

U.S. HEALTH REFORM 2010 :

How did that “sausage factory” work?

Uwe E. Reinhardt
Princeton University

9TH Annual Symposium of the International Network
“Health Policy and Reform”
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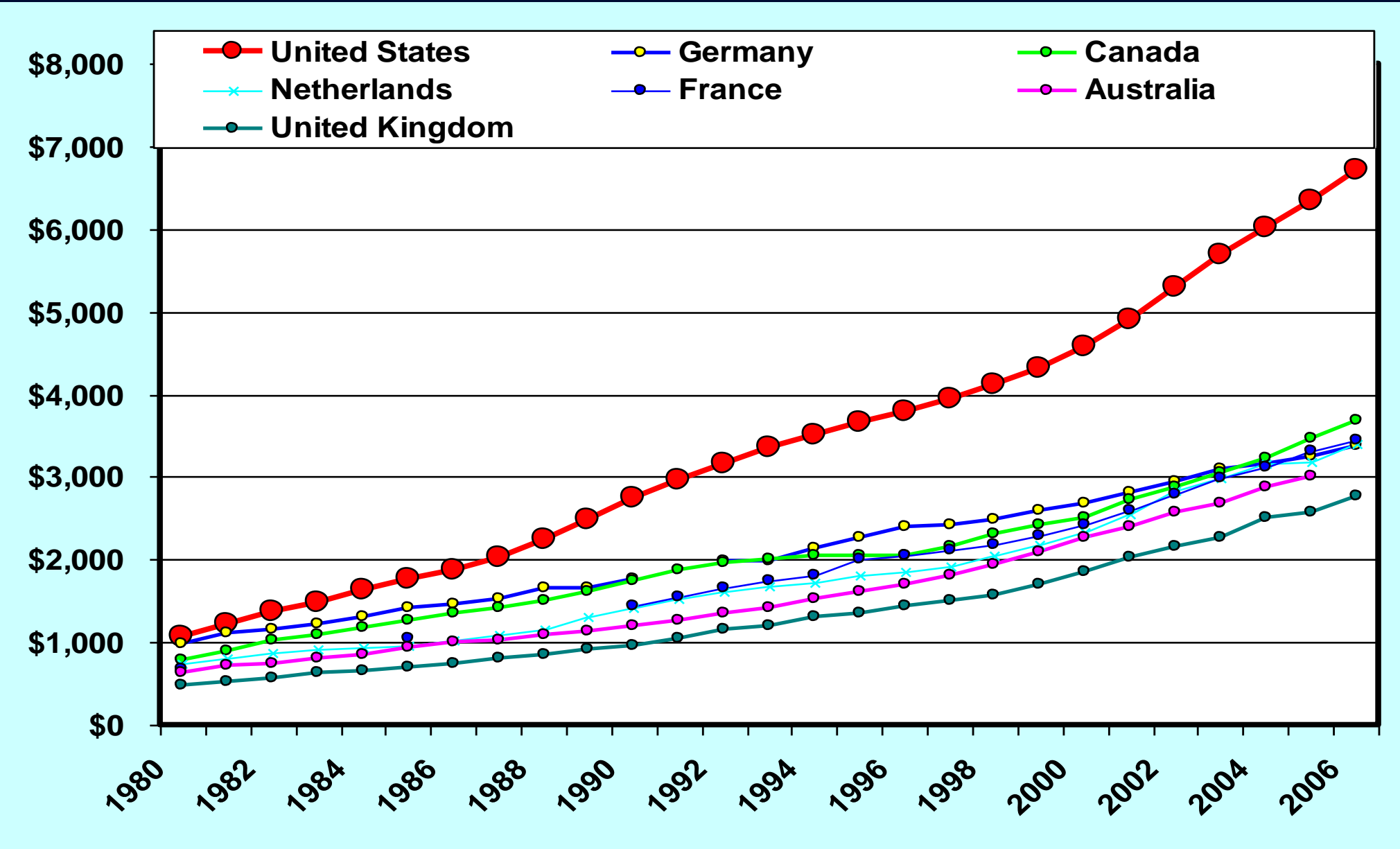
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How did that “sausage factory” work?

I. AMERICAN EXCEPTIONALISM: UNIQUE PROBLEMS

A. Unsustainable national health spending

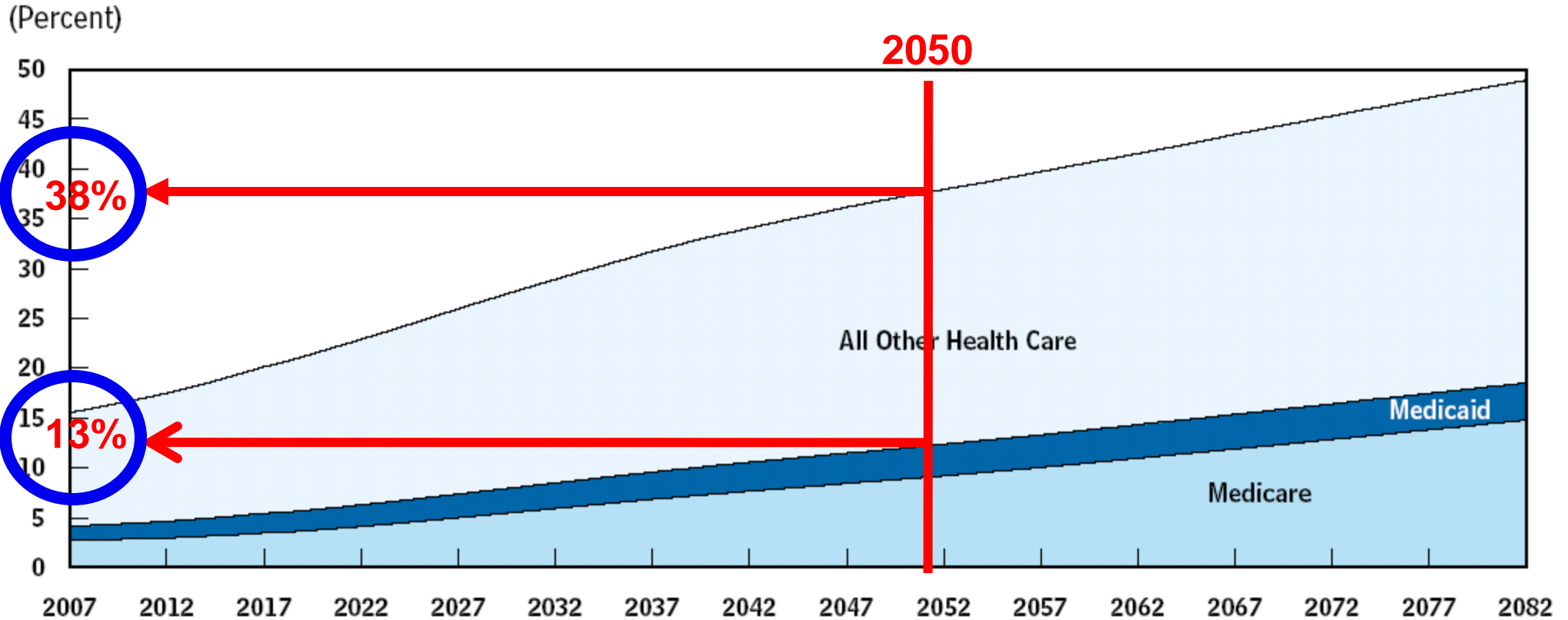
HEALTH SPENDING PER CAPITA IN PURCHASING POWER PARITY DOLLARS



SOURCE: OECD Health Data 2008. (Cited by Stuart Guterman, Commonwealth Fund).

Figure 4.

Projected Spending on Health Care as a Percentage of Gross Domestic Product



Source: Congressional Budget Office.

Note: Amounts for Medicare are net of beneficiaries' premiums. Amounts for Medicaid are federal spending only.

The preferred vision of physicians, hospital- and pharma CEOs and the plebs:

1. King-size beds from coast to coast, manufactured by *Mitshubishi* or *Mercedes Benz*.
2. Two Americans with M.D. degrees in each bed, giving one another check-ups 24-7, and billing one another electronically.
3. Some computer geek in India adds up all those electronic bills.
4. The bills total 40% of U.S. GDP.

Unfortunately, American employers, state governors, the federal government and economists (when they are vertical) consider this vision unsustainable.

They all cry out for health reform in general and cost-containment in particular.

