

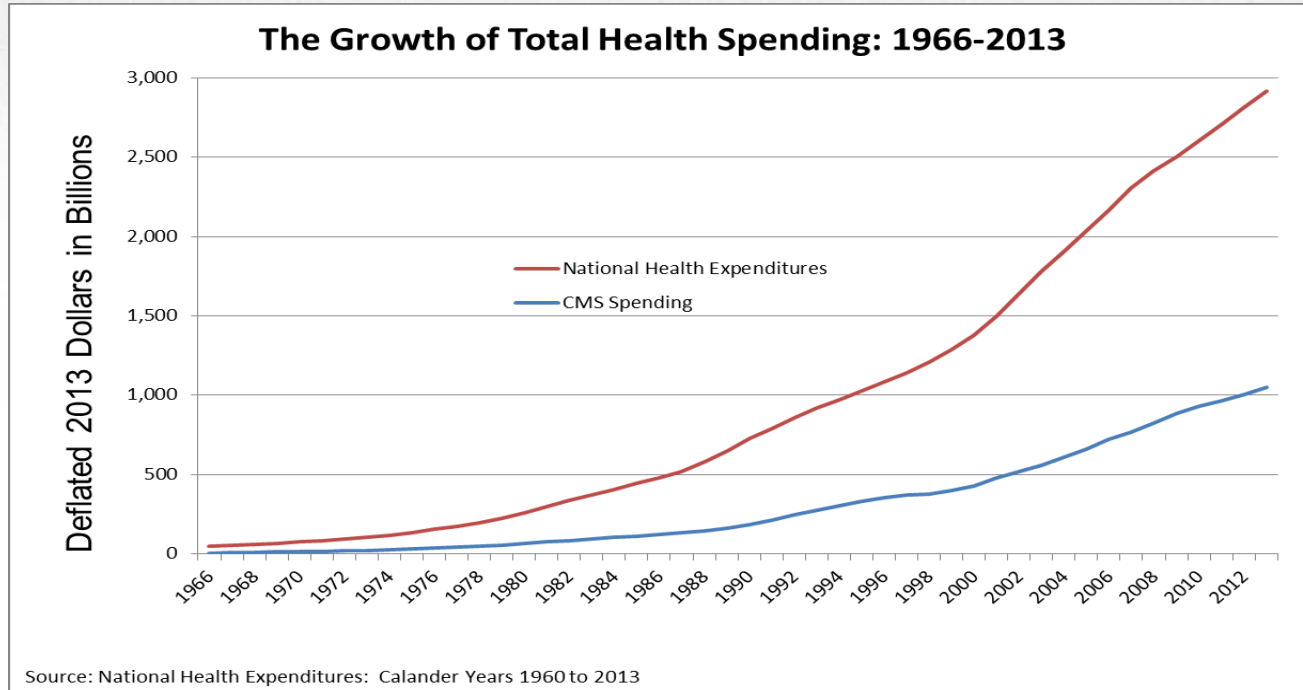
# MAJOR TRENDS IN AMERICAN HEALTH CARE FINANCING: 1966-2014

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The Heritage Foundation  
March 3, 2015

