

A Summary of Recent Health Care Reform Background Papers and Proposals

By George Faulkner, January 2009

Health Reform Proposals

- **Congressional Budget Office: Key Issues in Analyzing Major Health Insurance Proposals**, December 2008 – a comprehensive report on how the CBO would evaluate health reform proposals, including descriptions of specific reform ideas and how they might impact costs. <http://www.cbo.gov/doc.cfm?index=9924>

A few interesting findings:

- Administrative costs range from about 7% of the total for employment-based plans with 1,000 or more enrollees, to nearly 30% for policies purchased by small firms (those with fewer than 25 employees) and individuals.
 - The uninsured currently use about 60 percent as much care as the insured population, after adjusting for demographics and health status.
- **Call To Action: Health Reform 2009**, proposal by Senate Finance Committee Chairman Max Baucus (D–Mont.), November 12, 2008
<http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>
 - It lays out the case for reform and provides not only overall recommendation on financing and access, but also malpractice reform, coverage for long term care, tax code changes, and reducing waste, fraud, and abuse.
 - The comprehensive health reform proposal was only recently issued and said to be the one that may serve as the starting point for the Obama administrations' proposed legislation. The paper proposes an individual mandate, national exchange, expansion of Medicare and Medicaid, and a requirement for larger employers to provide coverage or help fund the cost.
- **Cost and Coverage Estimates for the “Healthy Americans Act”** (Rep. Ron Wyden’s (OR) Proposal) -- Staff Working Paper, Prepared By: John Sheils, Randall Haught, Evelyn Murphy. The Lewin Group, December 12, 2006.
 - Link to a description of the proposal:
http://www.standtallforamerica.com/content/healthy_americans_act
 - Link to the Lewin Group financial evaluation:
http://wyden.3cdn.net/6bef7159c09e936683_bdm6ibzp7.pdf
 - Key Elements of the proposal:
 - Except those covered through Medicare or the military, everyone would chose from a selection of private plans offered through newly created regional purchasing organizations called HHAs (“Health Help Agencies”)
 - Employers would be required to “cash-out” their health plans by terminating their existing health coverage and paying the amount saved to their workers in the form of increased wages.

- Participants would pay premiums through their annual income tax filings. The program would fully subsidize the premium for those below 100 percent of the federal poverty level (FPL), with the premium phasing-in for people living between 100 percent and 400 percent of the FPL. Employers also would be required to pay an assessment ranging from 2 to 25 percent of the national average premium for the minimum benefits package, depending upon firm size and revenues per worker (25% of costs is still much less than the roughly 75% share that larger employers generally now pay).
- The program provides incentives to demand lower-cost health coverage to control cost growth, since the worker faces the full cost of insurance increases, the tax exclusion for employer provided health benefits is eliminated, and people must pay the full increment of premium for enrolling in a more costly plan.
- Administration is streamlined by organizing plan selection through the HHAs, with employers administering annual open enrollment for their workers; no income-testing at the point of enrollment as under Medicaid, elimination of cost-shifting for Medicaid underpayments, and improved access for those now covered under Medicaid.
- Lewin Group key findings:
 - National health spending, projected to be \$2.3 trillion in 2007, would actually decline by \$4.5 billion despite the expansion in private coverage, due to savings in administration (\$29.8) and increased price competition for insurance (\$54.9). The CMS projects that total spending for administration of private insurance and public programs will reach about \$170.3 billion in 2007, including both the cost of administration and insurer profits. (Much of these savings are achieved by extending large group economies of scale: Administrative costs for groups of 10,000 or more workers are typically equal to about 3.4% of claims, while for individuals and very small groups they can be 30% or more of medical costs.
 - The annual rate of growth in national health spending would be reduced by about 0.86 percent. Savings over the 2007-2016 period would be \$1.48 trillion, which is 4.5 percent of spending over this ten-year period
 - All new federal program costs, \$812.9 billion, are fully funded by premium payments, employer contributions, and savings in other areas
 - State and local Government safety-net program savings of \$22.4 billion;
 - Employer health spending falls by \$309.8 billion (from \$428.8 billion to \$107.2 billion). This amount will be passed-on to workers as wage increases under the cash-out;
 - Overall, increases in family premium payments are offset by the increase in wages and subsidies provided under the plan.
- **Evolving Beyond Traditional Employer-Sponsored Health Insurance—The Hamilton Project**, The Brookings Institution (www.hamiltonproject.org)
 - Proposes a transition approach away from a partly employer-sponsored coverage system to state-chartered health insurance exchanges and an employer role that just enrolls and collects premiums.

