DO WE GET WHAT WE PAY FOR IN AMERICAN HEALTH CARE?

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NATIONAL COUNCIL FOR BEHAVIORAL HEALTH

Seattle, WA
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I. THE CRAZY-QUILT U.S. HEALTH-INSURANCE SYSTEM
CATEGORIES OF PEOPLE IN THE U.S. HEALTH INSURANCE SYSTEM

The Young

Working-age people

People age 65 and over

The very poor elderly are also covered by Medicaid

Near poor children may be temporarily covered by Medicaid and S-Chip, although 4 million are still uninsured.

Simplified

The millions of uninsured tend to be near poor

The employed and their families who are typically covered through their jobs, although many small employers do not provide coverage.

For the super rich, “Disneyland” the sky-is-the limit policies without rationing of any sort (Boutique medicine)

Persons over age 65, who are covered by the federal Medicare program, but not for long-term care. Often the elderly have private supplemental MediGap insurance

The federal-state Medicaid program for certain of the poor, the blind and the disabled

The rich

The near poor

The broad middle class

The rich
Left out of this chart is the VA health system reserved for our veterans – the purest form of “socialized medicine” in the world.

I find it ironic that we reserve that system for our veterans – whom we profess to adore – all the while condemning “socialized medicine” as evil.
Whatever the virtues of our pluralistic mosaic for health insurance may be, two things are certain:

1. Such a system is horrendously complex and expensive from an administrative point of view.
2. The system weakens the payment side of the health system and thus facilitates high prices for health care products and services.
3. It is enormously difficult to reform any part of the system, because it spills over into other parts of the system (e.g., employment-based insurance).
“Nobody knew that health care could be so complicated.”

President Donald Trump
February 27, 2017
II. THE COST OF U.S. HEALTH CARE
NHE as % of GDP in Select OECD Countries and Taiwan, 2015

SOURCE: Data for OECD countries from OECD Health Statistics viewed on March 5 2017. Data for Taiwan from National Health Insurance Administration, MOHW, Taiwan 2016.
Per-Capita Health Spending in PPP US $s, Selected OECD Countries, 2015

SOURCE: OECD Data 2016
Per Capita Health Spending and Per Capita GDP (PPP$) in Select OECD Countries and Taiwan in 2015

SOURCE: OECD Health Data 2016. Data for Taiwan from MOHW, Taiwan. 2015.
III. WHAT MAKES U.S. HEALTH CARE SO EXPENSIVE?
Among the reasons why U.S. health care is so expensive relative to health care in other countries two stand out:

A. Because the payment side of the health-care market is so fragmented and, thus, weak, prices for health care service and products are much higher than they are in other countries.

B. The administrative overhead of U.S. health care dwarfs that in other nations with simpler health insurance systems.
A. The high prices of U.S. health care
It’s The Prices, Stupid: Why The United States Is So Different From Other Countries

Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.

by Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan

PROLOGUE: In Fall 1986 Health Affairs published the first of nearly two decades’ worth of reports summarizing the state of health care spending in industrialized countries that are members of the Organization for Economic Cooperation and
Drugs: Humira

Humira is prescribed to treat rheumatoid arthritis.

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Price</th>
<th>USA 25th Percentile</th>
<th>USA 95th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>$552</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Switzerland</td>
<td>$822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>$1,253</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Kingdom</td>
<td>$1,362</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>$2,669</td>
<td></td>
<td>$2,996</td>
</tr>
</tbody>
</table>

Humira, 1 prefilled syringe carton, 2 syringes, 28 day supply
Diagnostics: Colonoscopy

- Australia: $872
- Spain: $89
- Switzerland: $604
- South Africa: $632
- United States: $547 (USA 25th Percentile)
- New Zealand: $1,421
- United Kingdom: $3,059 (USA 95th Percentile)

$/USD

Average Price

USA 25th Percentile
USA 95th Percentile
Total Hospital and Physician: Normal Delivery

- South Africa: $1,271
- Spain: $1,950
- Australia: $5,312
- Switzerland: $7,751
- United States: $18,383

$USD

- Average Price
- USA 25th Percentile
- USA 95th Percentile
B. The huge administrative overhead of U.S. health care
Medical Spending Differences in the United States and Canada: The Role of Prices, Procedures, and Administrative Expenses

The United States far outspends Canada on health care, but the sources of additional spending are unclear. We evaluated the importance of incomes, administration, and medical interventions in this difference. Pooling various sources, we calculated medical personnel incomes, administrative expenses, and procedure volume and intensity for the United States and Canada. We found that Canada spent $1,589 per capita less on physicians and hospitals in 2002. Administration accounted for the largest share of this difference (39%), followed by incomes (31%), and more intensive provision of medical services (14%). Whether this additional spending is wasteful or warranted is unknown.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3024588/
From their paper:

“Together, hospital and medical office administration accounted for $616 per capita of the total per capita spending difference [US vs Canada in 2002].”

