as found in other countries, these problems/costs don't exist—negotiations are done by the government to get lowest prices for MD and hospital services and a single-payer system is used with one form to be used for all patients

5. health care professionals have more influence on policymakers than do consumers

What does this mean? Examples?

a. health care professionals include doctors, hospitals, pharmaceutical and health insurance companies, etc.

b. health care professionals spend more (millions of dollars) on well designed lobbying campaigns

- to prevent national health care
- to prevent the government from controlling or negotiating prices of drugs
- To prevent laws that would require serving Medicare and Medicaid patients

6. health care is a business with health providers seeking to make as much profit as possible. Examples?

--for-profit health care providers must make a profit, not just "break even" in order to satisfy their shareholders or private owners

--pharmaceutical companies control which drugs come to market, how they are advertised, and at what prices (not so in nations that have a universal health care system)

--hospitals compete for patients and doctors by offering specialized units, expensive technologies, etc.

--doctors can increase the number of procedures they recommend for a patient to increase their income (fee-for-service encourages this)

7. health care providers have a great deal of power to influence future policy

What does this mean? Examples?

--have prevented the U.S. government from adopting universal health care

--have made it difficult for even small reforms to be passed and implemented unless health providers benefit financially

--health providers are able to "play" the system by billing for the most expensive diagnosis that is plausible for each patient

--health providers avoid seeing Medicare and Medicaid insured patients because the U.S. government sets how much it will pay and the providers have decided the amount set is too low

Overall, health care became too expensive. In review: How did hospitals and doctors contribute to this?

- Hospitals could get paid for as long as they kept a patient (so why not keep a patient for 30 days, even though s/he only needed to be there 5 days, if Medicare would pay for it)
- Doctors could order all kinds of tests that, in many cases, they profited from

A person can "buy into" Medicare (similar to purchasing a health insurance policy). The cost is $479/month for Part A and roughly $200/month for Part B (dollar amounts for 2021).

The cost will be adjusted down for those who have paid into Social Security but have not met the 10 year (40 quarter) requirement.

Moving into the 21st century, health care was becoming too expensive for the average American (purchase of health insurance to expensive, etc.)

What was the government's response to these problems?

(hint: Diagnostically Related Groups or DRGs)

What has occurred as a result of DRGs?

- Hospitals push patients out too soon because they only get paid for so many days by the government
- There is a high unplanned re-admission rate to hospitals because patients were pushed out too soon (or for other non-medical reasons)
- Government's response to hospitals pushing patients out too soon: hospitals are now fined if their readmission rate is higher than other hospitals in their region

How has the pharmaceutical industry affected health care costs and managed to make such a large profit (there are many ways)?

1. the pharmaceutical industry has been the most profitable industry in the U.S. since the early 1980s
2. the pharm. industry has the biggest spending lobby in Washington D.C.
3. when drug patents run out, the pharm. company develops "me-to" drugs that differ only slightly from original drugs but they advertise them as very different (why?)

4. the pharm industry has a tendency to interpret its pharmaceutical research more positively than it sometimes should be, i.e., they manipulate the data (why?)
5. by funding university research, the pharm industry can keep researchers from reporting results that show a drug to be ineffective or dangerous
6. pharm companies provide funding to various government advisory agencies and are a primary source of information/education for doctors

7. the industry attributes its high prices to its expenditures on developing new drugs
   - However this accounts for only 14% of their budgets
   - Roughly 50% of their budgets go to marketing drugs (almost all other countries don't allow pharmaceutical firms to advertise)
8. Medicalization to create illnesses that need their drugs

As the U.S. entered the 21st century, the health care system was not available to many Americans, in spite of a control on costs through the DRGs and gov't assistance for the elderly, poor and the disabled. Why?

- Hospital and MD costs rising dramatically
- 54 million Americans could not afford to purchase health insurance in 2010
- companies could not afford to purchase health insurance for their employees

- health insurance companies looked for ways to NOT provide health care services (e.g., dropping participants; selectively enrolling only healthy participants)
- insurance companies declined people who had pre-existing conditions

The Affordable Care Act (also referred to as "ObamaCare" or ACA) was introduced despite American values against "big government" and despite the power of the health care industry (i.e., hospitals, doctors, insurance and pharmaceutical companies).

What were some of the conditions that led to acceptance of this health care plan? That is, why did the American people support ACA (the answer is a summary of the previous slides)?

1. There were millions of people who could not afford to pay for health care insurance.
2. Many people could not "qualify" for insurance because the insurance companies would not allow someone to purchase their insurance if they might cost the company money. This was indicated by a "pre-existing" condition.
3. Even if the person could get insurance, the insurance companies were denying people services that they needed.
4. The health care costs were getting to high even for the U.S. Government which was paying for Medicare and Medicaid.

