The Healthcare Labyrinth: A Guide to Navigating Health Plans and Fixing American Health Insurance

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Audiobook Supplemental Guide

Chapter 5:

1 -- Different Types of Services/Benefits

- Inpatient hospitalization (various levels of care, including rehabilitation)
- Non-custodial skilled nursing and rehabilitation (acute stays)
- Outpatient services, either at a hospital or free-standing surgery center
- Emergency room care and services
- Ambulance and emergency transportation
- Non-emergency transportation
- Urgent care facilities
- Telehealth
- Primary care physician and provider services
- Specialist physician and provider services
- Retail drugs
- Drugs administered at a physician's office
- Laboratory services
- Imaging and radiology
- Durable medical equipment, prosthetics, and supplies
- Behavioral health and substance abuse services
- Dental services
- Hearing services
- Optometric or eye care services
- Various therapies, such as physical therapy, speech therapy, and occupational therapy
- Home healthcare and rehabilitation services
- Hospice care

2 -- Different Places of Service

- 01—Pharmacy
- 02—Telehealth
- 11—Office
- 12—Home
- 13—Assisted Living Facility
- 17—Walk-In Retail Health Clinic
- 19—Off-campus Outpatient Hospital
- 20—Urgent Care
- 21—Inpatient Hospital
- 22—On-campus Outpatient Hospital
- 23—Emergency Room—Hospital
- 24—Ambulatory Surgery Center
- 31—Skilled Nursing Facility
- 32—Nursing Facility
- 34—Hospice
- 41—Ambulance—Land
- 42—Ambulance—Air or Water
- 49—Independent Clinic
- 50—Federally Qualified Health Center
- 51—Inpatient Psychiatric Facility
- 52—Psychiatric Facility—Partial Hospitalization
- 55—Residential Substance Abuse Treatment Facility
- 56—Psychiatric Residential Treatment Facility
- 57—Non-residential Substance Abuse Treatment Facility
- 61—Comprehensive Inpatient Rehabilitation Facility
- 62—Comprehensive Outpatient Rehabilitation Facility
- 81—Independent Laboratory

Chapter 9:

1 – ***Cost of healthcare expressed as percentage of gross domestic product or GDP:*** Clearly, as managed care penetration reached its peak in the 1990s, the moderation in healthcare costs kicked in.[9-12]

- 1960: 5.0%
- 1970: 6.9%
- 1980: 8.9%
- 1990 12.1%

- 2000: 13.4%

Chapter 13:

1 -- ***Cost of healthcare expressed as percentage of gross domestic product or GDP:*** As discussed in earlier chapters, healthcare spending in America as a percentage of GDP has rapidly risen throughout our modern history. Let's repeat what we showed earlier:

- 1960: 5.0%
- 1970: 6.9%
- 1980: 8.9%
- 1990: 12.1%
- 2000: 13.4%
- 2010: 17.3%
- 2018: 17.6%
- 2019: 17.7%

2 -- ***Who pays the healthcare bills (for 2019)?***

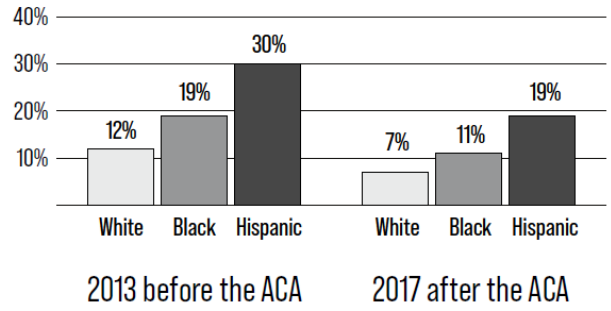
- Federal government—29%
- Households—28%
- Employers—19%
- State and local governments—16%
- Other—7%

3 -- ***How does coverage breakout (for 2019)?***

- Private employer-sponsored coverage—176.4 million
- Other private health insurance coverage—31.3 million
- Marketplace—9.8 million
- Medigap (companion to Medicare for those on the traditional fee-for service [FFS] system and sold privately)—12.3 million
- Medicare—60.2 million
- Medicaid—72.3 million
- State Children's Health Insurance Program —7.1 million
- Other public coverage—14.4 million

TOTAL—383.8 million

4 – ***Health equity -- gains in healthcare coverage by race/ethnicity:*** As of 2017, all categories recorded huge gains in coverage, but blacks and Hispanics the most. Thus, the ethnic and racial disparities related to healthcare coverage are closing.