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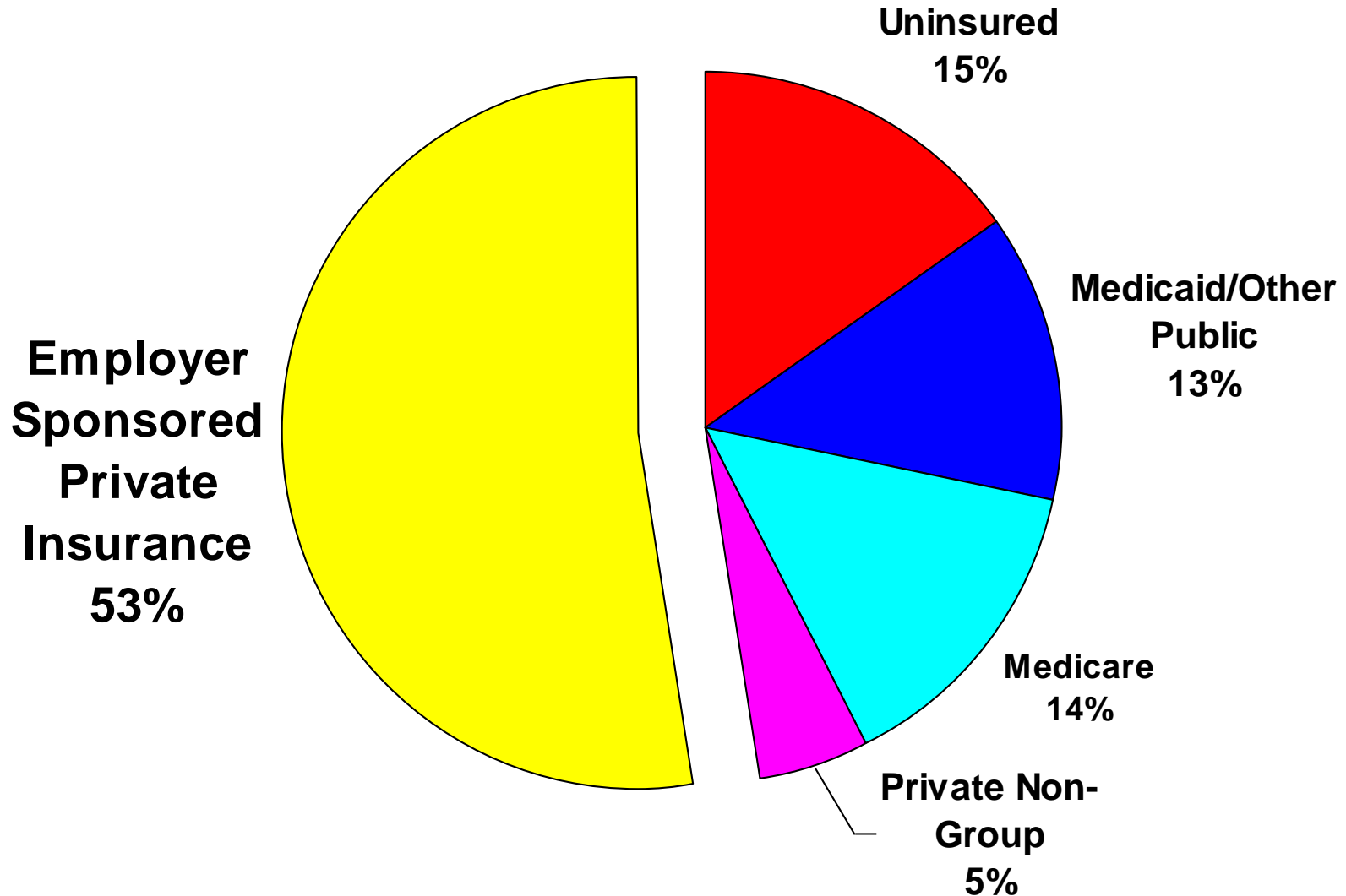
I. AMERICAN EXCEPTIONALISM

A. Unsustainable national health spending

B. Pricing the middle class out of health care

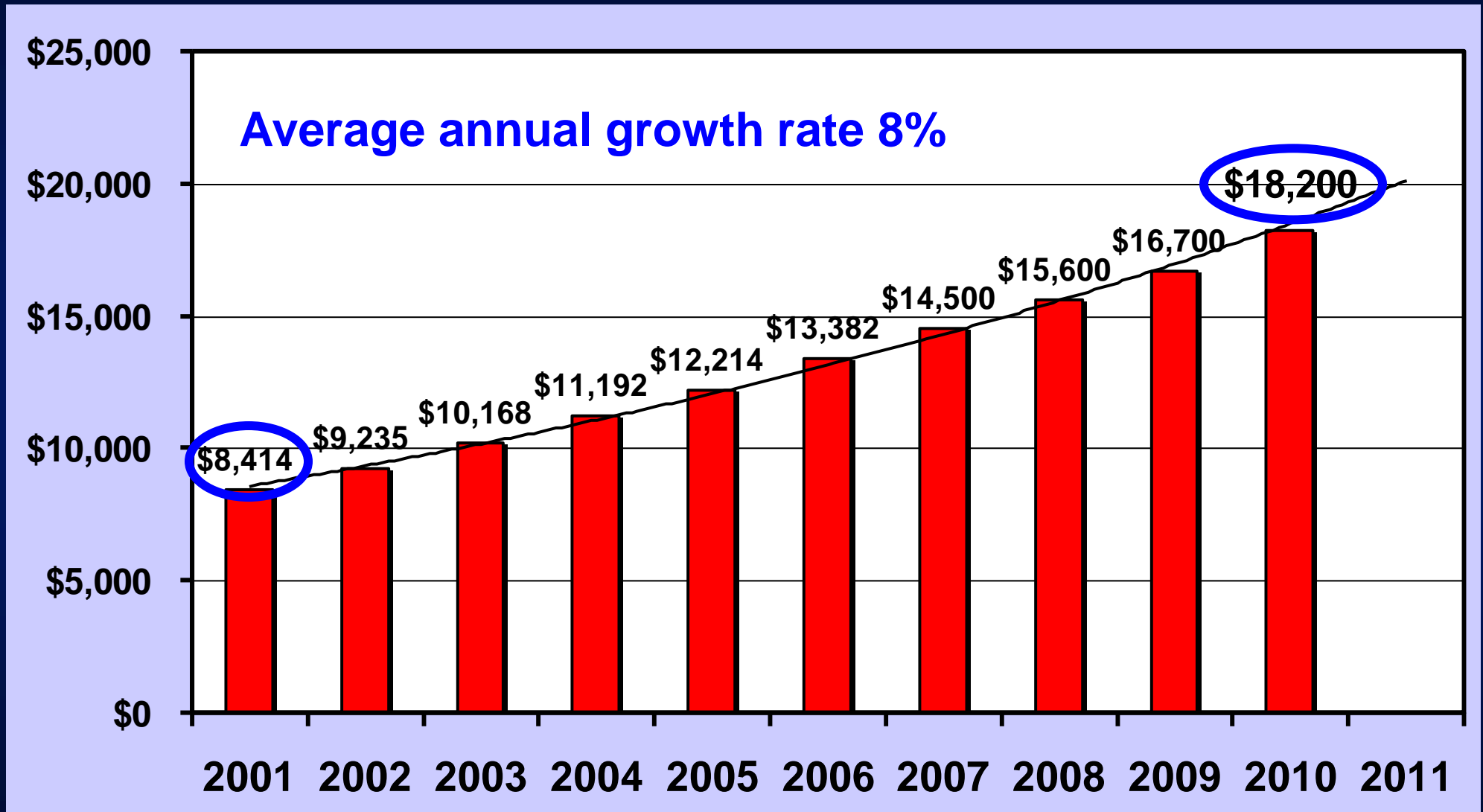
HEALTH INSURANCE COVERAGE IN THE U.S., 2008

Total population: \$300.5 million



MILLIMAN MEDICAL INDEX (MMI)

Average Annual Medical Cost for a Family of Four



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Employer healthcare costs expected to rise 9% in 2011, according to PricewaterhouseCoopers

NEW YORK, June 14, 2010 – The nation's employers can expect medical costs to increase by 9% in 2011, a decrease of 0.5% from the 2010 growth rate, according to the annual [Behind the Numbers](#) report published today by the PricewaterhouseCoopers LLP (PwC) Health Research Institute. For the first time, the majority of the American workforce is expected to have a health insurance deductible of \$400 or more, as more employers return to "indemnity style" cost-sharing by raising out-of-pocket limits, replacing co-pays with co-insurance and adding [high-deductible health plans](#).