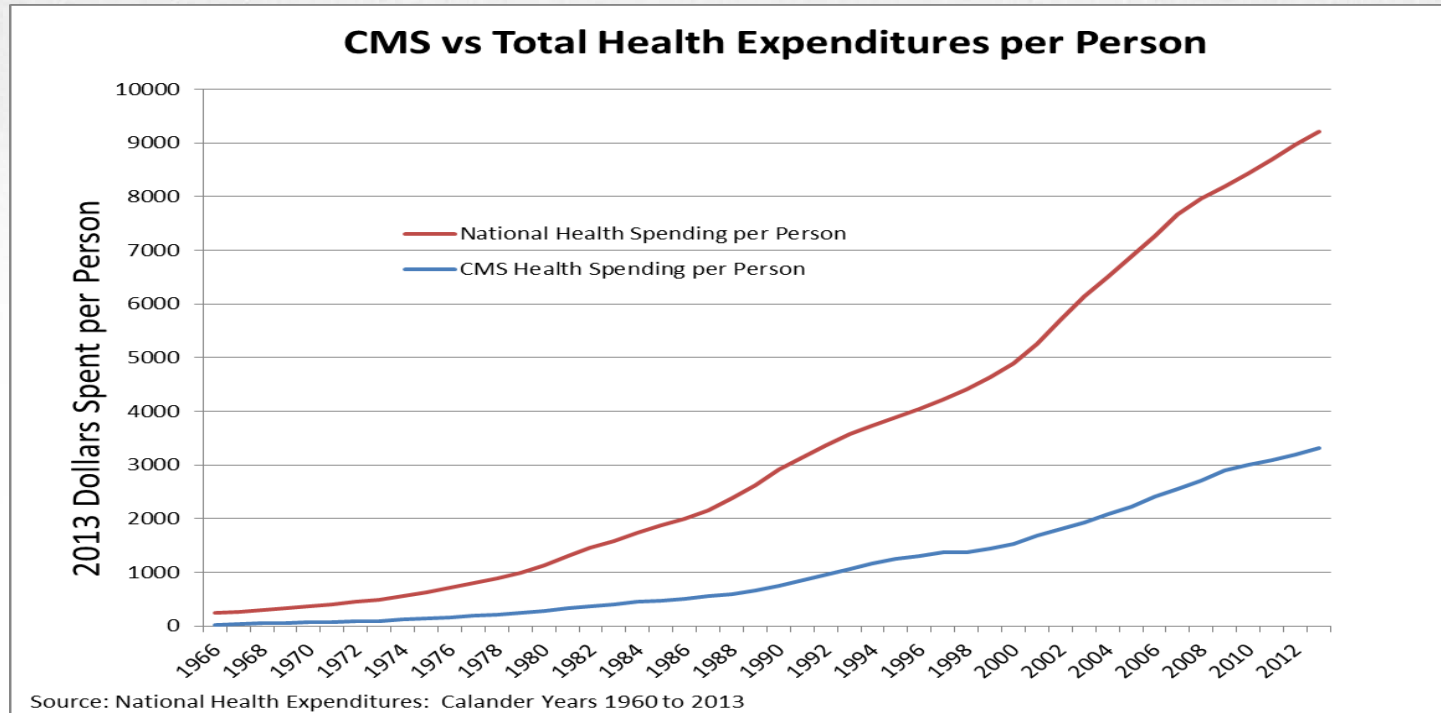


# Total Health Spending Growth: 1966-2013



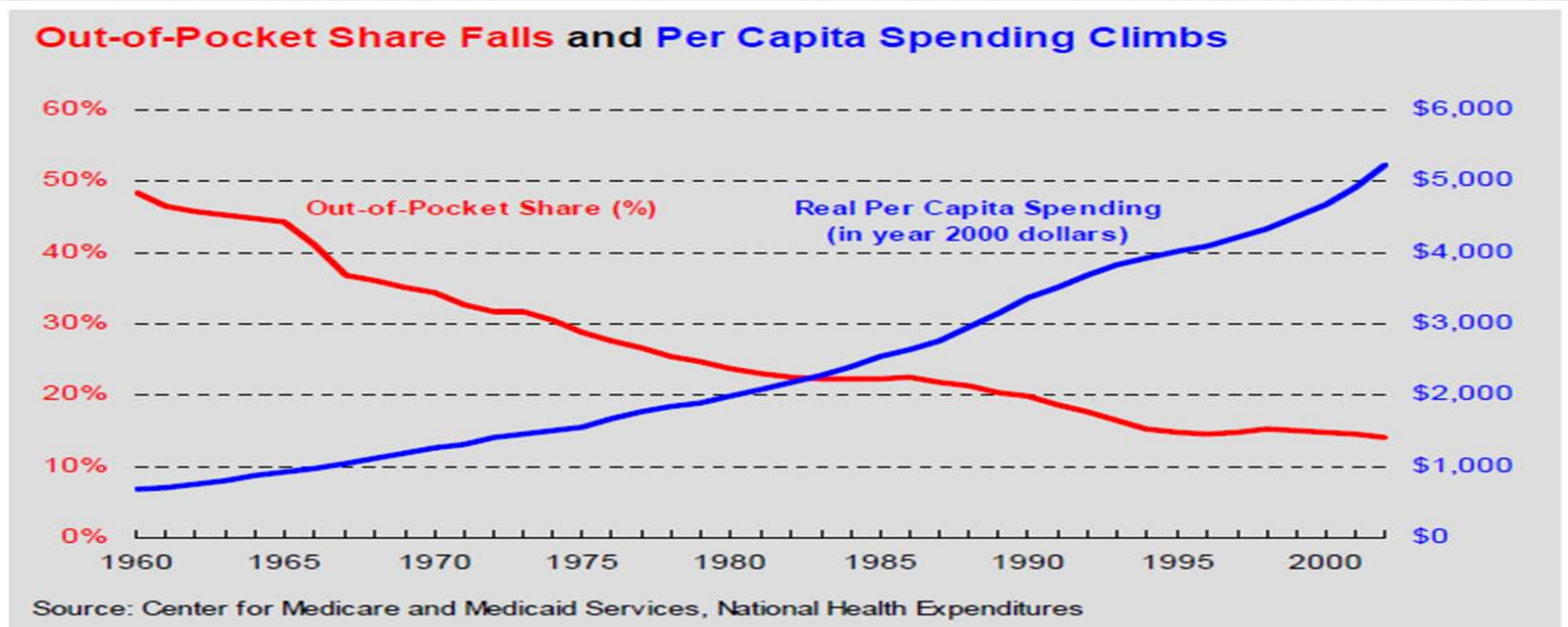


# Total Health Spending Per Capita: 1966- 2012