If that figure had grown by a modest 3% per year since 2002, the differential would be close to $1,000 per capita today.

And that figure does not include the huge overhead of insurers for marketing, administration and profits (about 18 cents per premium dollar) nor the value of the time patients’ spend on claims processing.
US ADMINISTRATIVE COSTS

By Dante Morra, Sean Nicholson, Wendy Levinson, David N. Gans, Terry Hammons, and Lawrence P. Casalino

US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers

http://content.healthaffairs.org/content/30/8/1443.abstract
United States. We estimated physician practices in Ontario spent $22,205 per physician per year interacting with Canada’s single-payer agency—just 27 percent of the $82,975 per physician per year spent in the United States. US nursing staff, including medical assistants, spent 20.6 hours per physician per week interacting with health plans—nearly ten times that of their Ontario counterparts. If US physicians had administrative responsibilities similar to those of Canadian physicians, the administrative burden in the United States might be even higher.
The typical academic health center or hospital system in the U.S. has anywhere between 300 to 500 billing clerks.

In Canada or in the European health systems, hospitals need only a handful of billing clerks.

All that costs money that does not buy any health care.
The huge difference in administrative overhead in the U.S. versus the simpler health insurance systems of other countries is the **PRICE** Americans seem willing to pay for choice among insurers and insurance products.

So strong is that apparent preference that Americans are willing to trade off free choice of doctors, hospitals and other providers of care for the sake of choice among insurers.
IV. DO WE GET OUR MONEY’S WORTH IN HEALTH CARE?
The Business Roundtable Health Care Value Comparability Study Executive Summary

http://businessroundtable.org/sites/default/files/Health_Care_Value_Comparability_Study_Full_Report.pdf
Health Care Costs Put U.S. Workers and Employers at a Significant Disadvantage Compared With Global Competitors

According to the Business Roundtable Health Care Value Comparability Study, a new measure of the "value" (cost and performance) of the U.S. health care system relative to our competitors' systems on a weighted scale, the workers and employers of the United States face a 23 percent "value gap" relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France (the "G-5 group") – and a 46 percent "value gap" compared with emerging competitors Brazil, India and China ("the BIC group"). What does this "value gap" mean for our ability to compete in the international marketplace?
Best Care at Lower Cost
The Path to Continuously Learning Health Care in America
<table>
<thead>
<tr>
<th>Source of Excess Costs</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary services</td>
<td>$210 billion</td>
</tr>
<tr>
<td>Inefficiently delivered care</td>
<td>$130 billion</td>
</tr>
<tr>
<td>Excess administrative costs</td>
<td>$190 billion</td>
</tr>
<tr>
<td>Excessively high prices</td>
<td>$105 billion</td>
</tr>
<tr>
<td>Missed prevention opportunities</td>
<td>$55 billion</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 billion</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$765 billion</strong></td>
</tr>
</tbody>
</table>

SOURCE: Institute of Medicine, Best Care at Lower Cost (2013) Table 3-1.
TO SUM UP AT THIS POINT

• On **average**, Americans probably do get their money’s worth in health care. **But only on average.**

• At **the margin** there seems to be much waste even in health care proper – the delivery of care with only modest benefits.

• In addition, much of the huge **administrative overhead** of U.S. health care strikes me as indefensible.
IV. REFORMING U.S. HEALTH CARE
Reform of the health system in the U.S. always faces two obstacles:

A. **ECONOMICS**: Reforms are caught between a rock (the **very high cost** of US health care) and a hard place (enormous **income inequality**). Bestowing even ordinary surgical procedures on poor people is like bestowing a Mercedes Benz on them. It can rankle the tax-paying well-to-do.

