

## **A Short History of Major Changes in the U.S. Health Care System since 1994: Costs, Coverage and Quality**

*By Doris Isolini Nelson*

The healthcare system in the United States has undergone major changes since 1994 after the defeat of President Clinton's effort to create a national system. "Over the last few decades, American health care has radically changed. A system that was largely not-for-profit has become a field where the profit motive and market forces affect every decision."<sup>1</sup>

The defeat of comprehensive health reform shifted the effort of cost control to the private sector. One major change, called "managed care," promised to control costs, provide good coverage, provide quality health care and eventually cover everyone. Have these promises been kept?

### **Has Managed Care Controlled Costs?**

Before 1995 the great majority of employer plans were traditional indemnity-insurance paying a fee for service and allowing access to any doctor, paying whatever the doctor or hospital required. In 1978, 95 percent of Americans with employer-sponsored coverage had fee-for-service plans. In 1998 only 14 percent were enrolled in such plans.

This drop was accompanied by an increase in enrollment in a wide variety of managed care insurance plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Point of Service plans (POSs). These plans controlled costs four ways:

- 1) limiting the choice of doctors by paying the total fee only if the physician was in the plan's network;
- 2) requiring patients to see a primary care doctor before obtaining a referral to a specialist;
- 3) requiring prior permission by doctors for admission to hospitals, diagnostic tests or medical procedures; and
- 4) negotiating predetermined fee schedules for physician payment which have been discounted from the usual fees.

For about five years, the total national expenditure for health care declined (1993 – 13.7 percent of gross domestic product [GDP]; 1998 – 13.5 percent of GDP).<sup>2</sup> There is disagreement among analysts about the major cause for this decline. Some say it is due to managed care's effectiveness in using cost control methods or marketing strategies that led insurers to underprice their products in order to expand market share. Others say that it was due to the one-time major shift from fee-for-service plans, which cannot be repeated.

In 2004, the National Coalition on Health Care (NCHC)<sup>3</sup> reported that since 1998 not only premiums but also the rate of increase in premiums had escalated. "What makes recent increases in premiums especially striking is that we have been in a period of low inflation."<sup>3</sup>

In 2009, the NCHC reported three key facts:

Since 1999 employment-based health insurance premiums have increased 120 percent compared to a cumulative inflation rate of 29 percent and cumulative wage growth of 34 percent during the same period.<sup>4</sup>

Since 2000, the average employee contribution to company-provided health insurance has increased more than 120 percent. The average out-of-pocket costs for deductibles, co-pay for medication and co-insurance for physician and hospitals rose 115 percent.<sup>5</sup>

Total spending in 2007 was \$2.4 trillion – 17 percent of GDP. “...the United States has \$480 billion in excess spending each year in comparison to Western European nations that have universal health coverage. The costs are mainly associated with excess administrative costs and poorer quality of care.”<sup>6</sup>

### **Have Managed Care Plans Provided Good Coverage?**

Most people would define “good coverage” to include preventive, primary care, hospitalization, mental health, dental and vision as well as prescription drugs – without deductibles and little or no co-pays. Rising costs for health services have led health insurance companies to market new products to younger and healthier enrollees where risks are low and profits high. Some of these plans have moderate deductibles but limited benefits, e.g., \$10,000 maximum benefit cap. Other plans may have more comprehensive coverage but with high deductibles, e.g., \$5,000 for an individual; \$10,000 for families in-network (double if out-of-network).<sup>7</sup> Thousands of plans now exist that lower premiums by reducing benefits and raising deductibles and co-pays.

### **Has the Quality of Care Improved?**

The 2004 NCHC reported on “an epidemic of sub-standard care.”<sup>3</sup>

*The dominant finding of our review is that for most care that has been studied, there are large gaps between the care that people should receive and the care they do receive. This is true for all three types of care [preventive, acute, and chronic]. It is true whether one looks at overuse or underuse. It is true in different types of care facilities and for different types of health insurance. It is true for all age groups, from children to the elderly.*<sup>3</sup>

The study went on to say: “The Institute of Medicine has estimated that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. That range of projections does not include the 88,000 deaths that, according to the Centers of Disease Control and Prevention, occur because of infections contracted during hospitalization, nor, obviously, does it include deaths due to preventable medical errors in settings other than hospitals.”<sup>3</sup>

NCHC also cited a major study by the RAND Corporation.<sup>3</sup> “A major new RAND study makes clear just how vast those gaps remain. Researchers examined the medical records of random samples of thousands of patients across twelve metropolitan areas and evaluated the care that these patients received over a two-year period. Using 439 indicators of quality developed by multi-specialty expert panels, the analysts found that participants in the study received only 54.9 percent of recommended care — a proportion that varied little across the categories of preventive, acute, and chronic care.”<sup>3</sup> While the Rand study provides an important quality benchmark, without electronic medical records, it is so labor intensive and expensive that it is rarely done and cannot provide an ongoing monitoring of the quality of health care delivery systems and help to improve it.

### **Are We Moving Toward Coverage for Everyone?**

- In 1994 there were 39 million uninsured people.<sup>8</sup>
- In 2002 there were 43.6 million uninsured people.<sup>9</sup>

- In 2003 there were 45.0 million uninsured people.<sup>9</sup>
- In 2004 there were 45.8 million uninsured people.<sup>9</sup>
- In 2006 there were 46 million uninsured people.<sup>10</sup>
- In 2007 there were 45.7 million uninsured people.<sup>10</sup>
- In 2009 it is estimated that there will be from 48 to 50 million uninsured people.
- As the costs rise, more businesses drop their health care benefit. The percentage of people (workers and dependents) with employment-based health insurance has dropped from 70 percent in 1987 to 62 percent in 2007. This is the lowest level of employment-based insurance coverage in more than a decade.<sup>11</sup>
- As more people lose jobs that provided coverage, the number of uninsured will continue to rise. There would be an even larger number of uninsured but for the fact that more people have become eligible for publicly funded insurance such as Medicaid and SCHIP (State Children's Health Insurance Program).<sup>10</sup> However, this increases both federal and state costs.

