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U.S. Healthcare System: how we got here

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Identifying investment opportunities in the rapidly changing U.S. healthcare sector requires a thorough understanding of the system and the issues underlying the current healthcare debate. As an aid in this process, Discern has produced a series of context-setting reports reviewing the current status of the U.S. Healthcare system, its key participants, major trends, and characteristics of potential winners and losers in the coming years. This first report in the series focuses on the history of how the U.S. healthcare system evolved, an element we consider essential to understand in order to put current issues and opportunities into context. Subsequent reports will cover the structure of industry sectors and how short-term political challenges and long-term trends are affecting different sub-sectors and players.

U.S. Healthcare Evolution 1940 - 2013

As Washington continues to struggle over the future of the Affordable Care Act (ACA or "Obamacare"), it is easy to forget that the U.S. healthcare system is not the result of a grand plan. Rather, it is the haphazard result of otherwise disconnected events, including the labor shortage of World War II, increased life expectancy, changing medical technology and the desire to help the aged and the poor among U.S. citizens. At each stage of the system's evolution, policymakers were focused on short-term problem solving and thus often overlooked the long-term implications of their decisions. Equally overlooked was the impact that future social and technological transformations would have on the U.S.'s growing – and ever more complex – healthcare system. An understanding of this history is essential if one wants to understand the current state of the U.S. healthcare system and identify the realistic possible outcomes of the current debate.

1940s: Company-sponsored healthcare an inexpensive employee benefit

Employers began providing health insurance in the 1940s as a way to attract workers without increasing wages. Healthcare was an inexpensive perk for companies to offer, as health services were limited in cost, in part because the list of possible medical interventions was pretty much limited to doctor visits, hospital stays and surgical interventions. There was only so much the system could do for a sick patient, and little of it involved expensive machines, elaborate interventions, complex implants or pricey drugs.

The foundation of U.S. healthcare payer system – employer-sponsored health insurance – thus came about almost by happenstance. But once it arrived, employer-provided health insurance quickly became popular. Today, nearly half of all Americans are covered by health insurance sponsored by an employer, and another 5% of relatively healthy people are able to purchase individual plans from these same insurance providers.

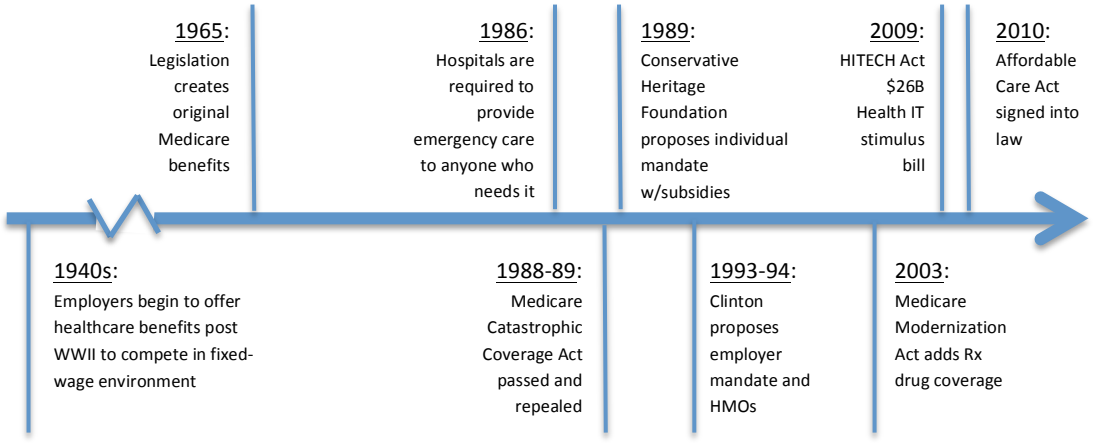

Figure 1: A chronology of U.S. healthcare policy, Source: Discern

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1965: The government steps in to help the disabled, the old and the poor

By the mid-60s, employer-provided healthcare became the norm for a majority of working-age Americans. It was working well, and combined with advances in medical technology (notably the anti-bacterial drug revolution) American workers were enjoying unprecedented health benefits.