Surveys

■ Kaiser Health Tracking Poll, Issue 11, October 2008

http://www.kff.org/kaiserpolls/h08_posr102108pkg.cfm

Highlights:

- Affordability is now the issue named by the largest number of Republicans (51 percent), Democrats (50 percent) and political independents (46 percent). Among Democrats, expanding coverage for the uninsured ranks second, named by 35 percent of those voters. Coverage also ranks second for political independents, named by a somewhat smaller proportion (23 percent). Relatively few Republicans (9 percent) name coverage as a health care priority.
- Overall, nearly twice as many voters agree that in the face of a struggling economy “it is more important than ever to take on health care reform” than agree the country cannot tackle this issue given the current situation.
- One in four Americans (25 percent) report that they or someone in their family has stayed in a job over the past year because of health care benefits, up from 18 percent in April 2008. Roughly one in ten (13 percent) report switching jobs in the past year mainly because the new job offered better health care benefits. The share who say either has occurred – that in the past year, they or someone in their household had decided to take a new job or stay at a job mainly because of better health benefits – has grown from nearly one-quarter (23 percent) in April to three in ten (30 percent) now.
- There is little bipartisan agreement as to the best way to achieve those cost cuts. Overall, roughly half of voters say that regulation by the federal government would do a better job restraining costs, while the other half believes that competition in the marketplace is a more effective strategy. Not surprisingly, Democratic voters tilt toward the former explanation, while Republicans tilt toward the latter. Independents split down the middle. In the midst of serious national disagreement.

■ The Public on Requiring Individuals to Have Health Insurance (Survey by NPR/Kaiser Family Foundation/Harvard School of Public Health, Feb. 2008)

<http://www.kff.org/kaiserpolls/pomr022908pkg.cfm>

- Six in 10 (59%) support a broad approach to ensure everyone has coverage that includes roles for individuals (a requirement to get insurance or pay a fine, with subsidies for people with lower incomes), employers (a requirement to cover workers or pay into a pool), insurance companies (a requirement to take anyone that applies), and the government (expansion of public programs and help for lower income people).
- About two-thirds also support another approach to expand coverage – a proposal that would require parents to get health insurance coverage for their children with government subsidies for lower income families.
- About half (47%) support and about half (44%) oppose an individual health insurance mandate for everyone – adults and children - that includes mentions of fines for non-compliance and subsidies for those with lower incomes, but no reference to expanded public programs and requirements on insurers and employers.

- **“What price universal health coverage? For many small employers, any price is too high”** <http://www.mercer.com/summary.htm?idContent=1325605>
 - From Mercer’s *National Survey of Employer-Sponsored Health Plans, 2008*:
<http://www.mercer.com/summary.htm?idContent=1328445>
 - Summarizes opinions of employer HR managers on various aspects of health care reform, and shows that their opinions differ substantially by employer size. Smaller employers are more open to non-employer-based reform alternatives.
 - 65% of all employers offer health care coverage in 2008, vs. 70% in 2000.
 - 53% of employers approve of an individual coverage mandate (30% oppose and the remainder are uncertain or have no opinion)
 - Only 31% approve of an employer mandate to provide coverage or pay into a fund for it, while 50% oppose this.
 - While 34% approve (30% oppose) replacing employer-provided plans with individual coverage through other exchanges, only 29% approve of replacing the current system with a single payer system (51% oppose).
 - Only 30% approve removing or capping the individual federal income tax exclusion for health benefit plans