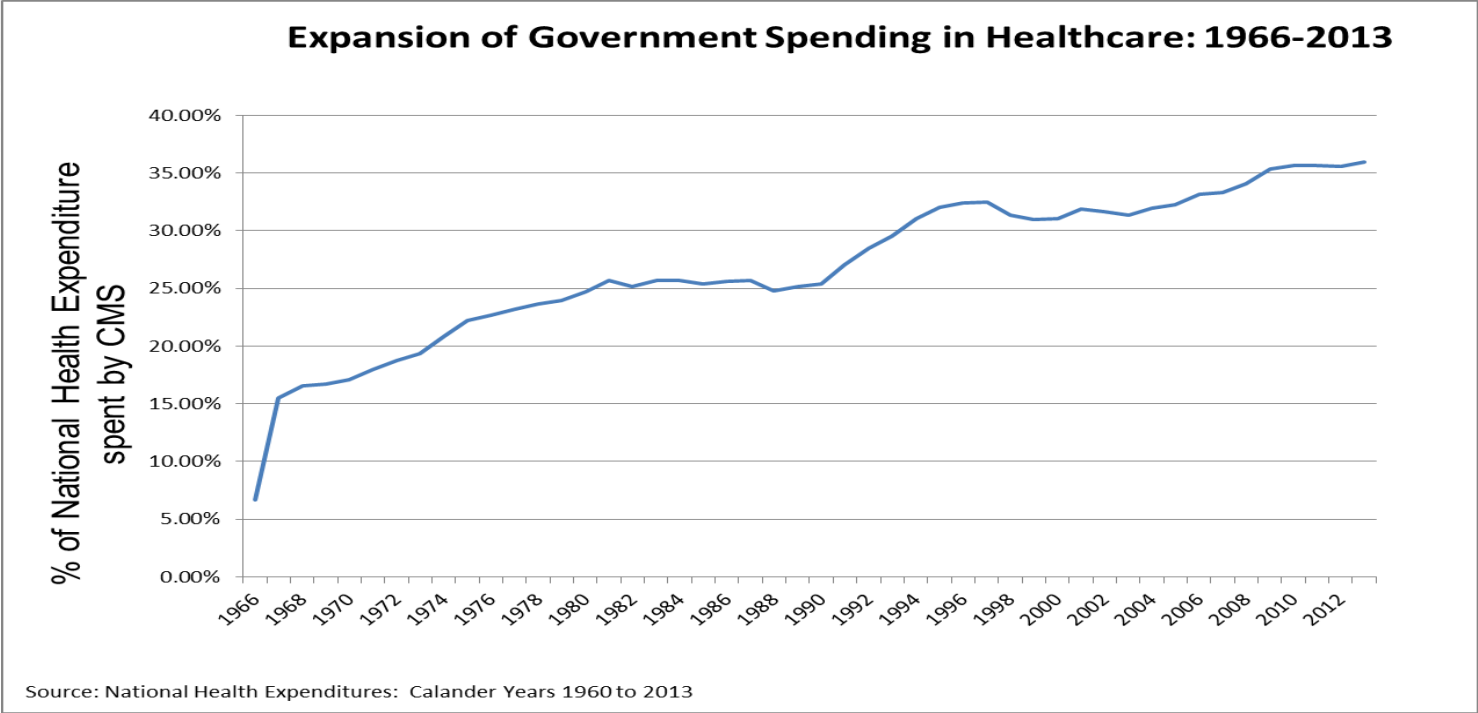


# Decline of Out-of-Pocket Spending: 1960-2000





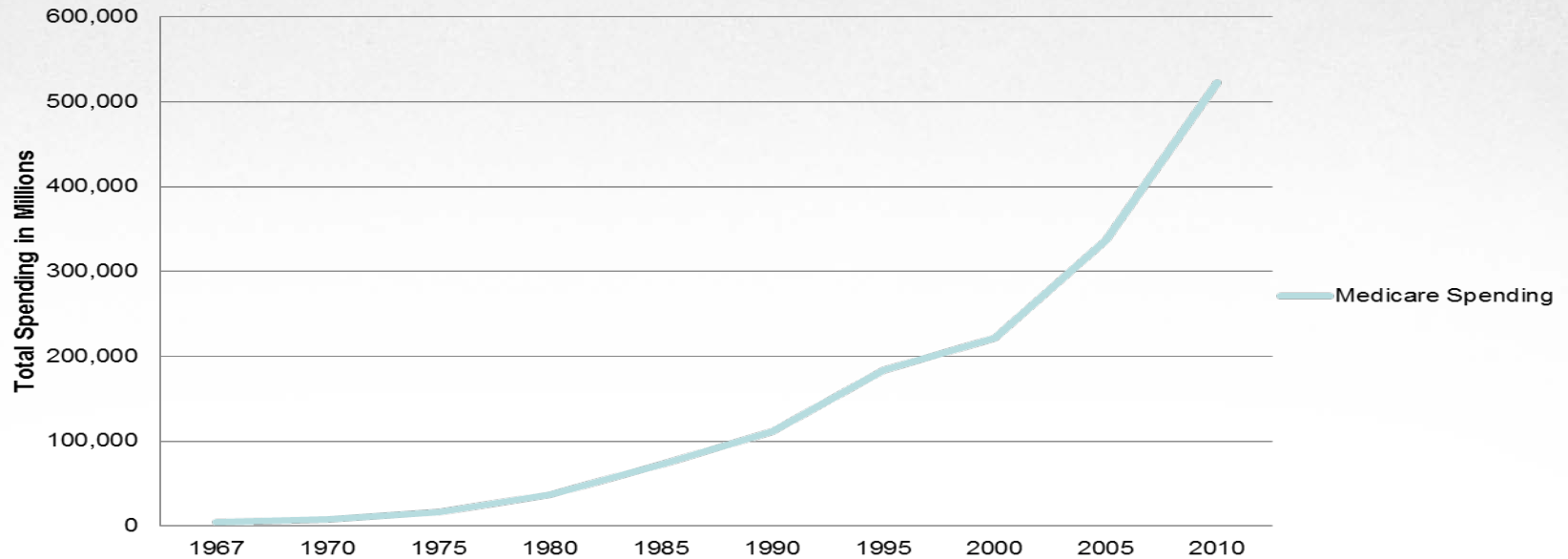
# The Growth in the CMS' Share of Health Spending: 1966-2013