B. **IDEOLOGY**: Unlike most other nations, the U.S. has never reached a political consensus on the **distributive social ethic** that should guide its health-care system.
A. Income inequality and the cost of U.S. health care
Milliman Medical Index of Health-Care Cost for Family of Four Covered by Employment-Based PPO

Source: http://us.milliman.com/mmi/
Percentage distribution of household income in the United States in 2015

<table>
<thead>
<tr>
<th>Annual household income in U.S. dollars</th>
<th>Percentage of U.S. households</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 15,000</td>
<td>11.6%</td>
</tr>
<tr>
<td>15,000 to 24,999</td>
<td>10.5%</td>
</tr>
<tr>
<td>25,000 to 34,999</td>
<td>10%</td>
</tr>
<tr>
<td>35,000 to 49,999</td>
<td>12.7%</td>
</tr>
<tr>
<td>50,000 to 74,999</td>
<td>16.7%</td>
</tr>
<tr>
<td>75,000 to 99,999</td>
<td>12.1%</td>
</tr>
<tr>
<td>100,000 to 149,999</td>
<td>14.1%</td>
</tr>
<tr>
<td>150,000 to 199,999</td>
<td>6.2%</td>
</tr>
<tr>
<td>200,000 and over</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

Median income: $56,516
The annual cost of the typical modern new cancer drug alone far exceeds the household incomes of the bottom half of the U.S. income distribution.

And the distribution of wealth in this country is even more uneven.
DISTRIBUTION OF WEALTH IN THE U.S., 2013

Cumulative percentage of households

Percent of total wealth owned

B. Ideology
ALTERNATIVE VIEWS ON THE PROPER DISTRIBUTIVE ETHIC FOR AMERICAN HEALTH CARE:

- **American Progressives**: A pure social good to be available to all on equal terms and to be financed by ability to pay.
- **The confused in-betweens**: ?
- **American Conservatives**: A private consumption good whose financing is primarily an individual responsibility.

#NATCON17 #BH365
These ideological differences directly affected the nature of the federal tax credits available under the Democrats’ Affordable Care Act (ObamaCare) and the Republicans’ ill-fated American Health Care Act.

A. The tax-credit under ObamaCare are **income related** in the following way:
OBAMACARE TAX CREDIT FOR INSURANCE

Federal tax credit toward purchase of insurance = Premium for 2nd cheapest Silver Plan, covering 70% of the actuarial costs of Essential Benefits - X% of Modified Adjusted Gross Income (MAGI), where X rises with income.

In other words, the tax credit is income related through X. It decreases as income rises and is large when income is small.
Percent (X) of Modified Adjusted Gross Income (MAGI) Households Pay towards Insurance Premium for 2\textsuperscript{nd} Cheapest Silver Plan 2017
2017 Federal Poverty Levels in Dollars

- 400% FPL
- 250% FPL
- 100% FPL

$0 $20,000 $40,000 $60,000 $80,000 $100,000 $120,000

These ideological differences directly affected the nature of the federal tax credits available under the Democrats’ Affordable Care Act (ObamaCare) and the Republicans’ ill-fated American Health Care Act.

A. The tax-credit under ObamaCare are income related in the following way:

B. The tax credit under the Republican AHCE were to be flat amounts related only to age, and not to income or the cost of health insurance.
AHCE: TAX CREDITS DO NOT VARY WITH INCOME

Income as percent of FPL

- <100%
- 133%
- 150%
- 200%
- 250%
- 300%
- 400%
- 600%

Tax Credit

- $0
- $500
- $1,000
- $1,500
- $2,000
- $2,500
- $3,000
- $3,500
- $4,000
- $4,500
- $5,000

27 YEARS

60 YEARS

$2,000
$4,000
$6,000
$8,000
$10,000

How the AHCA Might Shift Average Tax Credits by 2020, Individual's Income = $20,000

<table>
<thead>
<tr>
<th>Age 27</th>
<th>ACA</th>
<th>AHCA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$3,225</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 40</th>
<th>ACA</th>
<th>AHCA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$4,143</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 60</th>
<th>ACA</th>
<th>AHCA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$9,874</td>
<td>$4,000</td>
</tr>
</tbody>
</table>

How the AHCA Might Shift Average Tax Credits by 2020, Individual's Income = $75,000

- **Age 27**: ACA = $0, AHCA = $2,000
- **Age 40**: ACA = $0, AHCA = $3,000
- **Age 60**: ACA = $0, AHCA = $4,000

For a neat interactive map comparing estimated Premiums and Tax Credits by county and by age and income of the individual, see

“Premiums and Tax Credits Under the Affordable Care Act vs. the American Health Care Act: Interactive Maps”

Playing with that map, you will learn the bizarre fact that, relative to ObamaCare, the AHCE would have hosed particularly harshly the voters likely to have voted for President Trump.
According to the Congressional Budget Office, the AHCE would taken an estimated $1.2 trillion of federal spending out of health care over 2017-27 – mainly from older and poorer people – and used $882 billion of that amount for tax cuts accruing mainly to upper-income households.
Can Elephants Learn From Failure?