The *Behind the Numbers* report includes findings of the PricewaterhouseCoopers' Health and Well-Being Touchstone Survey of more than 700 employers from 30 industries, as well as interviews with health plan actuaries and other executives whose companies provide health insurance for 47 million American workers and their families.

Improving wellness programs and increased cost-sharing lead the planned changes employers will make in the benefit plan designs they will offer for next year. According to PricewaterhouseCoopers' Touchstone research:

- ▶ Two-thirds (67%) of companies intend to expand or improve wellness programs inside the US
- ▶ 42% intend to increase employee contributions for health insurance coverage.
- ▶ 41% intend to increase medical cost-sharing, including higher deductibles and co-pays, while only 26% intend to increase prescription drug cost-sharing.
- ▶ More employers are dropping health benefits for retirees. One-third of employers with over 5,000 workers subsidize pre-65 retiree medical coverage, down from 47% in 2009. Only 22% of employers with over 5,000 employees subsidize post-65 retiree medical coverage, down from 37% in 2009.

One problem with American-style “employer-paid” health insurance is that employees sincerely believe that the employer, not they, pay for health insurance.

Economists are convinced that the so-called “employer paid” health insurance is shifted backwards to employees in the form of lower take-home pay.

**Paid by
employer**

**Employee's
pay check
before
deductions
and
withheld
taxes**

**Employer's Share
Health Insurance**

Other fringes & taxes

Withheld taxes

Health Insurance, etc.

**Out-of-pocket health
care spending**

**Cash Take-Home
Pay**

**Total
Compensation
or
"Wage Base"**

RATIO OF FAMILY'S HEALTH SPENDING TO ITS WAGE BASE, 2019
Median family income = \$64,000

Family wage base in 2010 = \$50,000
Assumed Annual Growth in Family Health Spending
Family income in 2010 = \$40,000

Annual Growth in Wage Base	4%	6%	8%	10%	12%
1%	45%	54%	65%	78%	94%
2%	41%	49%	59%	71%	85%
3%	37%	45%	54%	64%	77%
4%	33%	40%	49%	59%	70%
5%	30%	37%	44%	53%	64%

These trends put before the American body politic the following moral question:

Will we allow their health system to devolve into a two- or multi-tiered system, stratified by income class?

Or will we allow taxes to increase to support families in the lower half of the income distribution with public subsidies toward their health care?

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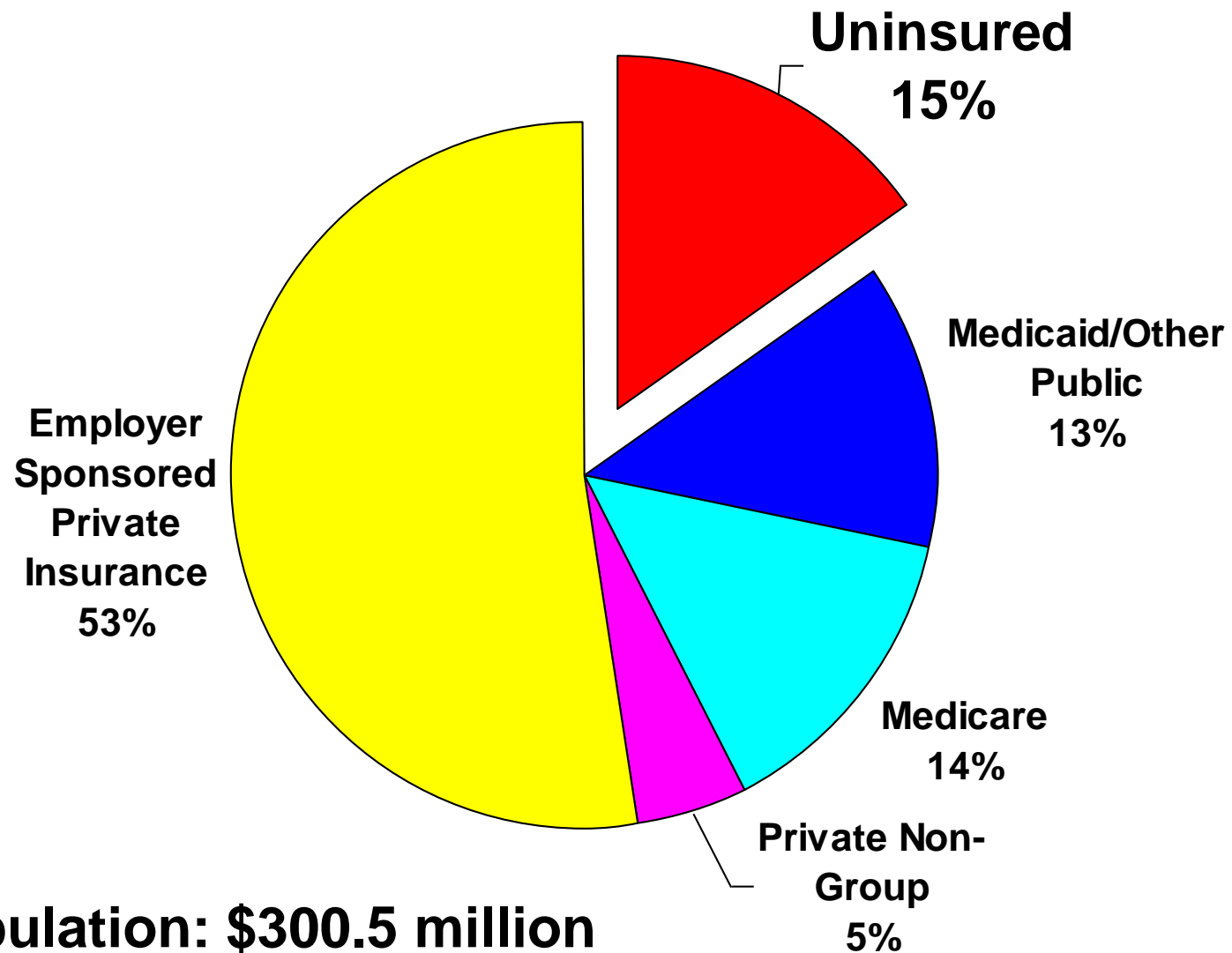
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C. The growing number of uninsured

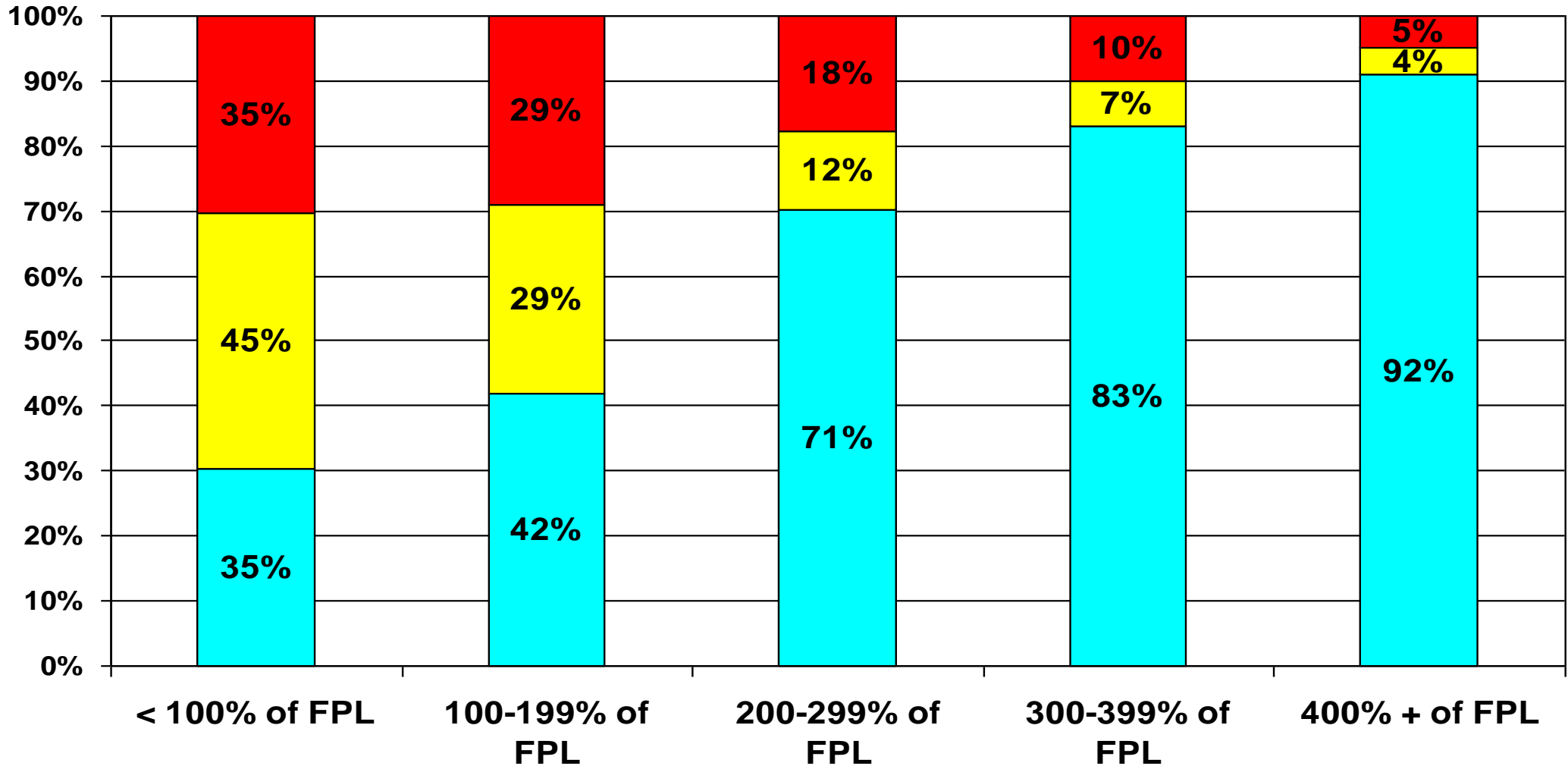
HEALTH INSURANCE COVERAGE IN THE U.S., 2008