But a minority of Americans remained outside the healthcare system, and the misery suffered by individuals – particularly the old and the very poor – outside the system became a source of widespread concern. Stepping in for those who could not get employer benefits, Congress created Medicare, an insurance-based safety net for seniors, and Medicaid, a framework for state-run programs to cover disabled and very poor patients. Half a century later, these programs cover 1/3 of Americans, most of whom face complex and/or chronic conditions exacerbated by age or poverty. Combined, Medicare and Medicaid account for half of U.S. healthcare costs today – all of which comes out of governmental budgets.

1980s and 90s: Problems recognized but a growing crisis and political gridlock ensue

By the early 1980s, nearly two thirds of the American public was covered by some form of health insurance and individual health risk and costs spread out across private and public payers. Those without insurance coverage however, typically working adults that were not offered this benefit from employers and could not afford it themselves, were faced with the intolerable choice between foregoing care or facing financial ruin occasioned by the absence of catastrophic coverage.

In 1986, policy-makers put in place safeguards for the most-extreme cases, requiring hospitals to provide emergency care regardless of a patient's ability to pay or insurance status. This solved the immediate problem, but further exacerbated growing long-term challenges. The Medicare Catastrophic Care Act was passed in 1988 to limit out-of-pocket costs for seniors, but was quickly repealed when it became apparent that seniors were unwilling to pay for it through fees and a surtax.

Advancing technology, better treatment options, and expanding public and private benefits led to growth across healthcare industries, but cost per capita in the U.S. nearly tripled from 1980 to 1990[1]. By the late 1980's, the range of solutions put forward included employer mandates (Clinton Administration) and individual mandates (conservatives), as well as expanded Medicare and single payer options. Political and ideological differences blocked any significant progress and costs continued to rise.

By the 1990s, frustration led to a quickly growing consensus that comprehensive reform of the U.S. healthcare system was desperately needed. The result was the Clinton Administration's 1993 Health Security Act (the HSA). The HSA famously failed in Congress, and moreover failed in a way that deepened the policy divisions and bitterness over health care reform. Nothing would happen in health policy for years to come.

2000 - 2010: Trying to patch a broken system

The decade just ended was in many ways a lost decade for healthcare reform. Distracted by 9/11 and two wars, riven by ideological differences, and recalling the political cost of the failed HSA, neither the conservative Congress nor the Bush Administration showed any enthusiasm for tackling comprehensive health care reform. Instead, it was back to fixing parts of the problem. The 2003 Medicare Prescription Drug Improvement and Modernization Act added prescription drug coverage for seniors, but inadvertently created the "donut hole" – a gap in drug coverage that means higher direct costs for some Medicare beneficiaries.

The Health Information Technology for Economic and Clinical Health Act (HITECH) was the decade's second legislative patch, which was enacted as part of the American Recovery and Reinvestment Act of 2009. The HITECH Act creates incentives for providers to adopt Electronic Health Records in hopes of reducing costs and improving health outcomes, and was also billed as a job-creating act, spending up to $26 billion to create digital health records.

2010: Reform efforts return with the Affordable Care Act

Health reform is like a comet on a loopy orbit returning every couple of decades; it first arrived in the mid-1940s, then returned with Medicare in 1965, fizzled in the 1990s and finally returned with the ACA in 2010. But unlike the comprehensive Medicare/Medicaid reforms of 1965, the ACA emerged from a poisonous atmosphere of gridlock and determined objection virtually without precedent in recent U.S. political history, and is considered by many in the healthcare industry to be little more than another patch. For better or worse however, the ACA is the most important fixture on the U.S. health landscape and is likely to remain so for at least the next decade as we discuss in subsequent reports.

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Implications:

The current status quo of U.S. healthcare – both public and private -- is unsustainable

Medicare was designed in 1965 for 18M retirees with an average expected lifespan of 6 more years, not the 41M seniors we have today whose average coverage lifespan is projected to top 14 years. Technology has delivered costly medical miracles; yet the U.S. pays far more per person than other developed countries with worse outcomes in overall health and mortality[2]

The rising cost of care has meant a decrease in benefits by many employer-sponsored plans and increases in out-of-pocket costs for even well covered employees. Economic challenges have left more people out of work and with no benefits at all. By 2012, nearly 1 of every 6 Americans is without health insurance and is in constant fear of potentially crushing medical bills. Unable to afford preventative or chronic care, working poor and sick uninsureds increasingly seek treatment for care at hospital emergency rooms, further contributing to the healthcare cost crisis. Today, medical debt is responsible almost half of all bankruptcies in the U.S., and unresolved costs are absorbed by the provider facilities.