THE REPUBLICAN HEALTH Care bill failed because it was a bad bill that had almost no authentic public support. It took benefits away from tens of millions of vulnerable people in order to give tax breaks to the rich few.
THE REPUBLICAN HEALTH Care bill failed because it was a bad bill that had almost no authentic public support. It took benefits away from tens of millions of vulnerable people in order to give tax breaks to the rich few.
GOP's Obamacare Replacement Will Make Coverage Unaffordable For Millions -- Otherwise, It's Great

Avik Roy, Forbes Staff

IV. CHALLENGES TO MENTAL AND BEHAVIORAL HEALTH
The mental- and behavioral health segment of U.S. health care also finds itself between a rock and a hard place.

A. The **rock** is the alarming and growing **incidence of illness** confronting this sector.

B. The **hard place** is the threat of **reduced financing** of this kind of care – especially in the face of proposed future budget cuts to Medicaid.
A. The incidence of mental illness and substance abuse
Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century

Anne Case¹ and Angus Deaton¹

Woodrow Wilson School of Public and International Affairs and Department of Economics, Princeton University, Princeton, NJ 08544

Contributed by Angus Deaton, September 17, 2015 (sent for review August 22, 2015; reviewed by David Cutler, Jon Skinner, and David Weir)

This paper documents a marked increase in the all-cause mortality of middle-aged white non-Hispanic men and women in the United States between 1999 and 2013. This change reversed decades of progress in mortality and was unique to the United States; no other rich country saw a similar turnaround. The midlife mortality reversal was confined to white non-Hispanics; black non-Hispanics and Hispanics at midlife, and those aged 65 and above in every racial and ethnic group, continued to see mortality rates fall. This increase for whites was largely accounted for by increasing death rates from drug and alcohol poisonings, suicide, and chronic liver diseases and cirrhosis. Although all other rich countries saw mortality rates fall for whites aged 45–54, the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE). The comparison is similar for other Organisation for Economic Co-operation and Development countries.

Fig. 1 shows a cessation and reversal of the decline in midlife mortality for US white non-Hispanics after 1998. From 1978 to 1998, the mortality rate for US whites aged 45–54 fell by 2% per year on average, which matched the average rate of decline in the six countries shown, and the average over all other industrialized countries. After 1998, other rich countries’ mortality rates continued to decline by 2% a year. In contrast, US white non-Hispanic mortality rose by...
Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.
Mortality by Poising, Suicide, Chronic Liver Disease and Cirrhosis

Fig. 4. Mortality by poisoning, suicide, chronic liver disease, and cirrhosis, white non-Hispanics by 5-y age group.

“Deaths of Despair” among Middle-Class Whites

Midlife ‘Deaths Of Despair’ In The U.S., 2000 and 2014

Deaths by drugs, alcohol and suicide among non-Hispanic whites, ages 45-54

![Death rate per 100,000](image)

2000 - 25

2014 - 100

“Deaths of Despair” among Middle-Class Whites

2000
“Deaths of Despair” among Middle-Class Whites
B. Funding mental and behavioral health care
Medicaid is a major funder of mental-health and substance-abuse treatments.
Percent of Adult Group Covered by Medicaid, 2014

- General adult population: 12%
- Substance abuse disorder: 16%
- Any mental illness: 20%
- Serious mental illness: 24%

Average Medicaid Spending on Enrollees With or Without Behavioral Conditions

Without behavioral health conditions

With behavioral health conditions

But Medicaid is threatened by future health reform. For example, the AHCE had called for:

1. An end to financing the Medicaid expansion under ObamaCare.
2. Conversion of the traditional federal matching (FMAP) of state Medicaid expenditures by block rants or per-capita caps with pre-set growth rates intended to reduce the growth of federal support for Medicaid.

States may respond by (a) cutting provider payments or (b) enact enrollment caps or (c) trim benefit packages.
IV. CHALLENGE AND OPPORTUNITY
In conclusion, let me remind you of the Chinese word for “Crisis”:危機

DANGER OPPORTUNITY
Thank you for your attention.