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HEALTH INSURANCE STATUS BY FEDERAL POVERTY LEVEL (FPL) 2008 = \$21,200 for a family of four)

■ Employer/Other Private ■ Medicaid/Other Public ■ Uninsured



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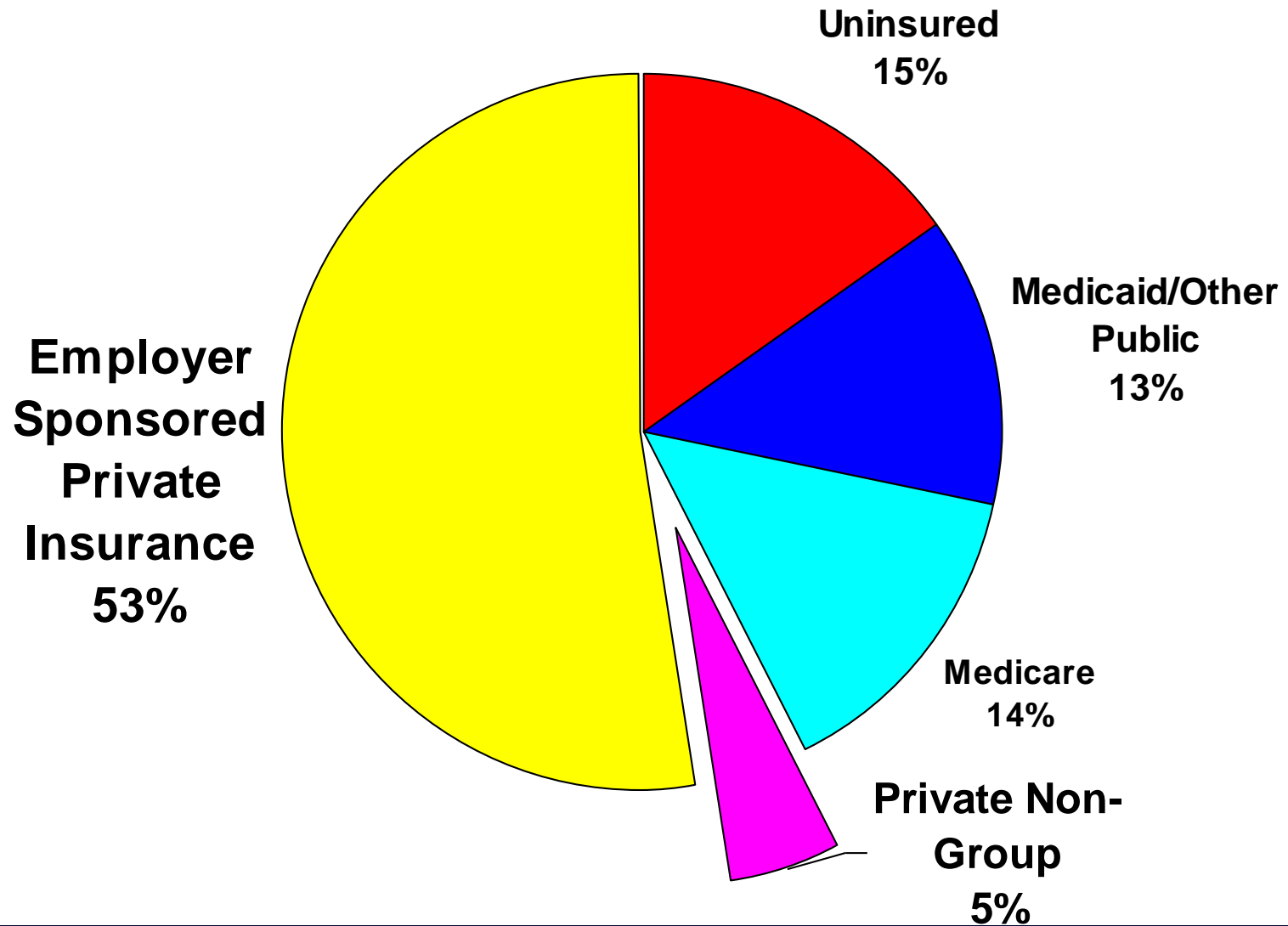
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C. The growing number of uninsured

D. Problems in the Non-Group market

HEALTH INSURANCE COVERAGE IN THE U.S., 2008

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Business



4 of 10
**WellPoint Scales
Back Rate
Increases**



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**Sant
Puzz**

HEALTH INDUSTRY | JULY 1, 2010

WellPoint Scales Back Rate Increases Sought in California

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Text



By **AVERY JOHNSON**

Health insurer WellPoint Inc. is backing off its plan to increase prices by as much as 39% for individuals in California, instead seeking rates for this year that it said would result in a \$100 million loss for the company there.

By AVERY JOHNSON

Health insurer WellPoint Inc. is backing off its plan to increase prices by as much as 39% for individuals in California, instead seeking rates for this year that it said would result in a \$100 million loss for the company there.

On Wednesday, WellPoint's Anthem Blue Cross unit told the California Insurance Department that it wants to increase prices for individual policyholders by an average of 14%, down from the 25% average it had previously sought. That is just below the 15% increase recommended by an outside actuary hired by the state, which found errors in the insurer's original filing.

Wellpoint also said it would cap increases at 19.9%, though the outside actuary, Axene Health Partners, said at least one of its product could merit a 24.5% increase.

WellPoint's rate refiling doesn't solve the health-cost problem, though. Company executives said medical costs have continued to rise this year in California, as healthy people drop coverage. McKinsey & Co., a consulting firm, predicts that underlying medical costs nationwide will rise by between 7% and 9% for 2010, compared with last year.

WellPoint's latest move could unnerve Wall Street. When the company pulled its previously proposed California rates in April, its stock fell almost 10% in one day. And the newly proposed increases are still in the double digits, which could reignite criticism from consumer groups.

Aetna Inc. also refiled its California rates on Wednesday after withdrawing its prices because of errors in a previous filing. The insurer is standing by its plan to raise prices by 18.7% for individuals. Aetna writes about 65,000 individual insurance policies in California.

An Aetna spokeswoman said her company is trying to address health costs by negotiating more aggressively with hospitals.

WellPoint's rates affect about 700,000 California policyholders. The company hopes the new rates will go into effect Sept. 1.

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E. Inadequate value for the money spent



The Business Roundtable **Health Care Value Comparability Study**
Executive Summary

Top-Line Findings: A Substantial Health Care Value Gap

On a weighted scale, **U.S. business faces a 23 percent “value gap”** relative to five leading industrialized competitors – and a 46 percent “value gap” against three rising economic powers.