Background Papers

- **An Agenda for Change** (A Dartmouth Atlas White Paper, Dec. 2008)
http://www.dartmouthatlas.org/topics/agenda_for_change.pdf
 - Data shows a large variation across the US on the quality and cost of health care delivery—e.g., a 2.5-fold variation in Medicare spending (even after adjusting for age, mix of health conditions, lost cost of living, etc.).
 - Certain organized systems of care deliver high quality care for lower costs and need to be replicated elsewhere. The federal government is best able to promote this effort, through its influence on Medicare and Medicaid, science and research, physician training and workforce.
 - Studies show such changes could save about 30% of costs for acute and chronic conditions and elective surgery under Medicare.
 - Other steps the federal government should take include reducing unwarranted variation in medical practice, overuse of supply-sensitive care, unwarranted variation in preference-sensitive care.
 - “...we predict that covering everyone will have a much smaller impact on the trend in overall costs of health care delivery than is commonly assumed, *provided that capacity is not increased.*”

- **The Price Of Excess: Identifying Waste In Healthcare Spending,**
 PricewaterhouseCoopers' Health Research Institute, 2008
<http://www.pwc.com/extweb/pwcpublications.nsf/docid/73272CB152086C6385257425006BA2FC>
 - Based on interviews with top experts, a review more than 35 studies about waste and inefficiency in healthcare, and a survey of 1,000 “consumers.”
 - Claims that wasteful spending in the health system amounts to \$1.2 trillion of the \$2.2 trillion spent nationally, more than half of all health spending. Spending can be classified into three waste “baskets”: behavioral (up to \$493M), clinical (\$312M), and operational (up to \$315M). These baskets cross all of the health sectors and include consumers, government and industry. Estimates of excess costs are provided for many specific areas, such as obesity (\$200B), defensive medicine (\$210B), and claims processing (up to \$210B).
 - The top three areas of wasted spending are defensive medicine (\$210 billion annually), inefficient claims processing (up to \$210 billion annually), and care spent on preventable conditions related to obesity and overweight (\$200 billion annually).

- **Massachusetts Health Care Reform: Two Years Later (Kaiser Commission Key Facts, May 2008)** <http://www.kff.org/uninsured/7777.cfm>
 - Key elements:
 - Effective July 1, 2007: individual coverage mandate and employers must provide a “fair and reasonable” contribution or pay a penalty
 - Commonwealth Care program to help pay for coverage for those with income <300% of the federal poverty level,
 - Commonwealth Health Insurance Connector, an insurance exchange to offer coverage options for individuals and small businesses (18,000 were enrolled as of April 2008).
 - Estimate that over 340,000 people have gained coverage -- more than half of the estimated 650,000 people who were previously uninsured, since launched late in 2006. (Estimate that 85,000 became enrolled in employer-based plans)
 - But costs are higher than expected: almost \$900M, vs. ~\$500M and participant contributions and out-of-pocket costs for those in the Commonwealth care program rose by 10% in 2008.

- **The Uninsured and the Difference Health Insurance Makes (Kaiser Commission Key Facts, Sept. 2008)** <http://www.kff.org/uninsured/1420.cfm>
 - Nearly 70% of the 45 million uninsured have at least one full-time worker in their family and another 12% have at least one part-time worker. About eight in ten of the uninsured (79%) are American citizens.
 - The percentage of firms offering coverage dropped from 69% in 2000 to 60% in 2007, in part due to rising premiums. (In 2007, the annual employer group premium for a family of four was \$12,106, nearly double what it was in 2000.)
 - Most uninsured are uninsured because they cannot afford to buy individual coverage policies. About two-thirds of the uninsured have family incomes below 200% of the federal poverty level (about \$42,400 for a family of four in 2007). Only one in ten of the uninsured have family incomes above 400% of poverty. In a recent government