What are the major features of the Affordable Care Act (ACA) which incidentally passed by one vote in Congress?

- People can not be denied health insurance (i.e., those with pre-existing conditions cannot be denied or offered only extremely expensive coverage).
- People can stay on their parents health insurance plan until age 26.
- Companies with more than 50 employees must provide insurance to their employees.

- Many more people had health insurance because the ACA required everyone to sign up for it—the government created "health exchanges" to help people find health insurance. Why was this provision (which was later repealed) added to the ACA (hint, it involves health insurance companies)?
- The federal government will allow more people to be eligible for Medicaid (raise the income level for eligibility) if the state agrees to pay its percentage and eventually take on most of the cost.

What are the major problems with the Affordable Care Act?

- People can purchase insurance through "government health exchanges" but there are still high deductibles (e.g., $5,000) and co-payments
- Those who already had insurance found their coverage got more expensive because insurance companies say they need more money to pay for those who can now enroll but are expensive to serve (they were previously denied enrollment)

In sum, major pluses and minuses of the ACA?

- 10's of millions of people now have insurance who would not otherwise due to health exchanges, BUT, many cannot afford the deductibles and co-pays
- More companies are providing their employees health insurance BUT they are now more likely to reduce an employee's hours to part-time or less than 40 hours/week to avoid this government requirement
- People with pre-existing conditions can now get insurance BUT their deductibles may be higher than they can pay and the cost to everyone else has gone up

What policy changes have occurred since ACA was passed in 2010?

- The U.S. supreme court allowed the Federal government to require all to buy insurance but the Trump administration changed the ACA so it is not required (How does this affect insurance companies?)
- The U.S. supreme court decided that the Federal government cannot make states participated in the ACA's expanded Medicaid program for the poor. The state has to agree to participate.

The Trump administration attempted to remove the ACA but has not been successful.

What do you think the American people like most about the ACA?

What don't they like about the ACA?

What are the myths related to the U.S. health care system?

- Myth: Americans receive more and better care than do citizens of other nations
  - Americans actually receive fewer days of inpatient hospital care and fewer doctor visits per capita (except for the rich)
- Myth: The high cost of health care is due to malpractice suits
  - malpractice suits account for 2% of total U.S. health care costs; high cost is more related to health care providers setting rates
- Myth: The sophisticated technologies in the U.S. are causing high health care costs
  - actually only contributes a small amount to total costs compared to other causes

What Does U.S. Health Care Look Like Abroad? | NYT Opinion (6:13 mins)

https://www.youtube.com/watch?v=EBklyksgbco

Why Are American Health Care Costs So High? (7:52 minutes)

https://www.youtube.com/watch?v=qSjGouBmo0M

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Health care: America vs. the World

https://www.youtube.com/watch?v=BytzrjEfyfA

(first 14 mins about the U.S.)
(14:00-24:45 Great Britain National Health Service)
(24:45 Switzerland)

Description of UK health system by an American (10 minutes)
https://www.youtube.com/watch?v=yPiMMCD3ec4

Germany's health care system (5 minutes)
https://www.youtube.com/watch?v=AR0d1BrhIMk

Money driven medicine:
(copy into browser, will take you to UNT media lib where can request it on line) (2009)
https://discover.library.unt.edu/catalog/b6189227

- Watch first 20:00 minutes—explains how doctors feel about the U.S. system

The real reason American health care is so expensive (6 mins)
https://www.youtube.com/watch?v=tNIa9nyRMmQ

Is the US running out of Social Security?
(8 min)
https://www.youtube.com/watch?v=j1Bfxxhdn6g

Medicaid: why it's worse to be sick in some states than others (11:30 minutes)

https://www.youtube.com/watch?v=sOo_aw-xgHQ

Alzheimer's and Dementia,
show first 13 mins
(an example of a person who has Alzheimer's following her over time)

https://www.youtube.com/watch?v=1oLQz1vMmvk

Sir Michael Marmot: Social Determinants of Health (2014 WORLD.MINDS) (compares U.S. to other countries (show first 4 mins)

https://www.youtube.com/watch?v=h-2bf205upQ

Social Determinants of Health: Claire Pomeroy at TEDxUCDavis (speaker experienced low status and how it affects people: start at 6:20 – 15:00))

https://www.youtube.com/watch?v=qykD-2AXKIU

Social Determinants of Health - an introduction

https://www.youtube.com/watch?v=8PH4JYfF4Ns

The Danger of Pesticides

www.mercola.com

https://articles.mercola.com/videos.aspx

Kahoot

https://create.kahoot.it/#login?next=