# The Growth of Medicare



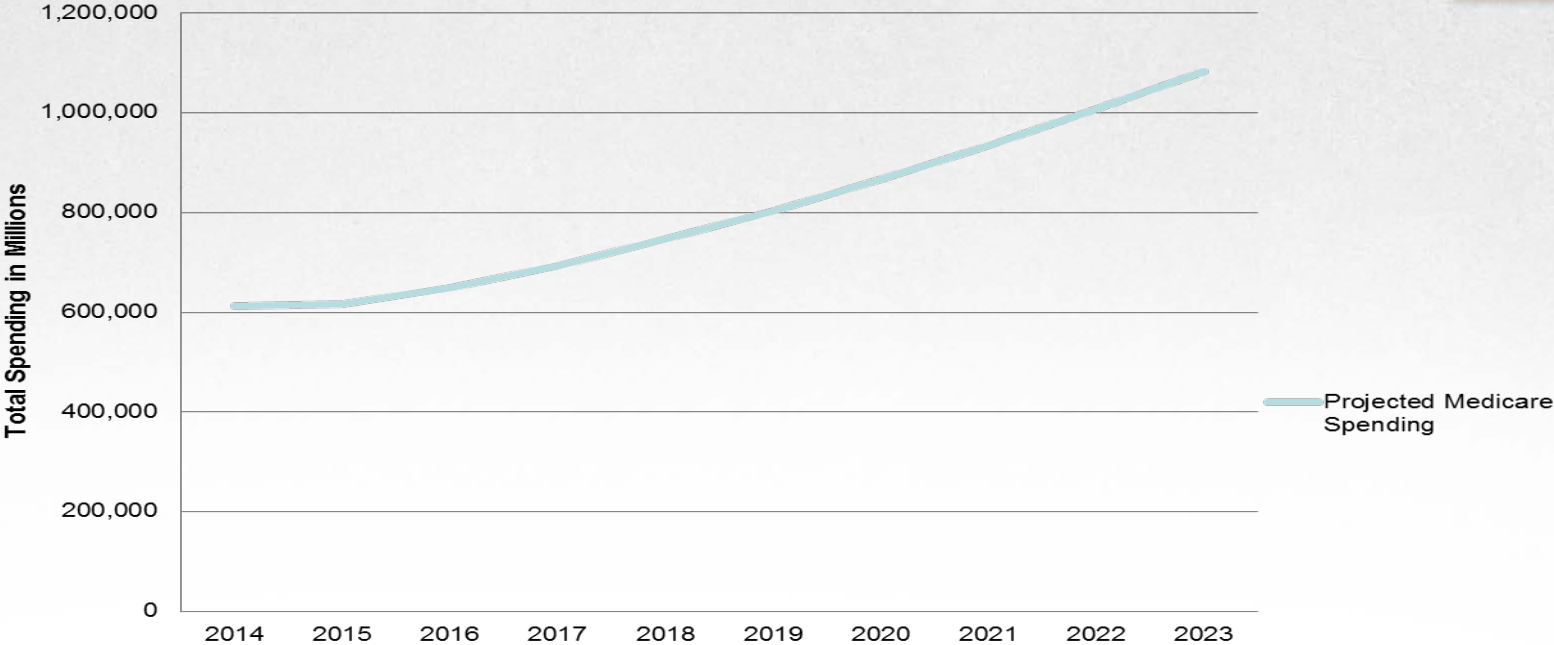
## Total Medicare Spending, 1967-2010



Source: 2014 Medicare Trustees Report



# Projected Medicare Spending, 2014-2023



Source: 2014 Medicare Trustees Report





## Average Annual Percent Change in National Health Expenditures, 1960-2010

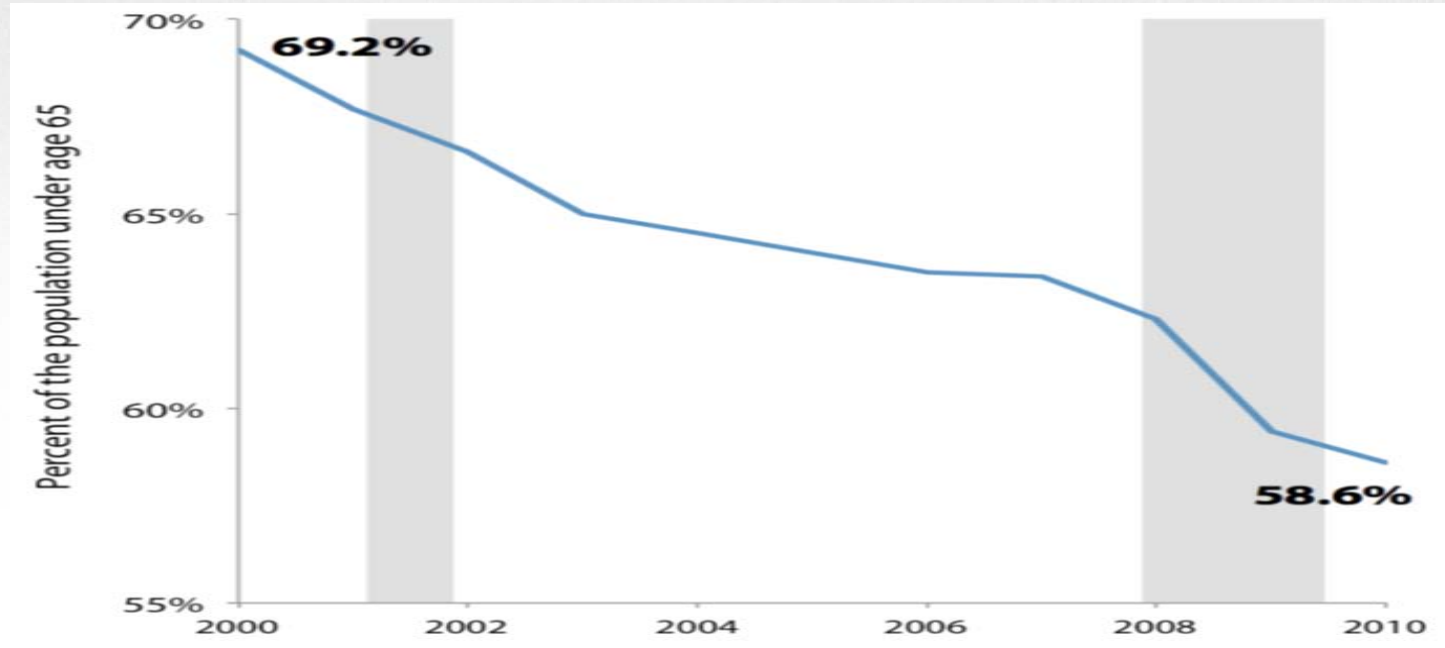


Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2010; file nhe2010.zip).





# Decline of Employer-Sponsored Coverage

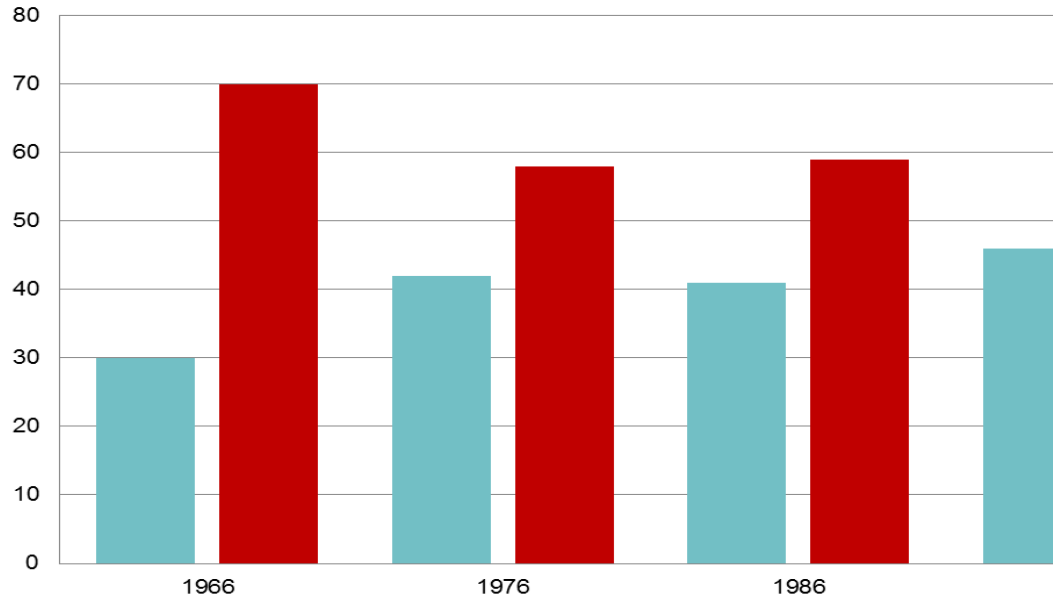


Source: U.S. Census Bureau Data



# The Growth of Public Coverage

Public versus Private Health Care C



Source: TIAA-CREF Institute, December 2008

Public Private



# The ACA's Big Changes

- **Transfer of regulatory authority from the states to the federal government.**
- **Federal standardization of health benefits offerings.** Carriers have less ability to compete on benefit offerings.
- **Federal requirements for exchanges in the states.** While premiums and benefit options will be more comparable among plans, the exchanges also become powerful vehicles for expansive federal regulation.
- **Federal-State Rate Review.** Carriers will seek meet government expectations in setting premium rates.
- **Medicaid Expansion.** Most of the newly covered Americans in are being covered by Medicaid.
- **Medicare Payment Reductions.** To help offset costs of Medicaid expansion and exchange subsidies.
- **The Impact of the Individual and Employer Mandates.** Their enforcement will is proving to be a public policy (IRS) challenge.