Why is it so hard to fix?

Employer-based insurance schemes have successfully safeguarded insureds and spread the cost risk across large pools of patients. But this came at the cost of breaking the free market effects of healthcare for consumers. As healthcare options and technology have expanded, so has coverage, removing cost from consideration as a factor for insured patients, and making healthcare an entitled expectation that came with a job. Meanwhile, employer and carrier attempts to contain costs narrowed the choices insureds could make in terms of health providers, available procedures and even choice of prescription drug sources.

In addition, the current system has caused a profound misalignment between payers' short-term profit incentives and patients' long-term health objectives. People change jobs, employers provide different plans each year, and private payers typically cover patients for a short time horizon. The result has been disincentives for insurers to focus on prevention and overall health in favor of managing health crises if they arose. Chronic illness, however, is affecting more people for longer periods of time. Preventive care that could avoid long-term illness and disability is not typically covered, and the fee-for-service model rewards providers for doing more procedures, not providing better care.

Providers are at odds as well. Doctors have been trained to make treatment choices without regard to cost, driving profitability of the pharma and medical device industries by choosing newer, though not always better, treatments. Hospitals and care facilities, on the other hand, operate with thin margins and tight regulations, having to care for whoever shows up on their doorstep and little bargaining power versus their largest customer, Medicare.

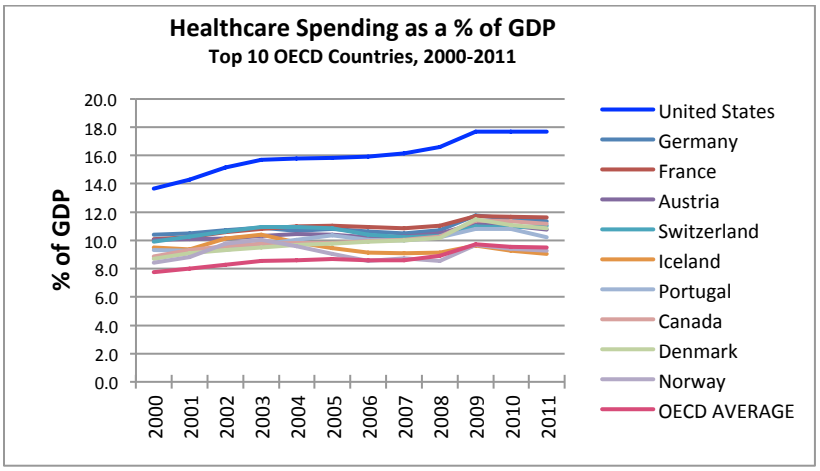

Figure 2: Growth of healthcare costs as % of GDP, 2000-2011 source: OECD Health Data 2013

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Is this a private fight, or can anyone join?

The rancor of the current debate stems from the intersection of historical accident, deeply held policy beliefs, a steadily rising sense of urgency – and decades of built-up frustration. The result is a situation of that old Irish saying, "Is it a private fight, or can anyone join?" but there is one important piece of common ground: people from across the policy spectrum agree that the current state is not sustainable. Healthcare costs in the U.S. are higher and have grown faster than anywhere else in the world, yet outcomes and access to care is do not measure up to results realized by less costly systems.

Universal healthcare advocates believe that the government has a duty to provide healthcare for all citizens, and would prefer a single-payer system like most other countries. Market purists would like the government to relinquish responsibility for any role in individual healthcare. Given current realities and entrenched industry players and lobbyists however, idealism must give way to compromise.

The Affordable Care Act was initially a bipartisan effort to address the uninsured sector of the market and initiate payment reforms. Despite implementation challenges, ongoing efforts to repeal it and perceived political uncertainty, healthcare industries have moved forward with changes. Underlying trends in demographics, technology, and care models have an even bigger impact on transformation across healthcare than short-term political wrangling. Although some highly visible elements of the ACA roll-out have had significant hiccups, most payers, providers and employers are more interested in managing larger trends that will have an even bigger impact on their bottom lines.

Next Report: Structure and Changes Across the U.S. Healthcare Industry

Our next report describes the major sectors of the $2.7 trillion healthcare industry, and identifies trends and characteristics that will create the leaders and long-term survivors in various sub-sectors. We invite you to participate in the conversation or request topics for future reports by contacting us.

Sources:

[1] Organisation for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics*.

[2] OECD Health Data 2013, http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

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