Chapter 14:

1 – ***Price, utilization, and spending trends in employer market:*** Here is a better breakout of price (unit cost), utilization (how much the service use increased), and spending increases in employer sponsored insurance (ESI) over the 2013 to 2017 claims period: [14-2]

Category	Price Increase	Utilization Increase	Spending Increase
Pres. Drugs:	25.0%	3.1%	28.9%
Outpatient:	18.9%	0.3%	19.3%
Inpatient:	15.6%	-5.0%	9.8%
Professional:	12.4%	0.3%	12.7%
Total:	17.1%	-0.2%	16.7%

2 – ***Employer coverage breakout:*** Let's now look at how spending areas stack up for employer-sponsored insurance (ESI), according to 2017 statistics from the Health Care Cost Institute (HCCI), which I summarize below.[14-2]

Inpatient spending accounted for 19.4% of ESI spending. In this case, HCCI counts only inpatient admissions in the inpatient spending category. The breakout of admissions is below, with the

percentage of spending that each represents in the inpatient category. Mental health/substance abuse saw a major increase in spending over the claims period (with substance abuse driving this).

- Surgical admissions: 49%
- Medical admissions (a stay for other than surgery): 28%
- Labor/delivery/newborn: 19%
- Mental health/substance abuse: 4%

Outpatient spending accounted for 28.0% of ESI spending. In this case, HCCI includes the broad categories below in the outpatient category. The percentage of spending in the list below represents that category's amount against the outpatient total. HCCI does note that ER spending increases over the claims period were high compared with other categories.

- Outpatient surgery (hospital and non-hospital facility based): 36%
- Emergency room: 24%
- Radiology: 13%
- Laboratory: 5%
- Durable Medical Equipment: 3%
- Observation (usually in a hospital or ER): 3%
- Ambulance: 3%
- Other 13%

Professional spending accounted for 33.6% of ESI spending. In this case, HCCI includes the broad categories below in the professional category. The percentages of spending below represent that category's amount against the professional total. This spending would be related to the physician's professional charges and the fees for a given service, such as drugs, radiology, or anesthesia, at a physician's office or when the physician visits the patient in an inpatient or outpatient setting. HCCI notes that office visits and administered drugs accounted for more than half of the cumulative increase over the claims period. Further, administered drugs grew at a faster rate than any other professional services subcategory in each year of the claims period.

- Office visits: 21%
- Surgery: 15%
- Administered drugs (chemotherapy and other infusibles/injectables): 13%
- Lab/pathology: 8%
- Radiology: 8%
- Anesthesia: 6%
- ER visit: 5%
- Other: 26%

Retail prescription drug spending accounted for 18.9% of ESI spending. In this case, HCCI includes drugs and devices (e.g., glucometers and supplies) obtained at pharmacies. HCCI notes that the costs here include negotiated discounts at the pharmacy level but do not count the impact of rebates from drugmakers.

3 – ***Medicare spending breakout:*** In another report, the Kaiser Family Foundation (KFF) indicated that federal fiscal year 2017 Medicare benefit payments were about $688 billion (numbers can differ slightly depending on how it is calculated). KFF reports the following breakout for that year[14-5]:

- Medicare Advantage (MA) medical payments (not Part D drug payment): 30%
- Traditional Medicare fee-for-service (FFS) inpatient services: 21%
- Part D payments for both MA and traditional FFS: 14%
- Traditional Medicare FFS physician payments: 10%
- Traditional Medicare FFS hospital outpatient services 7%
- Traditional Medicare FFS skilled nursing facilities: 4%
- Traditional Medicare FFS home health: 3%
- Traditional Medicare FFS other services: 11%

Based on membership percentage, I have allocated Part D spending between Medicare FFS and MA (I assumed the same costs between the two populations). I then computed out just Medicare FFS costs and found these rough percentages for major categories of spending:

- Inpatient: 33%
- Physician services: 16%
- Retail drugs: 12%
- Outpatient: 11%
- Skilled nursing: 6%
- Home health: 5%
- Other: 17%

4 – ***Medicaid spending breakout:*** According to the Kaiser Family Foundation (KFF), the 2017 breakout of the total $577 billion in Medicaid spending nationally was as follows:[14-7]

- Spending in the traditional, acute fee-for-service (FFS) system of each state: $142 billion
- Spending in the traditional, long-term care FFS system of each state: $119 billion
- Managed care spending: $282 billion
- Medicare premium and cost-sharing payments for dual eligibles: $19 billion
- Payments to hospitals for underfunding and uncompensated care: $15 billion

The Centers for Medicare and Medicaid Services' (CMS) National Healthcare Expenditure Data (NHED) website reports that gross spending for Medicaid was about $613 billion in 2019.[14-1] This is the state and federal spending in the partnership program. Enrollment from CMS for that year was about 75 million beneficiaries,[14-3] giving us a per capita annual cost of about $8,200 annually for all Medicaid spending. This compares with $5,641 annually for employer-sponsored insurance (ESI) and about $13,000 for Medicare. Note, though, that the Medicaid figure includes both acute and long-term care costs so comparison is not entirely valid.