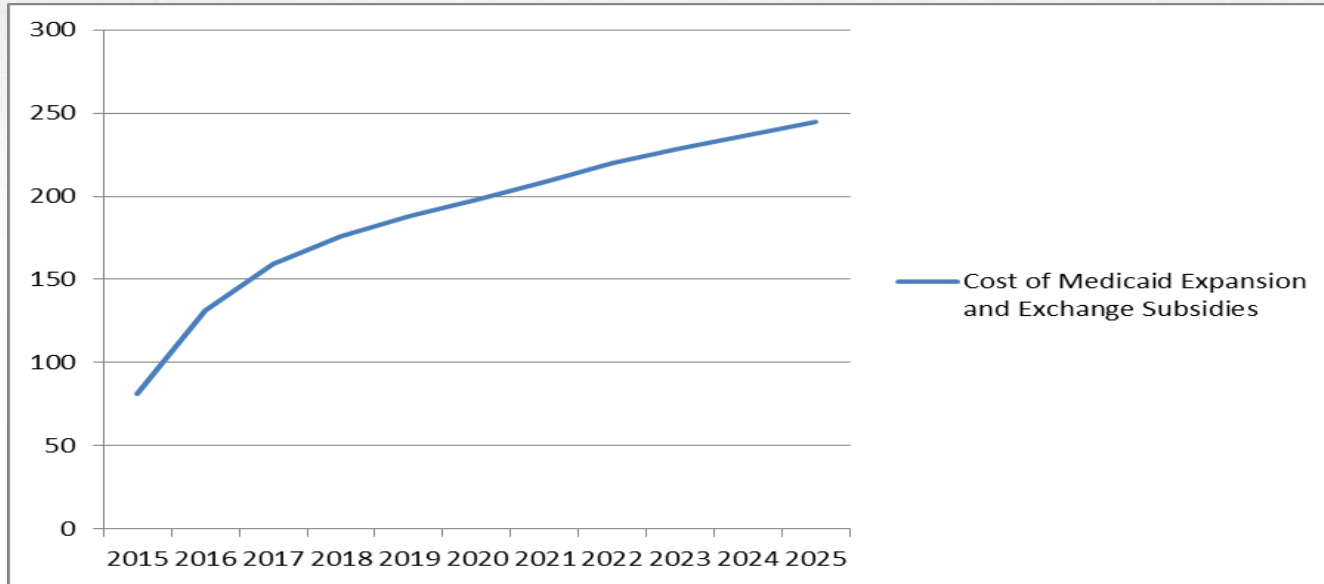


# Impact of ACA in 2014

- **Expanded Coverage.** Most of those newly covered are enrolled in Medicaid.
- **Higher Premiums.** In most states, and in almost every category, individual premiums in 2014 were significantly higher than those in 2013.
- **Higher Deductibles.** In most states, and for almost every category of beneficiary, exchange deductibles were much higher than those found in employer-based insurance.
- **Narrower Networks.** Exchange health plans had narrower networks than anticipated.
- **Greater Market Concentration.** Plan participation in the individual market was lower than it was in 2013.



# Ten Year ACA Coverage Cost: \$2 Trillion



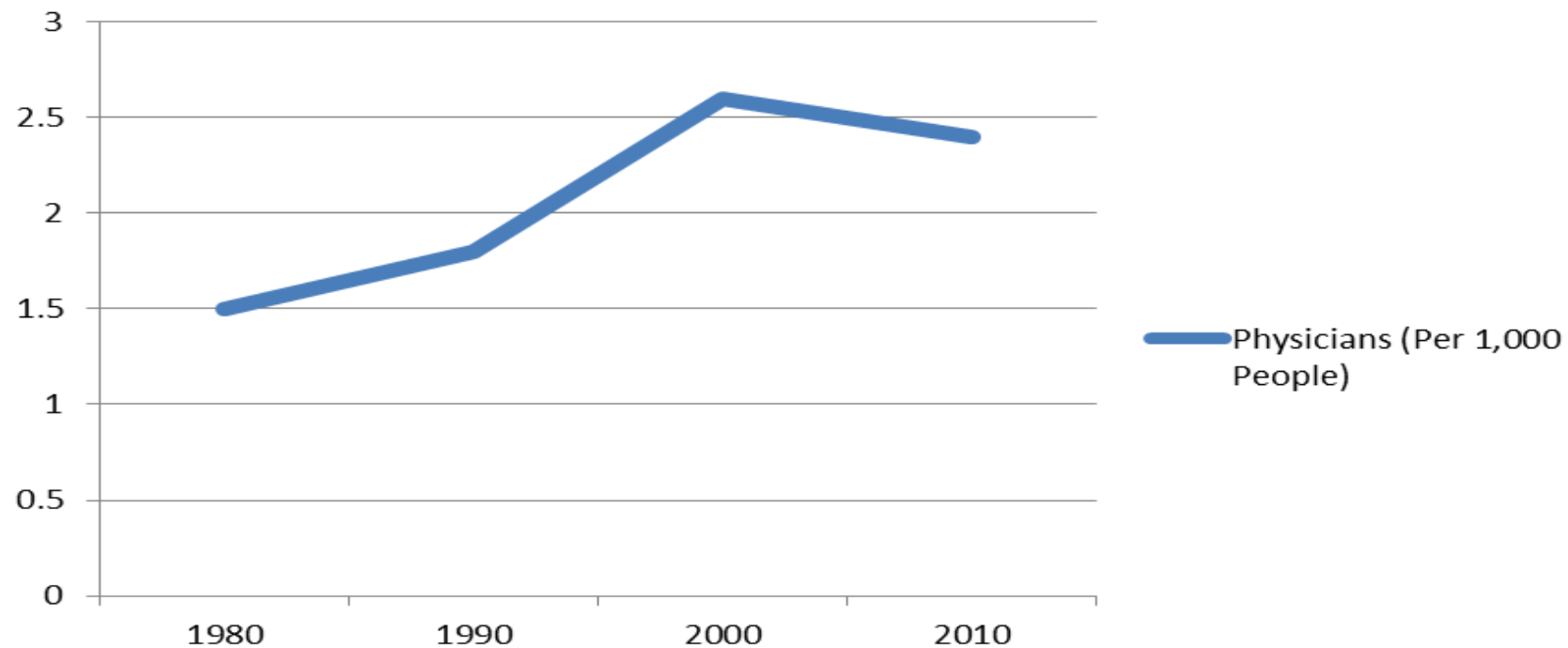


# America's Doctors: A Troubled Profession

- **Over-extended.** 81 percent of physicians say they are over-extend or working at capacity.
- **Reducing Patient Access.** A total of 44 percent of doctors plan to cut back on work, work part time, or close practice to new patients.
- **Declining Private Practice.** A total of 35 percent of doctors describe themselves as independent practice owners. Only 17 percent say they are in solo practice.
- **Wrestling with Paperwork.** Generally, doctors say they spend about 20 percent of their time on non-clinical paperwork.
- **Hostility to Current Health Policy.** 25 percent of doctors give the ACA an A or B grade; 46 percent give it a D or an F.