One could argue that, even with some early and temporary gains in reducing costs, the managed care model in the private sector has not stopped the deterioration of our health care system.

### **The Transformation of Health Insurance Companies**

Beginning in 1995, non-profit health insurance companies gradually transformed into for-profit companies, selling shares on the stock market in order to raise capital which could be used to expand market share by buying other insurance companies. In 1988, ten top insurers covered 27 percent of all insured Americans. Today, four publicly traded corporations – WellPoint, Inc.; United Health Group; Aetna, Inc.; and Cigna – dominate the market, covering 85 million people, or almost half of all Americans with private insurance.<sup>12</sup>

One result of this change is that insurance companies have become responsible to shareholders to maintain profit margins. The “medical loss ratio” is the insurance companies’ term for the amount of money a company pays for health services. Reducing the amount paid for services increases profit which is often translated into higher value for the company stock.

Four major ways that insurance companies manage risk and reduce their medical loss ratio are: 1) reducing covered services; 2) raising deductibles and co-pays; 3) refusing coverage for pre-existing conditions; and 4) marketing to the young and the healthy (“cherry picking”). “Even non-profits such as Blue Shield of California are obliged to follow prevailing market practices lest they be swamped with the highest-cost customers.”<sup>13</sup>

In the individual market, another method of keeping medical losses down is to cancel customers who insurers say did not qualify for coverage in the first place. “Several insurance companies have established departments dedicated to reviewing applications of customers who file costly medical claims. The goal is to discover evidence that the clients failed to disclose pre-existing conditions when they applied. Insurers cite these omissions as grounds to cancel policies retroactively, a process known as rescission.”<sup>13</sup>

For example, Health Net, Inc., a nation-wide insurer with 6.7 million members avoided spending \$35.5 million by cancelling the policies of 1,600 California customers over 6 years. Health Net paid bonuses to an employee based, in part, on how many policies of sick people she cancelled.<sup>13</sup>

## **Private Health Insurers: Managing Money, Not Health Care**

The development of Health Savings Accounts (HSAs) is rooted in the notion that health care expenses are rising in part because most Americans who receive health coverage as an employment benefit don't know how much their care actually costs. The argument continues: if people paid more out of their own pocket they would become more frugal and discriminating in their choice of doctors, hospitals and medications.<sup>14</sup>

In 1996, Congress approved a program providing tax relief for medical savings accounts. In 2003 the contribution limits were raised and indexed to inflation (in 2008 - \$2,900 for individuals; \$5,800 for couples). Under the rules, contributions to HSAs are tax-exempt, as are their investment gains. Withdrawals are also tax-exempt if they are used for qualified medical expenses. Over time, an HSA balance could grow to hundreds of thousands of dollars because the money can carry over year after year indefinitely.

Commercial banks, seeing the opportunity to collect fees for managing the account and transaction fees for investing the funds, jumped into the business. Medical insurers rushed to open their own banks. WellPoint, Inc., the nation's largest health insurance company, tried to convince the Federal Reserve Board that financial services was its core business. When questioned about its mail-order pharmacy and its program for managing chronic diseases, which were overseen by WellPoint doctors and nurses, WellPoint convinced the Fed that those activities were merely "complementary" to its main business – financial services. It pledged to limit them to less than 5 percent of total revenue.<sup>14</sup>

"That a medical insurer would agree to keep a lid on healthcare expenditures so it could get approval to open a bank illustrates a fundamental change in the industry: Insurers are moving away from their traditional role of pooling health risks and are reinventing themselves as money managers – providers of financial vehicles through which consumers pay for their own healthcare."<sup>14</sup>

<sup>1</sup> Donald L. Barlett & James B. Steele, "Critical Condition: How Health Care in America Became Big Business and Bad Medicine," Doubleday, 2004, page 2.

<sup>2</sup> Jonathan Oberlander "The US health care system: On a Road to nowhere?" Journal of the Canadian Medical Association, July 23, 2002.

<sup>3</sup> <http://www.nchc.org/documents/reform.pdf>

<sup>4</sup> <http://www.nchc.org/documents/costs-businesses-2009.pdf>

<sup>5</sup> <http://www.nchc.org/documents/costs-workers-2009.pdf>

<sup>6</sup> <http://www.nchc.org/facts/cost.shtml>

<sup>7</sup> John Geyman, MD, "Do Not Resuscitate: Why the Health Insurance Industry is Dying and How We Must Replace It,," Common Courage Press, June 30, 2009

<sup>8</sup> "Health Care Coverage for the Uninsured," Join the Debate: Your Guide to Health Issues in the 2000 Election, League of Women Voters Education Fund

<sup>9</sup> "The Number of Uninsured Americans Continued To Rise in 2004", Center on Budget and Policy Priorities, August 30, 2005

<sup>10</sup> "Income, Poverty and Health Insurance Coverage in the United States, U.S. Census Bureau: 2007", August 2008

<sup>11</sup> <http://www.nchc.org/facts/coverage.shtml>

<sup>12</sup> <http://articles.latimes.com/2008/oct/23/business/fi-insure23>

<sup>13</sup> <http://articles.latimes.com/2008/oct/21/business/fi-insure21>

<sup>14</sup> <http://articles.latimes.com/2008/oct/22/business/fi-insure22>

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