Given the challenging data collection efforts, the best source is 2013 data in a recent KFF report, which says that in 2013, rough Medicaid costs were as follows:[14-8]

Acute Care (annually):

- Children: $2,400
- Adults: $3,100
- Elderly: $4,300
- Persons with disabilities: $10,700

Long-Term Care (annually):

- Children: $100
- Adults: $50
- Elderly: $9,000
- Persons with disabilities: $6,300

CMS published the following in January 2020, and it combines acute and long-term care Medicaid services costs for 2017:[14-9]

- Children: $3,555
- Adults: $5,159
- Medicaid Expansion adults: $5,965
- Elderly: $14,700
- Persons with disabilities: $19,754

Chapter 19:

1 – ***Medicare spending breakout and beneficiary profile:*** Where did the money go? The Kaiser Family Foundation (KFF) says that in 2017, Medicare had a gross expenditure of about $688 billion ($705 billion, according to the Centers for Medicare and Medicaid Services' (CMS) National healthcare Expenditure Data (NHED) website) that was spent as follows:[19-3]

- 30% for Medicare Advantage (MA) plan payments; this is about right given enrollment in the program
- 21% went to inpatient costs for the traditional fee-for-service (FFS) program
- 14% went to outpatient prescription drugs in the Part D program
- 10% went to physician payments
- 7% went to hospital outpatient services
- 4% went to skilled nursing facility (SNF) visits
- 3% went to home health visits
- 11% to all other services

The profile of those on Medicare is one of ill health. That makes sense, as the program covers those who are aged or those with disabilities or serious disease states. Most have multiple chronic conditions and limitations in their activities of daily living. It is also the case that many have low incomes. A few statistics from KFF based on 2016 surveys:[19-3]

- 32% had a functional impairment
- 25% reported being in fair or poor health
- 22% had five or more chronic conditions
- 15% were under age sixty-five and living with a long-term disability
- 12% were ages eighty-five and over
- 3% lived in a long-term care facility
- Half of all people on Medicare had incomes below $26,200 per person and savings below $74,450.

2 – ***Medicare Part B services:*** Here are some of the major services provided in Part B.[19-11, 19-13, 19-18, 19-19] The services covered under Part B are so numerous that I cannot list them all here. For a complete list you can go to an Evidence of Coverage for a Medicare Advantage (MA) plan online or go to the "Medicare and You" pamphlet for the most current year (2021 is cited in this book). If needed, I updated premiums, deductibles, and cost-sharing with the latest figures for 2021 from official government sources. These figures go up each year based on inflation. Remember that in the traditional fee-for-service (FFS) program, unless the service is a preventive screening with no cost-sharing, most services require a 20% co-insurance against the allowed amount for the Medicare service. Providers cannot balance bill over that as long as they are Medicare physicians accepting assignment. In the MA world, co-insurance may be changed to a lower co-pay for a number of services.

- Ambulance services, usually limited to emergency and medically necessary transport
- Ambulatory surgery centers and outpatient care at a hospital for the facility and physician costs
- Ancillary providers, such as chiropractic

- Outpatient behavioral health services
- Chemotherapy, physician administered drugs, and related services
- Durable medical equipment (DME)
- Emergency and urgent care services
- Home health services (covered under Part B when not qualified under Part A and a doctor believes they are medically necessary and someone is homebound; cannot be personal or custodial care unrelated to an acute illness; no co-insurance except on DME.)
- Kidney dialysis
- Laboratory services
- Nutrition services
- Physician services
- Some prescription drugs (most are covered under Part D)
- Prosthetics and orthotics
- Preventive screenings
- Radiology and imaging
- Various rehabilitation services
- Various therapies
- Transplants
- Vaccines

What is not covered?