- Combining 19 internationally reported measures in a weighted scale that takes into account both the spending on, and performance of, our health care system, the United States stands at a 23 percent disadvantage relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France (the “G-5 group”) – and a 46 percent disadvantage relative to the emerging competitors of Brazil, India and China (the “BIC group”).

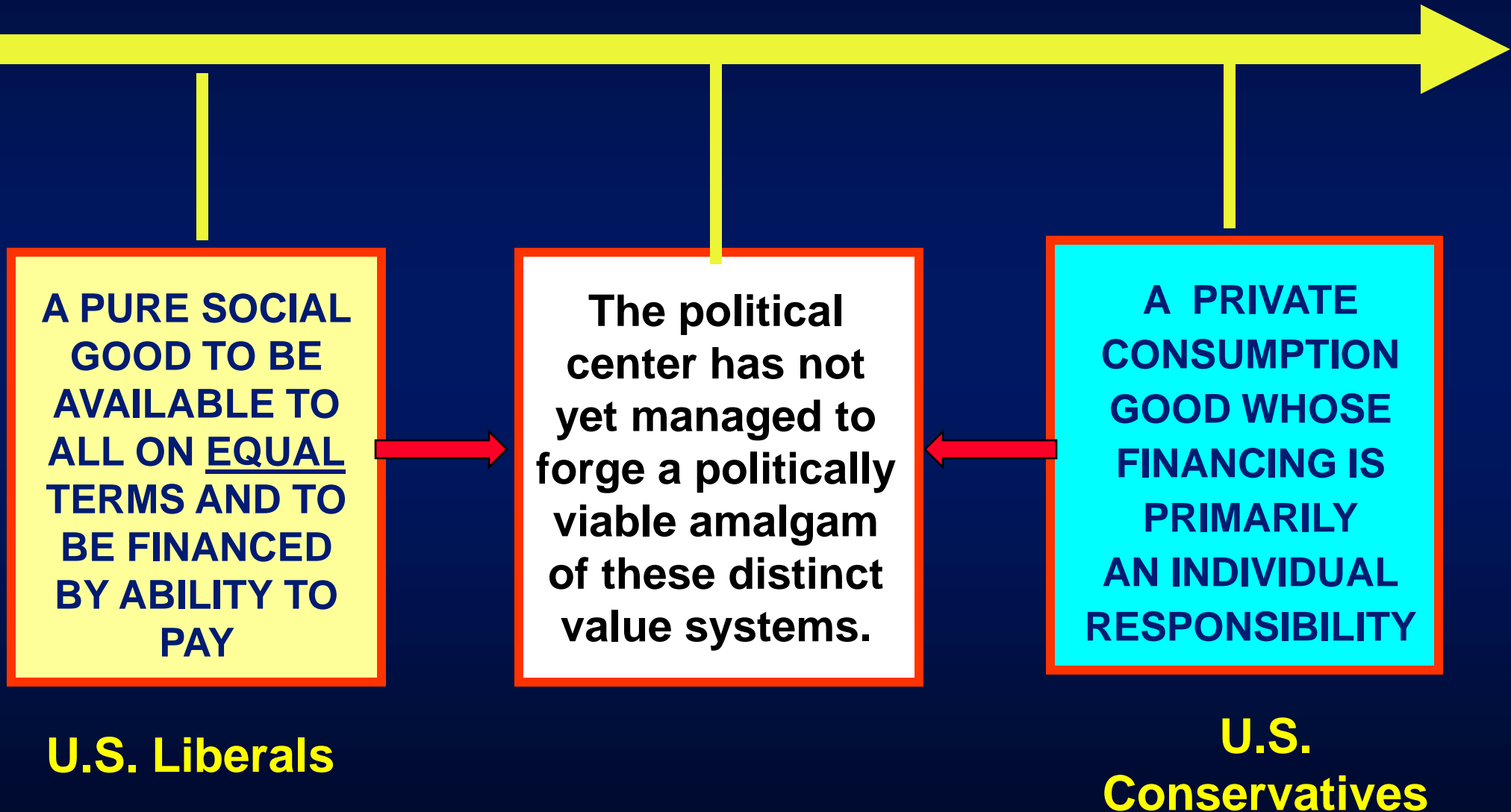
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II. AMERICAN EXCEPTIONALISM: SOCIAL ETHICS

THERE IS NO POLITICALLY DOMINANT VIEW IN THE U.S. ON WHAT HEALTH CARE SHOULD BE:



THE TYPE OF E-MAIL I FREQUENTLY GET IN THE U.S.

Page 1 of 1

Uwe E. Reinhardt

From: [REDACTED]
Sent: Sunday, November 02, 2008 3:33 PM
To: reinhard@Princeton.EDU
Subject: Why

"Do we have the money to be our brothers' and sisters' keeper? The answer is No,"
Why would I as an individual want to pay for someone else, someone who is unwilling to get a job and pay for what they need. Why should we cut what doctors earn because someone is unwilling to pay them what they deserve. Why I ask you?

MANY AMERICANS LOVE TO HATE THEIR GOVERNMENT



THE UNINSURED RUGGED AMERICAN INDIVIDUALIST

When they really need health care, they expect it for free



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ENACTING A BILL IN AMERICAN “DEMOCRACY”: THE PLAYERS

WHITE HOUSE

“HOUSE”

SENATE

A new bill must be introduced (“sponsored”) by a U.S. Representative in the House or a Senator in the Senate. The White House may originate a bill in draft form, but then must persuade a senator and a representative to sponsor it in Congress.

Once a bill has been introduced in Congress, the leader of each chamber assigns it to the committees whose purview may be touched by the bill, if the leader chooses to do so.

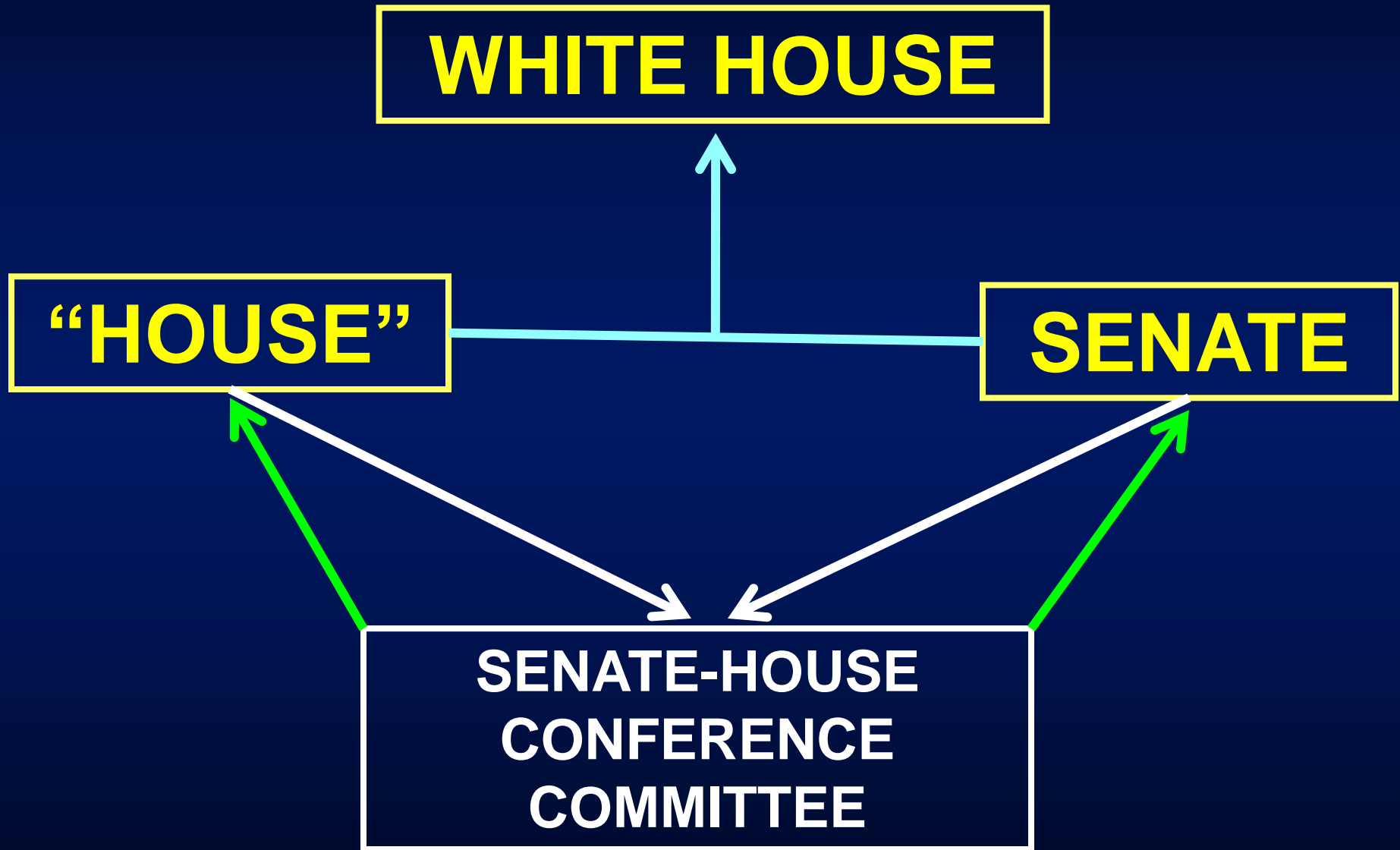
Each committee then discusses the bill and votes on amendments to it.