Source: *2014 Survey of The Physicians Foundation.*

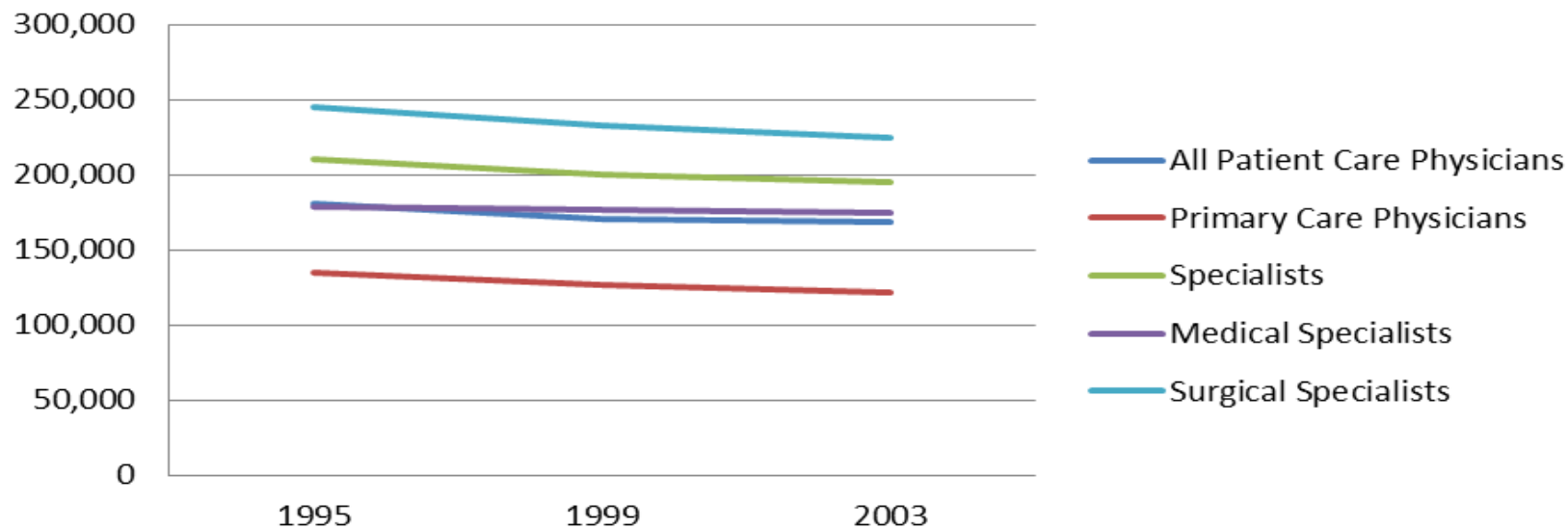
## Physicians (Per 1,000 People)



Source: World Data Bank



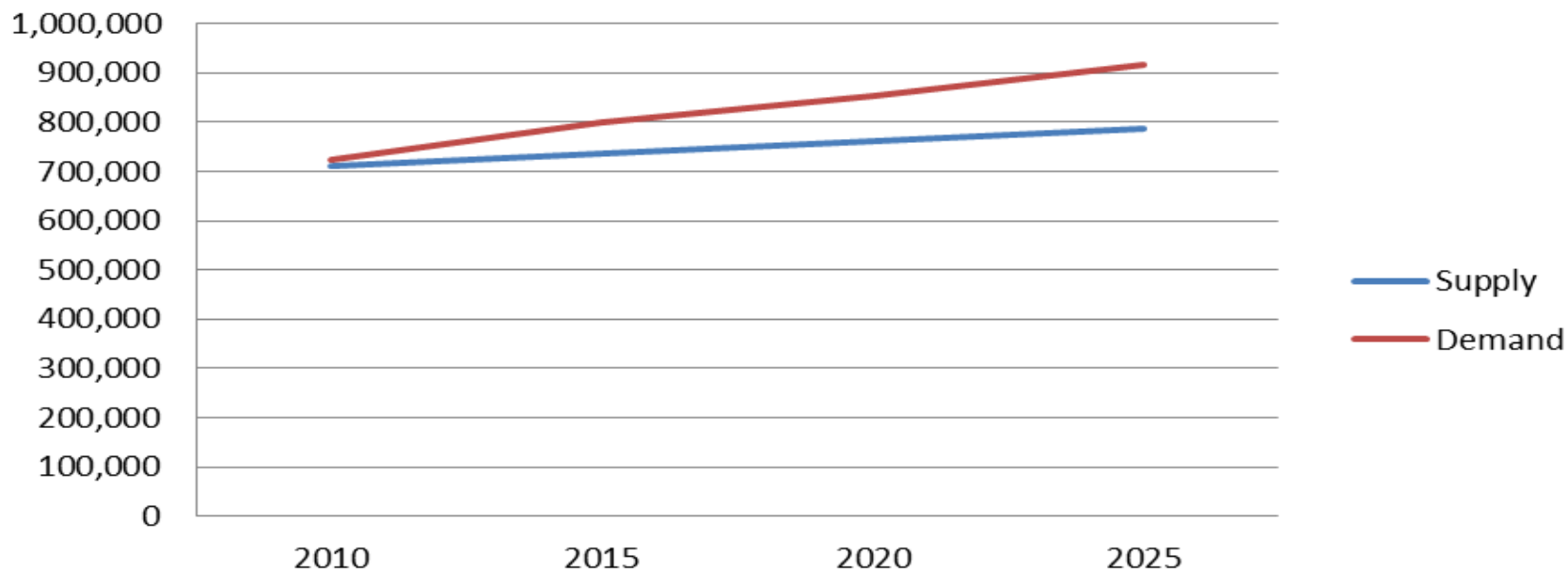
## Average Net Income, Inflation Adjusted, 1995 Dollars