- Alternative medicine
- Cosmetic surgery
- Most dental care
- Dentures
- Eye exams tied to prescribing glasses
- Routine foot care
- Hearing aids
- Acute long-term care, including personal and custodial care
- Most non-emergency transportation
- Most vision care

Chapter 20:

1 – ***Medicare Advantage cost caps and added benefits:*** Unlike the traditional fee-for-services (FFS) program, Medicare Advantage (MA) plans must have a maximum out-of-pocket (MOOP) cost threshold. The 2021 limits are $7,500 for in-network coverage and a combined in-network/out-of-network (OON) cap of $11,300 for products that have an out-of-network

option. In 2020, the average MOOP limits for plans were the following, with MOOP averages trending downward since 2017:

- HMO Only (no OON): $4,486
- Local PPOs: in-network coverage is $5,622 and combined is $8,795
- Regional PPOs: in-network coverage is $6,493 and combined is $9,010

Note that the above MOOP only applies to Part C (Parts A and B services). Part D has a separate out-of-pocket limit that applies to both MA members and traditional FFS members. This will be discussed in a subsequent chapter.

MA plans add non-covered Medicare benefits. The most popular ones in 2020 and 2021 included:

- Eye exams and glasses—79%
- Telehealth—77%
- Dental—74%
- Fitness—74%
- Hearing aids—72%
- Over-the-counter (OTC) drugs—61%
- Meal benefit—39%
- Non-emergency transportation—34%

Chapter 21:

1 -- ***Here is my pros and cons list for FFS and MA:***

Fee-for-Service: PROS	Fee-for-Service: CONS
Relatively open network—You can go to any doctor or hospital that accepts Medicare	Very expensive for those on fixed incomes (deductibles and cost-sharing), but can buy Medicare Supplement or Medigap policies (expensive, too)
You can join a Part D Plan—Prescription Drug Coverage with private insurance company	Little or no care coordination and beneficiary very much on their own to manage their care
No referral, prior authorization, or utilization management (UM) to go through	Little quality focus in program and very wasteful, which drives up costs for the nation and individuals

Medicare Advantage: PROS	Medicare Advantage: CONS
Usually covers well beyond traditional Medicare for little or no additional premium (reduced cost-sharing, added benefits, Part C maximum out-of-pocket [MOOP] cost, usually more expansive hospital benefit than FFS)	Usually confined to a network of providers. Any out-of-network access could be limited or expensive (although the cost may not be more than traditional FFS)
MA can provide very competitive Part D benefits by using Part C dollars to "buy down" D costs.	Must follow plan rules—authorizations, referrals, etc.
One-stop shopping for all your A, B, and D needs	
Focused on quality outcomes and member satisfaction	

2 – ***Medicare Advantage as safety net financial protection:*** Basically, it is an alternative social welfare program at no or minimal cost to the taxpayer.

Consider the following statistics: [21-1, 21-2, 21-3, 21-4]

Those sixty-five and older on traditional Medicare fee-for-service (FFS) were more likely to be a part of a family having trouble paying their medical bills than those who were on Medicare Advantage (MA). For 2018, the Centers for Disease Control and Prevention (CDC) found the

following with regard to adults aged sixty-five and over who were in families having problems paying medical bills in the past twelve months:

- 5.6% for those with private insurance
- 12.3% for those with Medicare and Medicaid
- 8.3% for those with MA
- 12.4% for those with traditional Medicare (no Medicare Supplement)

When it comes to those seventy-five and older, the statistics were as follows:

- 4.2% for those with private insurance
- 9.6% for those with Medicare and Medicaid
- 7.2% for those with MA
- 10.6% for those with traditional Medicare (no Medicare Supplement)

3 – ***Medicare Advantage support:*** Perhaps the best testament to the program is how members feel. In a 1,200-member survey undertaken by the Better Medicare Alliance (BMA), respondents showed overwhelming support for Medicare Advantage (MA), including record satisfaction in the following areas:[21-8]

- Coverage (98%)
- Networks (97%)
- Plans performance during the COVID-19 crisis (98%)
- Telehealth (91%)
- Simplicity of the enrollment process (71%)

Chapter 22:

1 – ***Chronic Care Special Needs Plans:*** The Centers for Medicare and Medicaid Services (CMS) has outlined fifteen disease states or conditions for which Medicare Advantage (MA) plans can set up Chronic Care Special Needs Plans (C-SNPs). As of this writing in early 2021, they include:

- Chronic alcohol and other drug dependence
- Certain autoimmune disorders
- Cancer
- Certain cardiovascular disorders
- Chronic heart failure
- Dementia

- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD)
- Certain severe hematologic disorders
- HIV/AIDS
- Certain chronic lung disorders
- Certain chronic mental health disorders
- Certain neurologic disorders
- Stroke

Chapter 24:

1 – *Medicaid waivers:*

1915(b) Managed Care Waivers[24-4]—While a state can take other routes to establish Medicaid managed care in their state—including a state plan amendment and 1915(a) waivers—most file these 1915(b) waivers in order to waive additional rules and enroll additional population categories in managed care, such as dual eligibles. The waiver of certain rules of the road in traditional Medicaid include:

- Allowing states to set up restrictive networks and requiring beneficiaries to seek care from these networks
- Establishing an enrollment broker
- Adding certain benefits to the program
- Contracting requirements
- Expansion of population groups subject to mandatory managed care enrollment

1915(c) Waivers[24-5] —These allow states to create home- and community- based programs under Medicaid, including home care, adult day care, assisted living, and certain facilities for those with developmental disabilities. Many of the same rules above are waived and states must ensure that:

- The home and community services are cost effective against providing such services in an institution.
- There are protections for people's health and welfare and that provider standards are in place.
- These programs follow an individualized and person-centered plan of care.
- There are more flexible eligibility rules.

1115 Waivers[24-4]—Section 1115 of the Social Security Act gives the federal secretary of the Department of Health and Human Services (HHS) broad authority to approve experimental, pilot, or demonstration projects.

2 – ***Medicaid mandatory and optional eligibility groups as well as mandatory and optional benefits:***

There are over two dozen mandatory Medicaid groups. These generally include:[24-6]

- Low-income children
- Certain low-income families
- Certain pregnant women and children
- The disabled who receive federal Supplemental Security Income (SSI). Those receiving SSI first go on primary Medicaid and after a period of time (usually twenty-four months for most people) move to Medicare for primary coverage and Medicaid for secondary coverage.
- Other aged, blind, and disabled individuals
- Certain low-income Medicare eligibles

In addition, there are over forty optional coverage groups that states can elect to extend Medicaid coverage to, including:[24-6]

- Other low-income children and/or families
- Higher-income pregnant women
- Individuals at higher incomes receiving certain home- and community-based care
- Women with breast cancer
- Individuals at higher incomes with high medical bills (the medically needy or "spend-down" category)
- Up to 133% of the federal poverty limit (FPL) per the Medicaid expansion provision of the Affordable Care Act (ACA). (This actually computes to about 138% of FPL due to income and related set-asides.)

As with eligibility groups, there are mandatory and optional benefits. Mandatory benefits include:[24-7]

- Inpatient hospital services
- Outpatient hospital services
- A strict regulation known as early and periodic screening, diagnosis, and treatment (EPSDT) for children. Many states complain that this is an unfettered mandate that allows coverage of almost anything.
- Nursing facility services
- Home health services

- Physician services
- Laboratory tests and X-rays

Optional services include:[24-7]

- Prescription drugs (covered by all states)
- Therapies
- Optometry and optical services and benefits
- Dental services
- Dentures
- Prosthetics
- Certain alternative medicine

Chapter 27:

1 – ***Marketplace Exchanges essential benefits:*** Under the law, these metal plans all must still cover what are known as essential benefits. Each metal plan may have higher or lower cost-sharing, but these benefits must be covered fully in each metal tier. The benefits that must be fully covered, largely without limitations, are as follows:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive, wellness, and chronic disease management services, which must be offered free of charge and without a deductible applying
- Pediatric services, including oral and vision care
- Mandatory dental coverage for children

2 – ***Marketplace Exchanges premium assistance:*** An example of the scaled premium assistance for a family of four is in the following table. (For clarification, the family of four poverty limit—100%—for 2021 is $26,500, meaning 400% of FPL is $106,000.[27-12]) Note that some of the sources used here published their articles before the most recent poverty guidelines were finalized. I have adjusted the figures below to the most updated values.

Family Income		Percentage of Income Paid Toward Premium
Percentage of FPL	Top Amount	
Up to 133%	$35,245	2.07%
133% to 150%	$39,750	Between 3.10% to 4.14%
150% to 200%	$53,000	Between 4.14% to 6.52%
200% to 250%	$66,250	Between 6.52% to 8.33%
250% to 300%	$79,500	Between 8.33% to 9.83%
300% to 400%	$106,000	9.83%
Over 400%	—	(no subsidy)

3 – ***Marketplace Exchanges cost-sharing assistance:*** The Cost-Sharing Reduction (CSR) eligibility and special Silver plan types are as follows:

- 100-150% of FPL—special Silver benefit with an Actuarial Value (AV) of 94%
- 150-200% of FPL—special Silver benefit with an AV of 87%
- 200-250% of FPL—special Silver benefit with an AV of 73%