- survey, only 1.5% of adults said that they are uninsured because they do not need coverage.
- Confusion over who qualifies for Medicaid or SCHIP and an enrollment process that can be difficult to navigate have left one-quarter of the uninsured without coverage despite being eligible for these programs.
 - About three-quarters of the uninsured are uninsured for more than one year.
 - The uninsured pay for more than one-third of their care out-of-pocket and are often charged higher amounts for their care than the insured pay (due to being charged the “non-network” price).
 - Health providers can choose to not provide care to the uninsured. Only emergency departments are required by federal law to screen and stabilize all individuals. If the uninsured are unable to pay for care in full, they are often turned away when they seek follow-up care for urgent medical conditions.
 - About one-quarter of uninsured adults go without needed care due to cost each year. Lack of access to timely care causes more than 20,000 uninsured adults to die prematurely each year.
- ***Employer Health Insurance Mandates and the Risk of Unemployment*** (National Bureau of Economic Research Working Paper 13528, Katherine Baicker and Helen Levy) <http://www.nber.org/papers/w13528>
 Estimates the potential job loss from *employer* health insurance mandates.
 Key findings:
 - 15 percent of full-time workers (those working 20 or more hours per week) have no health insurance coverage;
 - Many of those who will gain coverage from the mandate are not poor;
 - A significant number of workers who would be affected by a mandate already received health insurance as a dependent on a family member's policy, thus the mandate exposes them to the risk of unemployment without changing their health insurance status.
 - Employer pay-or-play mandates are "a blunt instrument for providing health insurance for the working poor," since many poor uninsured workers would not gain coverage and many of those who would gain coverage are not poor.
- ***Choice, Price Competition and Complexity in Markets for Health Insurance*** (National Bureau of Economic Research Working Paper 13817, Richard Frank and Karine Lamiraud) <http://www.nber.org/papers/w13817>
 - Studied Swiss program where individuals have an annual choice of 30 or more plans from various insurers to evaluate how well they competed on price. Price information is readily available and switching will generally not affect an individual's access to particular doctors.
 - The authors were surprised to find that large price differences persisted over time, and only about 3% of enrollees switched plans annually, even though those switching lowered their premiums by an average of 16%.
 - The authors conclude that results of certain psychological studies likely help explain the findings. Cognitive overload and fear of making incorrect decisions often arise when decisions are complex and have high stakes. These factors can lead to poor

decision making or attempts to avoid making a decision by opting for the status quo. Switching plans was inversely correlated with the number of choices available.

- **The New America Foundation: The Cost of Doing Nothing**, November 2008
 - http://www.newamerica.net/publications/policy/cost_doing_nothing
 - Estimates that in 2006, the US economy “lost as much as \$200 billion because of the poor health and shorter lifespan of the uninsured. This is by most estimates as much as, if not greater than, the public costs of ensuring all Americans have quality, affordable, health coverage.”
 - Projects that the cost of the average employer-sponsored health insurance plan (ESI) for a family will reach \$24,000 in 2016, an 84 percent increase over 2008 levels. “Under this scenario, we estimate that at least half of American households will need to spend more than 45 percent of their income to buy health insurance.”