Source: Tu and Ginsburg, "Losing Ground," Center For Health System Change



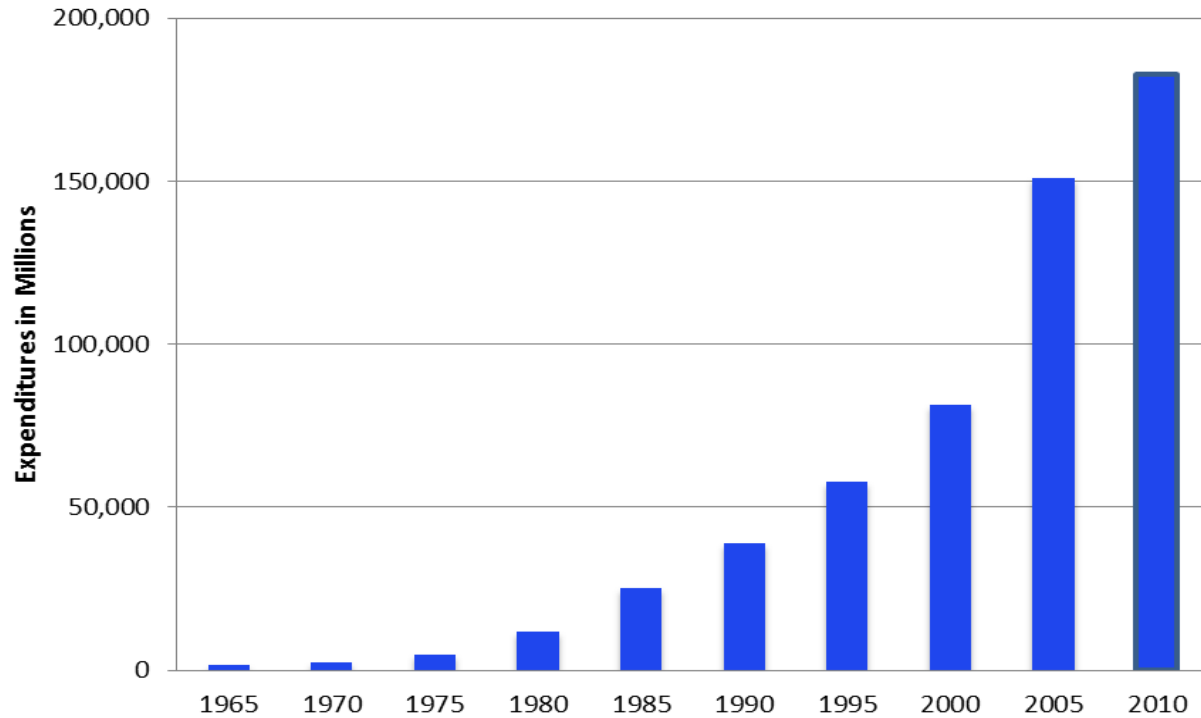
## Projected Supply and Demand of Physicians in All Specialties: 2010-2025



Source: "Impact of Health Care Reform," Association of American Medical



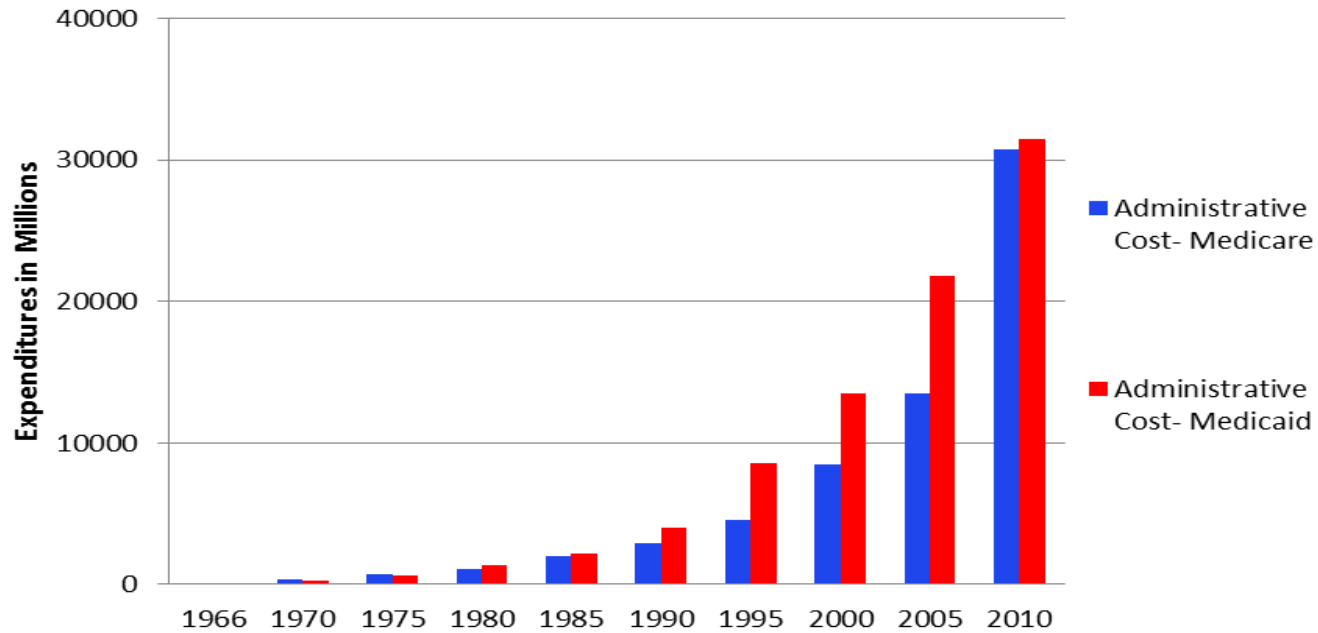
## Insurance: Administrative Cost Growth