4 – ***Marketplace Exchanges temporary premium subsidy enhancements:*** Here are the temporary increases in premium subsidies:

Income Levels	Permanent Law	2021 COVID-19 Relief Bill Temporary Enhancement
Less than 133% FPL	2.07%	0%
133-150% FPL	3.1-4.14%	0%
150-200% FPL	4.14-6.52%	0-2%
200-250% FPL	6.52-8.33%	2-4%
250-300% FPL	8.33-9.83%	4-6%
300-400% FPL	9.83%	6-8.5%
Over 400% FPL	N/A	8.5%

5 – ***Possible Marketplace Exchanges cost-sharing subsidy enhancements:*** A U.S. Senate Democratic bill would make the premium subsidies in the COVID-19 relief bill permanent, tie Cost-Sharing Reduction (CSR) subsidies to Gold plans as opposed to Silver, and enhance and extend CSR subsidies to 400% of FPL. The premium subsidy changes would match what has been adopted temporarily for 2021 and 2022. The CSR changes would be as follows, which would enhance the actuarial value (AV) of plans for many of modest to middle income.

Current ACA CSR Subsidies:	Senate Democratic Proposal:
100-150% of FPL—94% Actuarial Value (Individual/Family pays 6%)	100-200% of FPL—95% Actuarial Value (Individual/Family pays 5%)
150-200% of FPL—87% Actuarial Value (Individual/Family pays 13%)	200-300% of FPL—90% Actuarial Value (Individual/Family pays 10%)
200-250% of FPL—73% Actuarial Value (Individual/Family pays 27%)	300-400% of FPL—85% Actuarial Value (Individual/Family pays 15%)

Chapter 28:

1 – ***Employer-sponsored coverage costs:*** To understand the impact, let's turn to the largest area of coverage in America, large group employer coverage, and the Peterson-Kaiser Family Foundation Health System Tracker.[28-7] Here are some recent statistics:

- Total health spending by and on behalf of a family of four with large employer coverage in 2018 was almost $23,000.
- In 2018, the average family spent $4,706 on premiums and $3,020 on cost-sharing (deductibles, co-insurance, and copayments), for a combined cost of $7,726.
- Over the past decade, health spending by families has increased twice as fast as wages. Family combined premium and out-of-pocket spending was up 135% from 2003 to 2018. Employee costs increased an average of 9% per year from 2003 to 2018.
- The increase in family costs has been driven in part by rising deductibles, an increasingly prominent feature of the employer benefit design. Deductibles have surged from 2003 to 2017, up from 20% of cost-sharing to 51%. Co-insurance has remained roughly steady, with co-payments as a percentage of out-of-pocket costs dropping. This contributes to concerns about lack of access to early and preventive coverage.

- Thankfully, the family costs in the last five years of the study were more tempered, increasing 18% from 2013. Still, that is against an 8% general inflation increase and a 12% increase in workers' wages over the timeframe.
- The large group employer funding percentage is only slightly down from 2008. Employers paid about two-thirds of the cost of health coverage in 2018 and shared a reasonable part of the cost of the increase. Employer premium increases were 115% from 2003 to 2018. As such, the cost increases are huge for these employers to handle and threaten economic growth.

2 -- ***Employer-sponsored coverage costs:*** A Commonwealth Fund study of 2019 employer plan premiums shows something similar and concludes that health plan premiums are taking up much more of an employee's take-home pay:[28-9]

- Employee premium contributions and deductibles increased from 9.1% of incomes a decade ago to 11.5% in 2019.
- Premiums and deductibles were over 10% of employees' incomes in thirty-seven states in 2019, compared to ten states in 2010.
- In nine states, premiums and deductibles were 14% or more of household incomes.
- Average deductibles accounted for 5% or more of median income for people living in twenty states.
- The single coverage average premium contributions nationally were $1,489 in 2019.
- Family coverage average premium contributions nationally were $5,719 in 2019, within a range of $3,685 to $8,202.
- The average deductible for single coverage was $1,931, within a range of $1,264 to $2,521 in 2019.

