The U.S. Health Care Cost Conundrum
An Economic Analysis of Three Cost-Containment Measures in the Patient Protection and Affordable Care Act

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Abstract

The signing of the Patient Protection and Affordable Care Act (PPACA), on March 23, 2010, marked the beginning of a new chapter in U.S. health care policy. The landmark legislation became the most substantial piece of health reform since Medicare, mandating coverage for nearly all Americans, imposing new regulations on insurers to make insurance more affordable, and promising to reduce health care expenditures within the U.S. health care system. Although there are a myriad number of variables that contribute to the escalation of health care costs, my research focuses on the reform’s cost-containment measures, and examines whether the measures will actually reduce health care expenditures. I identify three major cost-containment initiatives in the reform act: comparative effectiveness research, health information technology, and preventive measures. I then examine the efficacy of these measures by, first, analyzing the projected reduction in health care spending data as researched and calculated by the Congressional Budget Office, Urban Institute, and Robert Wood Foundation and, second, by comparing the breadth of each initiative to the impact of similar cost containment programs in other countries. Based on this two-fold analysis, I argue that while the PPACA’s three cost containment initiatives have proven effective in other countries, their effectiveness in the U.S. is less likely, due largely to the initiatives not being as robust as their foreign counterparts.
Acronyms List
(In order of appearance)

PPACA—Patient Protection and Affordable Care Act
M.D.—Medical Doctor
OECD—Organization for Economic Co-operation and Development
CHIP—Comprehensive Health Insurance Program
HMO—Health Maintenance Organization
CHP—Clinton Health Plan
WHO—World Health Organization
CER—Comparative Effectiveness Research
PCORI—Patient-Centered Outcomes Research Institute
CMS—Centers for Medicare and Medicaid Services
NHS—National Health Service
HIT—Health Information Technology
ACO—Accountable Care Organization
EHR—Electronic Health Record
HITECH—Health Information Technology for Economic and Clinical Health
AQC—Alternative Quality Contract
AHRQ—Agency for Healthcare Research and Quality Center for Primary Care Research
BMI—Body Mass Index
EBRI—Employee Benefit Research Institute
The Cost Conundrum

The signing of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, marked the beginning of a new chapter in U.S. health care policy. The landmark legislation became the most substantial piece of health reform since Medicare: mandating coverage for nearly all Americans, imposing new regulations on insurers to make insurance more affordable, and promising to reduce health care expenditures within the U.S. health care system. Opposition to the legislation was plentiful, to say the least, and the passage provoked bickering between Republicans and Democrats, Republicans and Republicans, and Democrats and Democrats. The contentious debate and the length of time it took to pass the first significant health policy legislation since the 1960s is a testament to how polarizing this topic has become. American citizens desire both choice and affordability in their health care, and my focus throughout this paper is the latter, in particular, how the PPACA affects health care system costs. The failure of U.S. health policy to address health care costs over the past 60 years is a growing concern for policy experts and should be a concern for American taxpayers.

Within the past sixty years, U.S. health policy has failed to adequately address problems associated with costs in the U.S. health care system. Increases in costs are visible in the rising premium payments and drug prices for consumers, and rising prices for what hospitals and doctors charge insurance companies. Some of the failure to address the cost issue can be attributed to political demagoguery, but a large portion of the blame lies in the imbedded flaws within the health care system. Highlighting the shortcomings in U.S. health care can be a taboo subject; in particular, proposing methods that reduce health care expenditures can create a schism between people who want unlimited choice in medical services and people who seek affordability in health services. The reason for this is that in some cases the solutions to
containing costs are often perceived to include rationing care. Rationing is a term that has many
different connotations depending on your perspective on health policy. Some define the term as
considering economic implications along with the effectiveness of the drug, treatment or service;
while others view rationing as withholding needed care from patients and limiting their choices
in order to contain medical costs. No matter how rationing care is viewed, the majority of experts
will agree that one of the inherent problems with the U.S. health care system is that it encourages
patients to explore every possible treatment no matter the cost. Unfortunately, the more
treatments given, the greater the costs incurred by the system. And these costs are felt by
patients, doctors, insurance companies, state governments, the federal government, and other
medical providers. If aggregate costs are to be curbed, cost implications of medical care will
need to be considered. The PPACA puts forth several cost savings methods, but my goal is to
find and uncover the cost saving methods that decrease the costs while not sacrificing (or maybe
even increasing) the quality of medical care.