Source: CMS, NHE 2013



## Administrative Cost— Medicare/Medicaid



Source: CMS, NHE 2013



# Countervailing Pressures

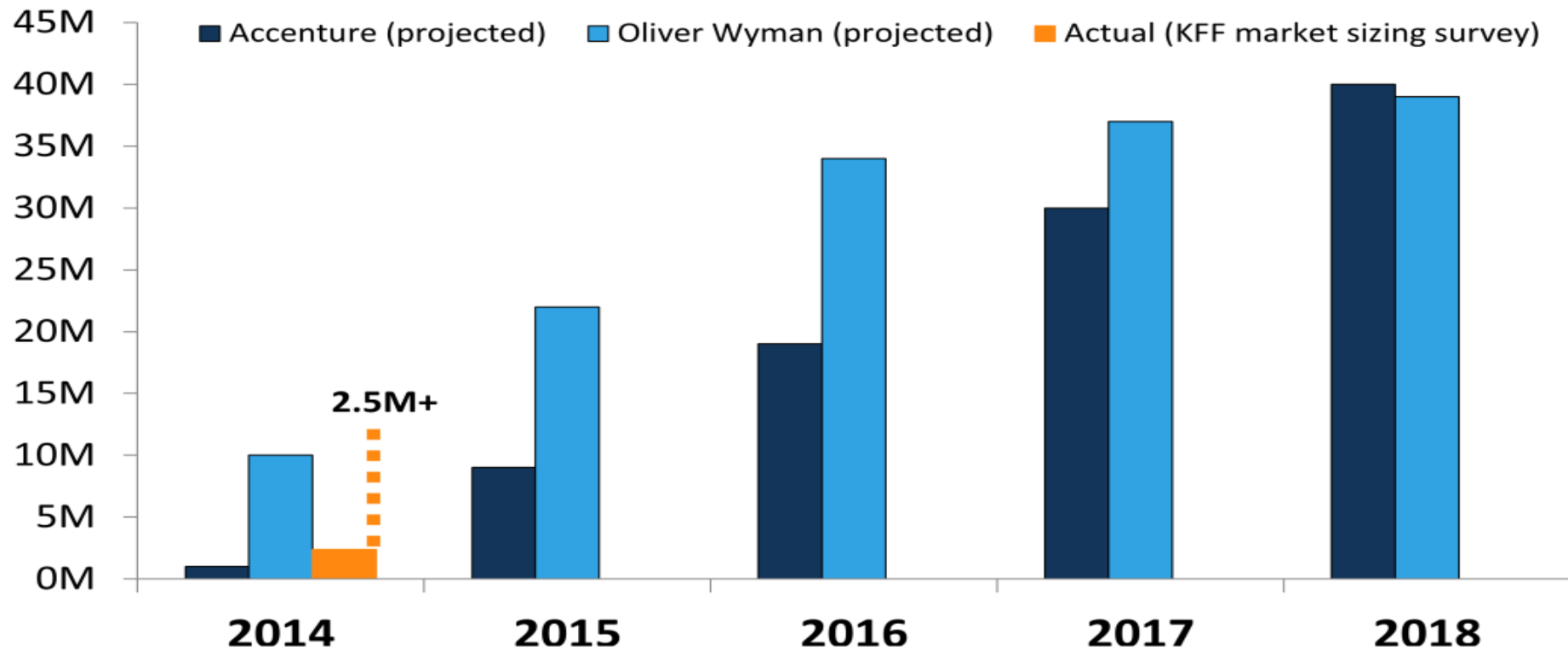
- Consumer Choice Models.
- Private Exchanges.
- Direct Payment Arrangements.
- Repeal or Replacement of the ACA



# Consumer Choice Models

- **The Federal Employee Health Benefits Program (FEHBP).** Created in 1960, the program is a consumer-driven system of competing private health plans.
- **Medicare Advantage.** Created by the Medicare Modernization Act (MMA) of 2003, it is a national program of competing plans on a regional and local level.
- **Medicare Part D.** Created by the MMA, it is a national program of competing drug plans.
- **High Deductible/HSA.** MMA created the recent version of health savings accounts combined with high deductible insurance.

# Actual and projected size of private exchange market, millions (M)

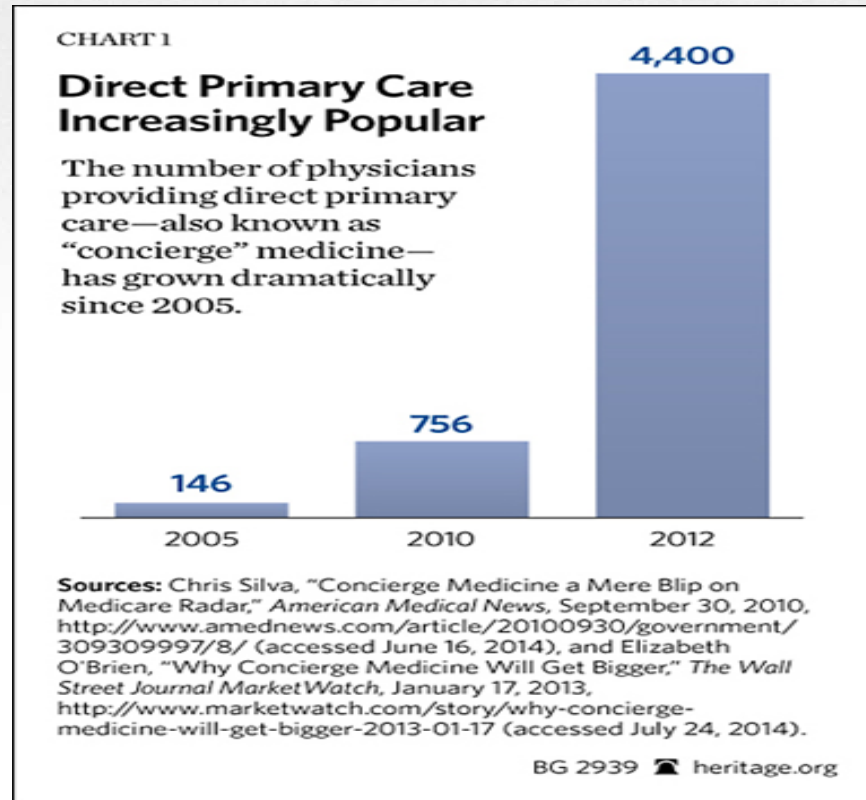


SOURCE: Accenture (2012), Oliver Wyman (2012), Kaiser Family Foundation private exchange interviews/survey





# Direct Physician Payment





# The ACA's Uncertain Future

- Generally Unpopular.
- Key Provisions are Unworkable.
- Key Promises are Unbelievable.
- Legal Challenges are legion.
- Political Challenges are incessant.



# A New Agenda: Build on What Works

- **Repeal the Unpopular ACA.** “Reformers won the war in 2010, but they lost the battle for public opinion: Americans were convinced that reform was needed but not that government could do it. Reformers cannot afford to lose the second battle for public opinion.” (*Jacob Hacker, The American Prospect, August 2010*). As of March, 2015, the “reformers” are still losing it.
- **Establish tax equity in the treatment of health insurance.** Create a level playing field and individual tax relief, and allow personal ownership and portability of policies.
- **Promote Federalism and Reform Grants to States.** Allow states to design and run their own health insurance exchanges; craft their own regulations and reforms; create new mechanisms for coverage expansions, such as automatic enrollment; and improve their own safety net programs.
- **Build on Real Consensus: Coverage of the Poor and the Sick.** Protect persons with pre-existing conditions from coverage exclusions; target federal funding for high risk pools and risk adjustment mechanisms; give direct assistance for persons with low incomes or high health costs.
- **Reform federal health entitlements on the basis of a ( Medicare Part D-style) defined contribution:** Medicare and Medicaid change is inevitable; the task is to effect change without further jeopardizing access to care.