If each committee approves an amended version of the bill, the leader then must forge it into one bill to be put to a vote by the whole chamber.

If both chambers vote to pass their version of the bill, it then goes to a Conference Committee to forge it into one common bill, after possibly numerous changes.

The modified, common bill then goes back to each chamber for a vote. If both approve it, it is sent to the President for signature.

ENACTING A BILL IN AMERICAN "DEMOCRACY"



Several features make US governance rather unique:

- 1. It costs a fortune to run for Congress, and even more so to run for the Presidency (\$1.3 trillion in 2008 versus \$700 billion in 2004).**
- 2. Most of the campaign financing is supplied by interest groups whose lobbyists therefore hold much sway over individual legislators.**
- 3. As a result, the governance process resembles more and more a bazaar at which legislative favors can be openly purchased by special interest groups.**

**This is how legislative “sausages” are made in the U.S..
The result is very messy laws.**

The U.S. Senate has 100 members – two from each state.

Although, in principle, majority vote rules, any Senator can hold up a bill being debated – i.e., “filibuster” it – by endlessly talking about it on the floor.

To end such a filibuster requires a “cloture” vote, which requires at least 60 votes, not just a simple majority.

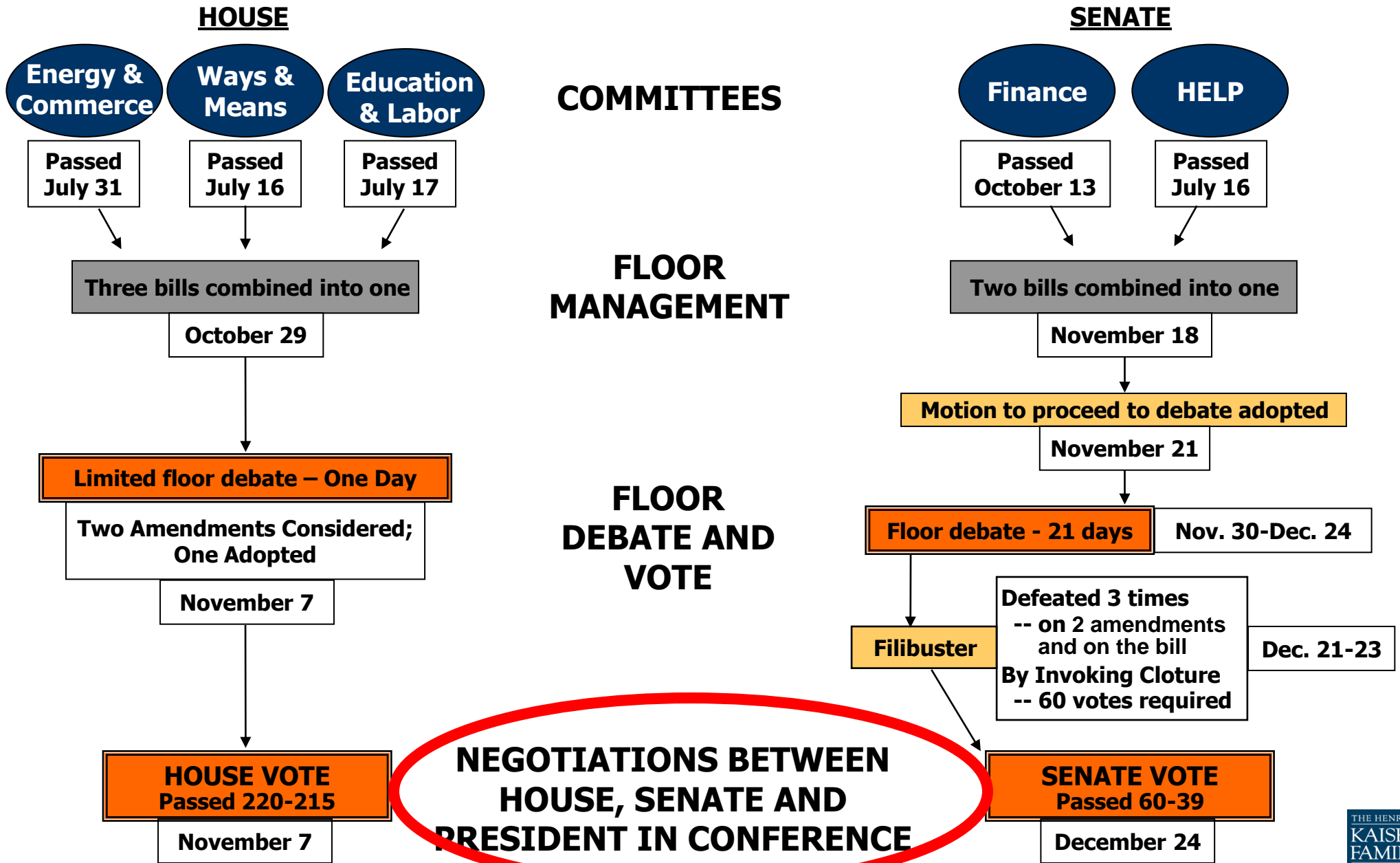
Therefore, if neither party has at least 60 votes, a bill can be killed by filibustering it.

The Democrats had 60 votes in the Senate, but there is no party discipline in the US – certainly never among Democrats – so that to get 60 votes required special deals even with Democratic Senators to get their vote.

It is where lobbyists with their campaign-finance support find a fertile field for their pleas for special deals.

And thus a clean, coherent original bill can end up a confusing and unseemly mess – in fact, it usually does.

Overview of the Health Reform Legislative Process: Committees and Floor Debate



THE MASSACHUSETTS SHOKU

In early 2010, to everyone's surprise -- and the Democrat's dismay -- the late, left-of center, Democratic Senator Ted Kennedy was replaced by Massachusetts voters with a strongly right-of center Republican Senator.

The Democrats had lost their 60 member majority to stop a filibuster. The health-reform bill therefore seemed dead.

But then the Democrats pulled out of the hat a very clever parliamentary trick.