3 -- ***What do the uninsured look like?*** [28-14, 28-17]

Most are lower income and have at least one worker in the family. But the uninsured crisis does hit the middle class. Here is the breakout of the uninsured in 2018:

- Under 100% of the federal poverty limit (FPL)—23%
- 100-199% of FPL—28%
- 200-99% of FPL—32%
- 400% and over of FPL—16%

4 – ***Importance of continuous and robust coverage:*** Continuous coverage means a greater likelihood that you will seek appropriate preventive care; if you are underinsured or uninsured, you may forego it. Consider the following:

Insurance coverage status	Have regular source of care	Blood pressure checked	Cholesterol checked	Seasonal flu shot	Females receiving a pap test	Females receiving a mammo-gram	Received colon cancer screening
Insured all year; not underInsured	93%	94%	79%	48%	73%	71%	63%
Insured all year; underInsured	94%	94%	76%	44%	70%	71%	60%
Insured but had cover-age gap	84%	89%	63%	30%	72%	48%	38%
Uninsured	68%	72%	44%	20%	53%	32%	35%

A more recent study by Peterson-Kaiser Family Foundation Health System Tracker found similar results related to the uninsured for the 2019 calendar year:

- High costs meant about 1 in 10 adults delayed or did not get care, with minority groups having even worse rates.
- Those in worse health are twice as likely to delay or forego care.
- For those who are insured, care delay or avoidance is below 10%, while those who are uninsured delay or forego care at a rate of 30% or greater.
- Those below 200% of the federal poverty limit have an almost 18% rate of delaying or foregoing care.
- Over one-third of those who are uninsured do not have a usual place of care, such as a primary care physician.

5 – ***Fraud, waste, and abuse***: An abstract by the *Journal of the American Medical Association* notes several prior studies that estimated fraud, waste, and abuse (FWA) to be as much as 25% of healthcare spending.[28-34] The conclusion is that despite recent government crackdowns and health plan efforts, the percentage attributable to FWA likely remains unchanged. According to the studies, the FWA breakdown is as follows:

- Failure of care delivery—$102.4–$165.7 billion annually
- Failure of care coordination—$27.2–$78.2 billion annually
- Over-treatment or low-value care—$75.7–$101.2 billion annually
- Pricing failure—$230.7–$240.5 billion annually
- Fraud and abuse—$58.5–$83.9 billion annually
- Administrative complexity—$265.6 billion annually

6 – ***Concentration curve of healthcare spending:*** Let's sum up with two last points to put this in context. Uwe Reinhardt's book *Priced Out* discusses a study brief, the most recent of which was published in early 2021 by the Agency for Healthcare Research and Quality, which sums up why we are so dysfunctional. Perhaps along with price, our lack of primary prevention, wellness, and care coordination seems to be the biggest problem we have that drive high costs and low quality. We are driving people to expensive forms of care late in their medical episodes. The most recent survey looked at the U.S. civilian, non-institutional population's share of spending in 2018. The so-called concentration curve of healthcare spending is phenomenal.[28-35]

- The majority of spending in the United States is concentrated in a small percentage of the population.
- 1% of the survey population consumed about 21% of total healthcare expenditures, while the bottom 50% accounted for only about 3%.
- 5% of the population accounted for about 48% of total healthcare expenditures.
- Inpatient hospital care was about 36% of spending for persons in the top 5% of the spending distribution.
- Individual, per-capita healthcare consumption was as follows:

    - The top 1% of consumed $72,212 or more, annually, with a mean of $127,284
    - The top 5% consumed $26,355 or more annually, with a mean of $58,609
    - The top 10% consumed $14,651 or more annually, with a mean of $38,980
    - The top 30% consumed $3,776 or more annually, with a mean of $18,027
    - The bottom 50% consumed less than $1,317 annually, with a mean of $384

- Aggregate healthcare consumption was as follows, with total expenditures for the surveyed group being about $1.979 billion:

    - The top 1% consumed $415 million
    - The top 5% consumed $956 million
    - The top 10% consumed $1.272 billion
    - The top 30% consumed $1.765 billion
    - The bottom 50% consumed about $63 billion

Chapter 33:

1 – ***Health plan consolidations:*** Here are some major failed or successful health-plan consolidations and other vertical health plan activities I have tracked over the past several years. Dates are when the proposed acquisitions were announced, with formal takeover taking a year or more:

- 2015 horizontal—acquisition of long-term care pharmacy Omnicare by CVS Health
- 2015 horizontal—acquisition of Catamaran PBM by Optum (United's services subsidiary)
- 2015 horizontal—acquisition of Group Health Cooperative by Kaiser Permanente
- 2015 horizontal—acquisition of Health Net by Centene
- 2015 horizontal—acquisition of Humana by Aetna failed on antitrust grounds
- 2015 horizontal—acquisition of Cigna by Anthem failed on antitrust grounds
- 2017 vertical—Anthem and CVS announced they would collaborate on an Anthem-owned, in-house PBM; launched in 2019
- 2017 vertical—acquisition of Aetna by CVS Health (which owns PBM Caremark)
- 2018 vertical—acquisition of PBM Express Scripts by Cigna
- 2019 horizontal—acquisition of WellCare by Centene
- 2019 horizontal—merger of Tufts Health Plan and Harvard Pilgrim
- 2020 vertical—acquisition of Beacon Health Options, a behavioral health managed care company, by Anthem
- 2021 vertical—acquisition of Magellan Health, a PBM and specialty service company, by Centene