- ***“Is American Health Care Uniquely Inefficient?”*** (National Bureau of Economic Research Working Paper 14257, Alan Garber and Jonathan Skinner)
<http://www.atypon-link.com/doi/abs/10.1257/jep.22.4.27>
 - In 2006, health care expenditures were 15 percent of GDP in the U.S., compared to 11 percent in France and Germany, 10 percent in Canada, and 8 percent in the United Kingdom and Japan. The paper attempts to find out why US costs are so much higher.
 - While administrative costs are often blamed for lower health care productivity in the U.S., the authors note that these expenses are not large enough to explain differences in spending between the U.S. and other countries, nor can they explain why expenditures are growing more rapidly in the U.S.
 - Comparing several indirect measures of health care consumption across countries, they find that the U.S. is about average in the number of acute hospital beds and practicing physicians per capita and in prescription drug use. However, the number of MRI machines per capita in the U.S. is about five times higher than in most other wealthy countries, though lower than in Japan. Also, the rate of invasive and expensive treatments (such as particular coronary procedures) and the intensity of care per day of hospitalization are higher in the U.S. than in other countries.
 - The authors find that increases in spending in the U.S. have greatly outpaced those in other countries, while improvements in life expectancy have been similar, if not slightly worse. They conclude that the spread of new technology, fueled by favorable reimbursement rates, are the most compelling explanation for the more rapid rise in health care costs in the U.S. Adoption of electronic records and universal insurance coverage will not help control or reduce costs.
 - "what sets the U.S. apart is a combination of incentives for the overuse of some services and underuse of others in a predominantly fee-for-service system, coupled with few supply-side constraints." The dynamic effects of these incentives may be profound, as insurance coverage is extended to technologies without regard to their proven benefits or cost.
 - The authors conclude "perhaps the greatest hope for improving ... efficiency will come from efforts to measure and reward accurately outcome productivity - improving health outcomes using cost-effective management of diseases - rather than rewarding on basis of unit service productivity..."

- **Accounting for the Cost of Health Care in the United States**, McKinsey Global Institute (downloading requires free registration)
http://www.mckinsey.com/mgi/publications/US_healthcare/
 - The main cause for higher costs in the US than in other developed countries is the lack of incentives for consumers to be value-conscious and the lack of mandates or incentives for providers to manage supply of services. A contributing cause is the “significant for-profit element and its multi-state and multi-payor administrative structure.”
 - The US population disease mix is not sufficiently different to account for any material costs differences. But targeting certain increasingly prevalent conditions, such as diabetes and heart conditions, could also help reduce costs significantly.
 - Even adjusted for average wealth, the US spends: 28% more overall, including 40% more for hospital care, 36% more for outpatient care, 27% more for drugs, 82% more for administration, and 15% more for public health investments. In two expense areas we spend less than other developed countries: long term care (57% less) and durable medical equipment (70% less).
 - For its added costs, the US does not provide better quality of care or access.

- **“We're Number Two: Canada Has as Good or Better Health Care than the U.S.,”** *Scientific American*, May 03, 2007, By Christopher Mims
<http://www.sciam.com/article.cfm?id=canada-has-as-good-or-better-healthcare-than-united-states>
 - A review of various studies, concluding that “Despite spending half what the U.S. does on health care, Canada doesn't appear to be any worse at looking after the health of its citizens.” Canadians are 5 percent less likely than Americans to die in the course of treatment.
 - A study by Steffie Woolhandler of Harvard, published in *The New England Journal of Medicine* in 2003 found that 31 percent of spending on health care in the U.S. went to administrative costs, whereas Canada spent only 17 percent on the same functions.

- **“Lessons for Obama's Health Care Team,”** in *On Innovation* (HarvardBusiness.org) and reprinted in *Business Week Magazine*, Jan. 22, 2009, by Clayton M. Christensen and Jason Hwang.
http://www.businessweek.com/managing/content/jan2009/ca20090123_697807.htm?chan=careers_managing+index+page_top+stories
 - Some health reform proposals promote regional or national exchanges where insurance plan options are offered and regulated and where annual enrollments and billing are administered. The 18-month old Massachusetts reform program has a state version called the Commonwealth Health Connector (launched in July 2007). This essay notes that certain shortcomings observed in the Massachusetts Connector role provide valuable lessons for federal reform proposals:
 - The Connector provides little information on the cost or quality of health care services and providers. So citizens have limited ability to evaluate plans and providers. Without the ability to capture, report fairly and objectively, and

provide access to this information, both free-market and single payer programs will not control costs or spur quality improvements.