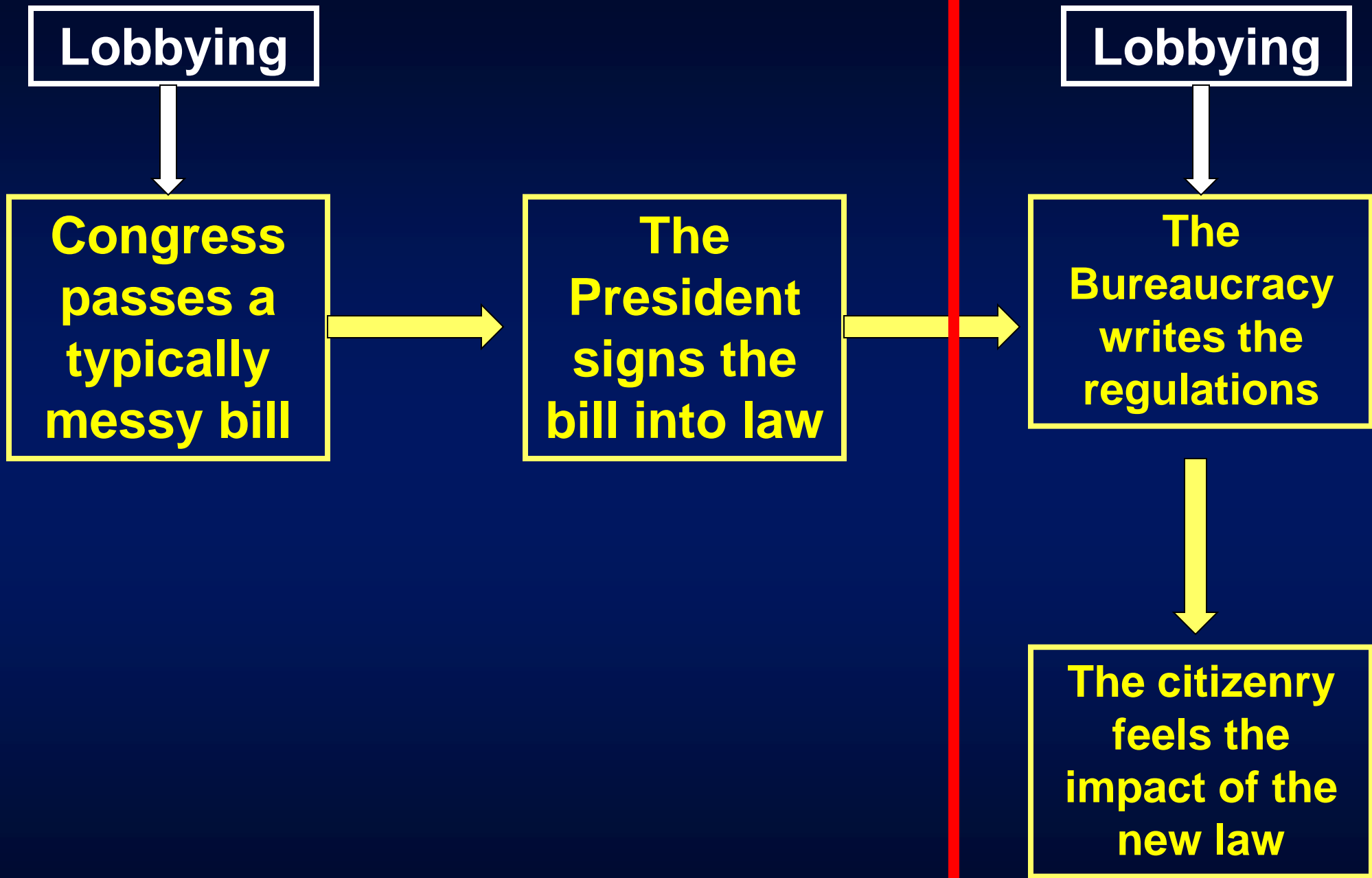
THE PARLIAMENTARY MANEUVER THAT GOT THE BILL PASSED

Senate passes H.R. 3590, the *Patient Protection and Affordable Health Care ACT (PPACA)* on December 24, 2010 (60 votes)

House passes Senate bill H.R. 3590 on the promise that Senate later will pass the new *House Reconciliation Act H.R. 4872* (majority vote only)

Senate passes House bill H.R. 4872 as part of “budget reconciliation” which requires only a 51 vote majority.

House then crafts and passes its new *House Reconciliation Act H.R. 4872* (majority vote only) and sends it to the Senate



Lobbying

Congress passes a typically messy bill

The President signs the bill into law

Lobbying

The Bureaucracy writes the regulations

The citizenry feels the impact of the new law

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IV. THE HEALTH-REFORM BILL THAT BECAME LAW

INSURANCE

INSURANCE REFORM:

1. Move toward universal health insurance;
2. Reforming the small- and non group insurance mkt.

DELIVERY

HEALTH CARE DELIVERY:

1. Move to clinically fully integrated health care
2. Greater transparency on and accountability for the use of resources and outcomes

PAYMENT REFORM:

A move away from piece rate (FFS) payment toward evidence-based case (bundled) payments or capitation, both rewarding superior quality processes and outcomes.

CONTROLLING THE FUTURE GROWTH IN HEALTH SPENDING

Avoiding, somehow, to devote 40% or more of 2050 GDP on health care

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A VERY ROUGH MAP INSURANCE EXPANSION

PRIVATE INSURANCE (65%)

GOVERNMENT INSURANCE (35%)

No major changes, only some minor ones

People under age 65 with employment-based private health insurance in relatively large companies.

Very poor people in Medicaid

Sizeable Expansion

People under age 65 with employment-based private health insurance in relatively small companies.

People over age 65 in Medicare

Not much touched, but some cuts in future spending growth

Individually insured

Without health insurance

Reform and expand



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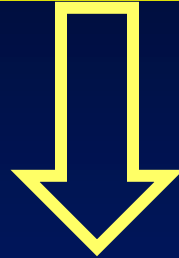
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Health Insurance plans list their offerings



**HEALTH INSURANCE EXCHANGE
(LIKE A FARMER'S MARKET FOR HEALTH INSURANCE)**



Self-employed or other individuals and employees of small employers have a choice among listed insurance plans.

REGULATIONS IMPOSED ON INSURERS IN THIS MARKET

- 1. Specified minimum package of “essential” benefits;**
- 2. Guaranteed issue;**
- 3. Premiums cannot be based on health status;**
- 4. Premiums may vary by age (ratio of 3:1), family size and use of tobacco (1.5:1)**
- 5. No life-time limit on benefits**
- 6. No rescission of policy *ex post***

CAVEAT

Reform of the insurance market is a three-legged stool:

- a. guaranteed issue and community rating,
- b. a mandate on individuals to be insured,
- c. adequate subsidies toward the purchase of health insurance.



You can't just have two of the three. They go together.

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Much so-called “innovation” in U.S. health policy consists of giving old ideas new names.

The latest new, new, old idea of this sort is something called “Accountable Health Systems” (ACOs)

In fact, ACOs seem to be just a weaker and messier version of the fully integrated *Kaiser Permanente Health System*.

The health-reform bill encourages the formation of such ACOs.

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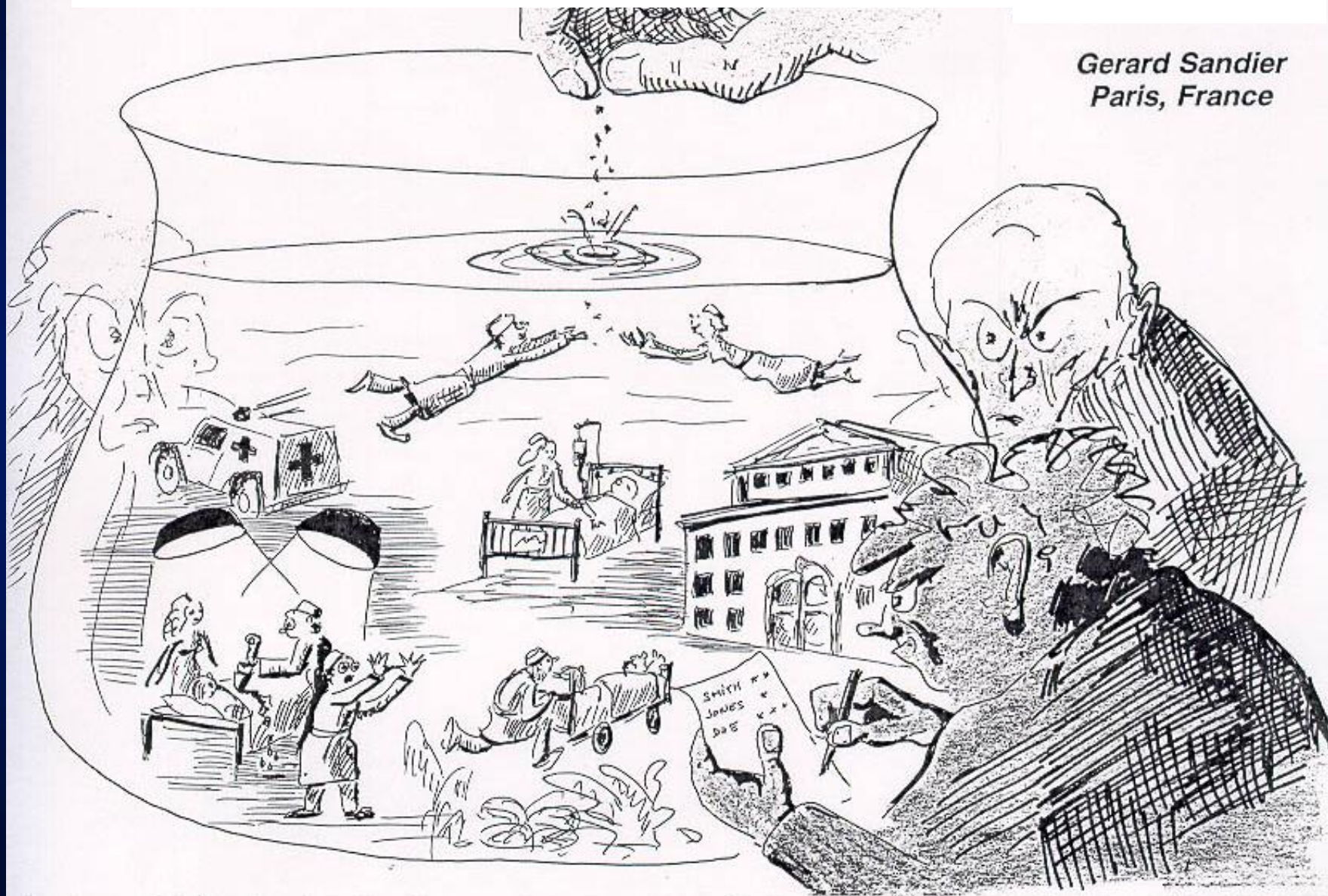
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FISHBOWL MEDICINE