Some of these methods I will discuss in following paragraphs. But I would also like to
note that the goal of health policy should not be to withhold needed care from patients in order to
lower health expenditures. Instead, finding ways to eliminate wasteful medical spending,
uncovering fraudulent practices, and evaluating marginal benefit treatments that have enormous
ticket prices should be considered in moderating medical costs. A proper policy should exist that
rewards hospitals, doctors, and specialists for keeping patients healthy and providing quality care
at an affordable cost, and this should be the top priority. I will discuss and evaluate the health
measures in the PPACA and other cost-containment initiatives in foreign health systems that
strive to accomplish the policy goal above. But first, a deeper analysis of why health care costs
are rising is needed to support the argument for implementing health policy initiatives that focus on lowering costs.

Through my research and consultation with health care experts at two prominent health care policy institutes, the Center for Bioethics at the University of Minnesota and the Hastings Center in Garrison, New York, three prominent reasons were offered to explain the rise in health care costs: the fragmented fee-for-service structure, the implicit practice of defensive medicine, and the lack of preventive care. In general, the fee-for-service approach has plagued the health care system because doctors are motivated to perform vast amounts of testing and procedures. In Medicare, the federal government run insurance program for the elderly, the fee-for-service incentive is particularly prevalent. Under the incentive structure, the more tests doctors run, the more they can charge the patients, the government, and the insurance companies and the more revenues they are able to receive. Essentially, some doctors are motivated to write scripts, perform tests, and suggest alternatives to patients no matter what the cost. Fee-for-service pervades all systems in the U.S., but is most prevalent in Medicare. In economic terms, some medical providers may view patients as a revenue source because greater amounts of care result in greater amounts of money generated for providers. The fee-for-service structure is criticized as being a contributor to the increase in health care spending such that the Medicare reform in the year-old legislation creates “an advisory board to submit to Congress recommendations to reduce the rate of spending” (Staff of the Washington Post 132). Although the panel has no enforceable power, the recommendations would be based on quality and cost effectiveness, hopefully eliminating some of the fee-for-service practices. But this is part of the problem. If the panel has no enforceable power, doctors will not be mandated to follow these rules, and health care cost reduction will be minimal (Callahan Interview). As you will see, the lack of mandating
guidelines or rules is a common theme in U.S. health policy. Words like “incentivize” or “encouragement” will appear in many cost-containment initiatives, but these words do not have any enforceable power.

Uncovering and identifying different ways the fee-for-service incentive is being used has been a goal for many health policy experts. At the Dartmouth Institute for Health Policy and Clinical Practice, Elliot Fisher, M.D. and Director for the Center of Population Health, and John Wennberg, Professor for the Evaluative Clinical Sciences, have conducted extensive geographical region research and uncovered data that coincidentally strengthens the fee-for-service argument and relates to containing health care costs. Their research indicates that in areas where greater amounts of medical services are offered, i.e., more hospital beds, more medical specialists, more medical technology, the more these medical resources are used and the more money that is spent on patients. According to Dartmouth's 2006 report, “high-cost regions boast 32% more hospital beds, 31% more physicians, 65% more medical specialists, 75% more general internists, and 29% more surgeons than low-cost regions…yet with all of these resources the outcomes are no better” (Mahar 30). The results of their research indicate that the health care system contains waste and is not efficient, and that more care does not mean better care. In an economic perspective, Wennberg and Fisher claim that the supply of care is fueling the demand for more care and a better usage of medical resources is necessary to reduce the costs. I will discuss some of these efficient practices i.e., managed care, health information technologies, comparative effectiveness research, and preventive measures in the following sections.