- Whoever sets the standards, such as what expenses must be covered and at what level (e.g., various prescriptions—and generic or brand, or types of providers and treatments), needs to have a mechanism to remain flexible, open to research, innovation, and technology that disrupts existing approaches. Otherwise, frozen standards stifle innovation, or at best more and more expenses get covered with the less effective ones never getting phased out.

- **“Health Care Reform: Why We Cannot Afford To Fail,”** Health Affairs, January 16, 2009, by Denis Cortese and Jeffrey O. Korsmo.
<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.2.w173>

Highlights:

- “For the past two years, the Mayo Clinic Health Policy Center has convened more than 2,000 stakeholders—including patients, providers, academics, medical industry leaders, businesspeople, insurers, and political leaders—in a series of events. The goal was to help develop patient-centered, consensus-driven principles and action steps to accelerate the reform process. Participants recommended focusing health reforms around these four broad cornerstones: (1) create value through improved health outcomes and service to patients; (2) coordinate care; (3) reform the payment system; and (4) provide insurance for all. Interestingly, the first two of these recommendations must be addressed primarily by the health care industry itself. The government should take the lead on the last two. However, all four areas must be addressed, if systematic health care reform is to be truly accomplished.”
- On coordination of care: “Coordinating care for patients with chronic diseases, whose care accounts for 75 percent of the nation's health care spending, is a clear priority in this arena. Many chronically ill patients “ping-pong” among multiple providers and care settings...”
- On reform of the payment system: “Congress must also give up its role as an unwieldy combination of day-to-day manager and board of directors for Medicare. Instead, we support an idea also endorsed by incoming HHS secretary Daschle: that of a U.S. Health Board modeled after the Federal Reserve Board. An independent board made up of providers, payers, and patients could focus on the complex decision making that must be insulated from the politics of Capitol Hill. This board could have responsibility for a number of decisions affecting Medicare as well as other health spending programs. According to the Blue Ridge Academic Health Group fall 2008 policy proposal, a U.S. Health Board could be authorized by Congress to make national policy decisions within an established set of guidelines, with authority to include health insurance regulation, payment mechanisms (although not specific payment rates), and dissemination of evidence-based standards of medical practice.”
- “Dartmouth Atlas research has shown that quality of care is worse when spending and utilization of care (more visits, more imaging tests) are greater.⁶ Fisher says that if all U.S. regions would safely adopt the organizational structures and practice patterns of the lowest-spending regions, Medicare spending would decline by about

30 percent.⁷ Currently, physicians in low-spending areas who offer more-efficient, high-quality care are financially penalized for providing value. We need new payment arrangements that pay for value and outcomes, rather than volume.”

- On coverage for all: “The federal government should mandate the purchase of a basic insurance plan and provide income-related, sliding-scale subsidies so that all Americans could purchase insurance.”
- **Dutch Treatment: In Holland, Some See Model For U.S. Health-Care System -- - Private Insurers Compete, But All Get Coverage;** By Gautam Naik, September 6, 2007, *The Wall Street Journal* <http://online.wsj.com/article/SB118903445878218649.html>
 - In 2006 the Netherlands switched from a mostly government-run single-payer program (for all but wealthier individuals) to a “managed competition” program, due to rising cost trends. The new program mandates individual coverage and that insurance carriers cover all (with the government “equalizing” their payments based on enrollee risks).
 - Results: cost trend has declined significantly, patient waiting lists are shrinking, individuals are much more aware of the costs of health care (previously less noticeable when funded by payroll taxes), and insurance carriers are trying out various innovations, as in ways to compete on preventive care services and reward doctors for prescribing lower cost drugs.
- **“The Swiss example on health insurance reform,”** by Beatrice Schaad Noble, Boston Globe, June 18, 2007
<http://www.nonprofithealthcare.org/documentView.asp?docID=832>
 - Switzerland adopted a market-based universal coverage program in 1996 (mandatory coverage with standardized plans covered by insurance companies). While most citizens do not want to go back to a single-payer plan, the program is suffering from several problems:
 - Coverage is only subsidized for the poor, and middle class is struggling with a cost amounting to 16% of household income
 - Costs are still rising much faster than general inflation, despite more enrollments in high deductible plan options, and there is increasing recognition of the need to focus on getting all parties to better manage costs.
 - People suspect the “nonprofit” insurance companies are still profiting and do not provide sufficient financial transparency.
- **Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries,** *Position Paper,* American College of Physicians, 2008 <http://www.annals.org/cgi/content/short/148/1/55>
 - Compares the US health care system with those in 12 other developed countries and identifies lessons for reform of the US system.
 - Without recommending a specific delivery approach, other than universal coverage, the report notes that:

- “Single-payer systems, which generally have the advantage of being more equitable, with lower administrative costs than systems using private health insurance, lower per capita health care expenditures, high levels of consumer/patient satisfaction, and high performance on measures of quality and access. Such systems typically rely on global budgets and price negotiation to help restrain health care expenditures, which may result in shortages of services and delays in obtaining elective procedures and limit individuals’ freedom to make their own health care choices.”
 - “Pluralistic systems, which can be designed to assure universal access while allowing individuals the freedom to purchase private supplemental coverage. Such systems are more likely to result in inequities in coverage and higher administrative costs.”
 - It also recommends patient cost-sharing (e.g., deductibles and coinsurance) be used to encourage prudent use, but that they be somehow prorated by income level so that those who cannot afford to pay are not discouraged from seeking care.
- **“Three imperatives for improving US health care,”** *McKinsey Quarterly*, December 2008, Paul D. Mango and Vivian E. Riefberg
http://www.mckinseyquarterly.com/Three_imperatives_for_improving_US_health_care_2274
 - Argues that in addition to covering the uninsured, the public and private sectors need to focus on the most critical problem—runaway costs and lack of affordability, which is driven by three underlying problems: First, “the high incidence and cost of treating lifestyle- and behavior-induced diseases, such as obesity. These diseases are responsible not only for a majority of the deaths in the United States but also for the fastest-growing share of health care costs. Second, public and private stakeholders should make health care more affordable and improve its quality by minimizing the economic distortions that now tend to prevent consumers and providers from making value-conscious decisions. Finally, we need to simplify the system’s pervasive and unnecessary administrative complexity to remove the waste that drives up costs, to facilitate the real-time flow of critical information, and to promote the introduction of productivity-enhancing technologies.”
 - Since individuals ultimately pay for all health care costs (employers and governments are only intermediary payers), the healthy increasingly subsidize costs for the chronically ill (e.g., the obese whose incidence has double to 34% of the population since 1980). Reducing obesity incidence back to 1980 levels would save \$60 billion and
 - The authors “estimate that unnecessary administrative expenses currently represent fully 5 percent of total system costs, or about \$100 billion a year. This complexity comes primarily in two forms:” the regulatory complexity imposed on payers in developing, distributing, and managing insurance products” in 50 states; and “transactions between payers and providers: the innumerable claims-management systems, IT platforms, reporting requirements, and contracting terms payers use. The average US hospital, for example, may work with 40 to 60 different payers.”

- **“Why Americans pay more for health care,”** *McKinsey Quarterly*, December 2008, Diana Ferrell and Eric Jensen.
http://www.mckinseyquarterly.com/Why_Americans_pay_more_for_health_care_2275
 - The “United States spends \$650 billion more on health care than might be expected given the country’s wealth and the experience of comparable members of the Organisation for Economic Co-operation and Development (OECD). The research also pinpoints where that extra spending goes. Roughly two-thirds of it pays for outpatient care, including visits to physicians, same-day hospital treatment, and emergency-room care. The next-largest contributors to the extra spending are drugs and administration and insurance.”
 - The third-largest source of excess spending is health administration and insurance, at \$91 billion.

- **Fundamentals of Insurance: Implication for Health Coverage,** American Academy of Actuaries Issue Brief, July 2008
http://www.actuary.org/pdf/health/coverage_ib_08.pdf
 - Describes various principles of insurance and the extent that health insurance plans reflect or deviate from these principles.