Gerard Sandier
Paris, France



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ALTERNATIVE SYSTEMS FOR PAYING HEALTH-CARE PROVIDERS

Method of setting fee level	- Base for Payment -			
	Piece Rate (Fee-for-Service)	Bundled Payments for treatments	Capitation per patient	Budgets or Salary per year
Unilateral administrative fee setting				
Negotiation between associations				
Individual, free-market fee setting				

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The bill does little to constrain future health spending, but the earlier economic stimulus bill had funded a platform that could be used for future cost-effectiveness and spending control in U.S. health care, to wit:

- 1. About \$20 billion to support the use of electronic health-information technology (HIT).**
- 2. The mysterious IPAD – *Independent Payment Advisory Board* with quasi governmental powers.**
- 3. About \$1 billion over the decade for comparative clinical effectiveness analysis (alas, NOT cost-effectiveness analysis). IT IS STRICTLY VERBOTEN AS FASCIST.**

Many people on the right of the political spectrum
decry cost-effectiveness analysis as a fascist tool.

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EDITORIAL: Health 'efficiency' can be deadly

By | Wednesday, February 11, 2009

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Article

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Secreted in the House version of the stimulus bill the President is trying to rush through Congress is the germ of a major overhaul of the American health care system. One provision causing increasing concern is the future role of the National Coordinator of Health Information Technology, who will be in charge of collecting

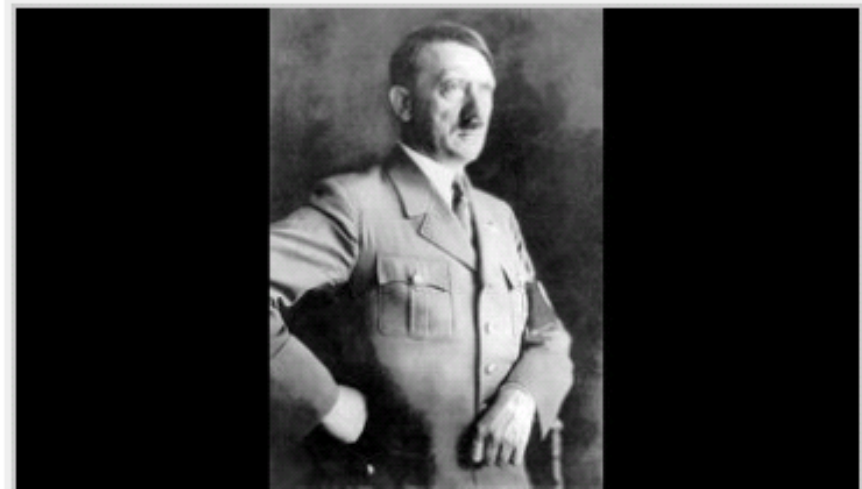
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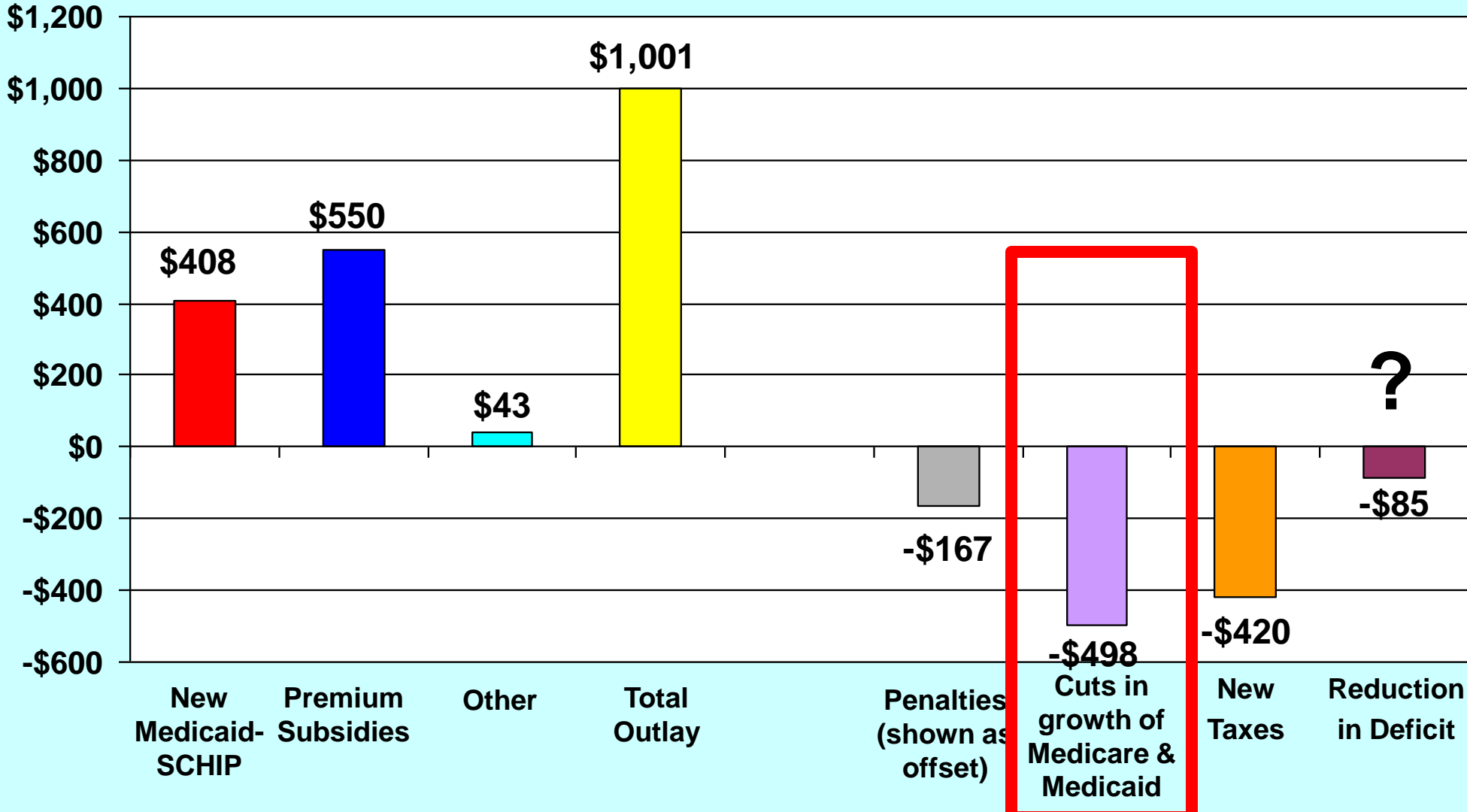
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V. COST AND FINANCING OF REFORM BILLS

Federal Costs and Revenues Under the Act — 2010–2019 (billions)



SOURCE: Slightly adapted from slide courtesy of John Sheils, The Lewin Group-Ingenix.

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V. COST AND FINANCING OF REFORM BILLS

VI. A CHINESE PERSPECTIVE ON IT ALL

THE CHINESE WORD FOR “CRISIS”: Wei Ji



DANGER

OPPORTUNITY

THE END