Chapter 34:

1 – ***Drug costs trends:*** Here are a few quick facts on past and expected drug trends. In general, we have been in a relative drug cost increase lull over the past five years. Inflation was robust some time ago and is expected to rise again. However, this does not take away from the fact that Americans have real issues paying for needed drugs.[34-6, 34-7, 34-8, 34-9, 34-10]

- On a per capita basis, inflation-adjusted retail prescription drug spending increased from $90 in 1960 to $1,025 in 2017.
- The United States saw drug spending and inflation begin to shoot through the roof in the late 1990s, throughout the 2000s, and until about 2015. Retail prescription drug spending growth for private health insurance peaked in 2014 and 2015. High-cost hepatitis C treatment drugs were a big factor in the increased overall costs.

- Between 2016 to 2019, inflation was extremely modest or negative. Beginning in 2020, annual inflation was expected to rise from 3.2% to the mid-to-high 5% range. This will be due to the introduction of new drugs, primarily specialty drugs—those used for complex, extremely chronic, or rare conditions. Included in this category are so-called biologics. Of the almost 300 drugs to be released between 2019 and 2021, about two-thirds will be specialty drugs. Between 2010 and 2016, specialty drugs moved from 19% to 42% of retail drug spending. By 2020, 55% of all retail and medical drug spending will be specialty drugs.
- By 2015, retail drug spending per capita was over $1,000 per person. Prices for common generic drugs have dropped by 37% since 2014, while we have seen an increase of over 60% for brand drugs.
- Another study said that brand-name prescription drug prices in the United States have increased nearly 100% in the past six years.
- Through 2027, retail drug costs will represent the same rough percentage of healthcare expenditures—just below 10%. This is due to overall high growth in costs across the healthcare sectors.
- Medical drugs are driving overall healthcare costs up considerably. From 2014 to 2018, medical drug costs grew by 65% and 40% in commercial and Medicare, respectively.
- In the commercial world, the ten most expensive medical drugs averaged about $522,000 per patient in in 2019. In Medicare and Medicaid, it was about $301,000.
- The newly approved and controversial Alzheimer's drug Aduhelm threatens to further blow the roof off of medical drug costs in the future.

2 – ***Specific drug costs:*** It is interesting to look at some specific costs of commonly used drugs. This gives us a chance to see what the burden is not only on the system in general, but on the out-of-pocket costs people pay:

- Humira is a biologic drug used for a number of different diseases, including Crohn's disease, ulcerative colitis, rheumatoid arthritis, psoriatic arthritis, and plaque psoriasis. In 2014, the average price of Humira in the United States was $2,699 per month, or over $32,000 per year. In the United Kingdom it was $1,362, and in Switzerland $822. That is a range of 96-225% higher. (What is interesting here is that the United Kingdom has socialized medicine, but Switzerland has a universal access model.)
- Xarelto, a drug used to prevent or treat blood clots, was more than twice the cost in the United States than in the United Kingdom or Switzerland in 2014.
- Harvoni, a high-cost specialty drug used to essentially free someone from a lifetime with Hepatitis C, was 42% higher in the United States in 2014 than in the United Kingdom and 90% higher than in Switzerland.

- Truvada, used to treat HIV/AIDS, was 44% higher in the United States than in Switzerland, and 89% higher than in the United Kingdom.
- Avastin is used to treat some cancers. It was 124% higher in Switzerland in 2014 and 125% higher than in the United Kingdom.
- In 2015, another study found something similar for drug prices:
    - Crestor for high cholesterol: U.S. $86; other surveyed nations $4 to $41
    - Advair for asthma and pulmonary disease: U.S. $155; other surveyed nations $10 to $74
    - Januvia for diabetes: U.S. $169; other surveyed nations $14 to $68
    - Lantus for diabetes: U.S. $186; other surveyed nations $42 to $139
    - Humira for various chronic diseases: U.S. $2,505; other surveyed nations $570 to $1,750
    - Herceptin for breast cancer infusion: U.S. $4,755 every three weeks; other surveyed nations $1,557 to $3,547