- **Taking Control: An Actuarial Perspective on Health Spending Growth,** American Academy of Actuaries Issue Brief, September 2008
http://www.actuary.org/pdf/health/spending_ib_08.pdf
 - Argues that health reform will not succeed unless rising costs are better controlled. Costs rise much faster than general inflation for the following reasons:
 - Health service *price* increases due to such reasons as: broader provider networks limiting the ability of health care purchasers to negotiate discounts; a shortage of primary care physicians, resulting in greater use of specialist care at higher service fees; and provider consolidation, increasing size and leverage, and thus potentially reducing price competition.
 - Health care *utilization* increases for reasons such as: new medical technology; payment structures that reward health care providers for providing more services; benefit plan designs that limit out-of-pocket costs in ways that shelter consumers from the need to make prudent choices; and less healthy lifestyle choices that increase the need for medical services to treat chronic diseases.

- **“Single-Payer Health Care Systems: The Roles and Responsibilities of the Public and Private Sectors,”** *Benefits Quarterly*, Third Quarter 2007, by Jeffrey D. Munn and Lynne Wozniak
<http://www.iscebs.org/PDF/bqpublic/bq307a.pdf>
 - Summarizes single payer programs around the world, including in Asia, and concludes that even though cost in the US are higher, rising health care costs are a problem that most major countries are struggling to address, not just one unique to the U.S. They also find that private solutions, including employer roles, are

increasingly being tried to supplement public programs, in order to stem the cost tide.

- **Health Care Systems Around The World**, Alyssa Kim Schabloski, JD, MPH, *Insure the Uninsured Project*, 2008
<http://www.scribd.com/doc/7983921/Health-Care-Systems-Around-World>
 - Comprehensive inventory of financing, administration, and other elements of ten major health care systems in developed countries

- **Value-Driven Health Care: A Purchaser Guide**, Version 1.0 - February 2007
http://www.leapfroggroup.org/media/file/Purchaser_Guide_Final2-07-07.pdf
 - The guide is a response to former Secretary of HHS Leavitt’s “Value-Driven Health Care initiative” and provides a resource for “utilizing health information technology, measuring and publishing quality information, measuring and publishing price information, and creating positive incentives for high quality, efficient health care.”
 - The guide was issued by various business and non-profit organizations, such as the Leapfrog Group which has lead the effort to reduce medical errors and improve quality of care. While many of these initiatives are just getting started, they are central to helping to control costs and improve quality under any approach to health care reform.

- **Designing Benefits With Evidence in Mind**, *Employee Benefit Research Institute Issue Brief No. 290*, February 2006, Dr. John Santa, Oregon Health & Science University, and Mark Gibson, Oregon Health & Science University and Milbank Memorial Fund
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=887311#
 - Good overview of the potential role of “evidence-based medicine” to reduce costs and improve quality of care.
 - Finds that challenges to its use include:
 - A current benefit design language that does not offer sufficient detail to allow the explicit integration of evidence.
 - Limitations of the research literature on the effectiveness of health services.
 - Resistance to change among providers and vendors.
 - Fragmentation among purchasers and consultants.
 - Lack of capacity among human resource administrators and benefit consultants.
 - Resistance to change among consumers.

- **Transparency and Disclosure: The Route to Accountability**, *Institute on Health Care Costs and Solutions (from the National Business Group on Health)*, 2003
 - A good summary of objectives for hospital and other provider reporting on service and outcome measures.<http://www.docstoc.com/docs/631090/Institute-on-Health-Care-Costs-and-Solutions>

- **“Employment-Based Health Insurance Is Failing: Now What?”** *Health Affairs*, by Alain Enthoven, May 28, 2003
<http://content.healthaffairs.org/cgi/content/full/hlthaff.w3.237v1/DC1>
 - A good summary of by leading proponent of managed competition on why this approach can best work using health exchanges and not employer-based system.