Tangentially related to the fee-for-service structure is another component of U.S. health care that adds to the cost of receiving care. This component is the market-oriented setup of the health system. As I will explain later, a health care system driven by deregulation and
privatization is not cost-effective. The market-oriented approach breeds consumer choice, and technological innovation, but also facilitates wasteful spending. Attempts at using market forces to manage health care costs have proven ineffective time and time again. In the 1980s, there was a movement towards for-profit hospitals and for-profit insurance companies in order to provide capitalistic competition. And as of late, a push by free market enthusiasts has been consumer-driven care. Consumer-driven care seeks to give the consumer more autonomy in their insurance plan purchasing, by enabling the consumer to shop for their most appropriate coverage policy. The problem with these market-oriented proposals is the lack of consumer knowledge, lack of familiarity, and the complexity of insurance policies. I breakdown the economics of why health care does not function like a normal good later, but it is important to elucidate some of these market proposals to show how difficult it is to find a solution to the problem.

A second explanation of what leads to large amounts of health care spending is the practice of defensive medicine. Doctors practice defensive medicine in order to prevent any mistakes or misjudgments on their part that may lead to a malpractice suit. In the minds of doctors, politicians, and the media, malpractice suits and malpractice insurance are a severe financial burden on the health care system. In the previous health care reform debates, tort reform was a focal point for arguments among those in Congress. Much debate surrounds the degree to which malpractice insurance and malpractice lawsuits affect health care expenditures. Some research indicates malpractice lawsuits to be a trivial part of health care costs. Dr. Steven Miles, a physician and faculty member at the Center for Bioethics at the University of Minnesota claims that “defending malpractice insurance claims accounts for 2-6% of health care spending or .46% per person;” nonetheless, doctors may possess a sub-conscious fear that guide them to order more tests (Anderson et al 903). So while malpractice and defensive medicine receive a
large amount of attention from doctors, politicians, and the media, studies like the one Miles cites indicate otherwise.

Even if this is the case, the study completed by the Organization for Economic Co-Operation and Development (OECD), an international non-governmental organization, does not measure what intrinsically is motivating doctors to run these tests. Anecdotally, doctors may have the thought of malpractice in the back, if not in the front, of their minds. Although it is nearly impossible for a study to capture a doctor’s implicit motives for running tests, if doctors are constantly being told that malpractice law suits are a large part of health care spending (true or false), the thought of how they can best protect themselves from a lawsuit may weigh heavily on their minds.

Finally, preventive measures in the United States are less substantial in comparison to other countries. These include less frequent visits to the doctor’s office, more skipped treatments, and failures to fill prescriptions when sick. In the subsequent paragraphs, I expand on the topic of preventive measures, and introduce it as one of three ways the PPACA and other countries try to reduce costs. But for right now, it is important to note that the United State’s health care system does not provide adequate preventive care and also note that there are competing opinions as to whether preventive measures actually reduce costs. In order to add some historical context to the health care cost issue, a brief overview of legislation of American health policy since World War II clarifies why the U.S. health care system is structured the way it is.

The end of WWII marked the beginning of the health care battle. Market advocates drew their lines and proponents of tighter health care regulation settled in for what would be 60 years of quarrelsome, and at times acrimonious, health policy debates. Daniel Callahan, Senior Research Scholar at the Hastings Center, and Colin Gordon, Professor of History at the
University of Iowa, wrote two books, *Medicine and the Markets* and *Dead on Arrival*, that offer a timeline of significant health policy events that shaped the U.S. health care system. From the years after World War II and beyond, the U.S. government took on a bigger role in health care policy. President Roosevelt’s administration’s passage of Social Security set a precedent for government influence on social issues, and in 1947, the Truman administration passed the Hill-Burton Act which subsidized, and therefore, encouraged the construction of hospitals. The act was a response to the rise in employee-based health insurance, and President Truman wanted to provide more hospitals for the increased number of people insured.

The 1950s marked the end of most infectious diseases, but since that time chronic diseases have plagued people’s lives and been a financial drain on the U.S. health system. The 1950s and 1960s saw a period of increasing government stimulus to nonprofit and for-profit hospitals. President Eisenhower was opposed to any socialization (a larger role for government) of medicine, and encouraged the continuation of private health insurance as a remedy for the rising health care costs. The closest the Eisenhower administration got to government intervention in health care policy was proposing reinsurance plans. Reinsurance was meant to insure the insurers and encourage insurance companies to cover more risky patients. Reinsurance failed to catch on because insurance companies saw the government insurance as too expensive and the extra costs of paying for the reinsurance would be passed down to the insured in the form of increased premiums. In 1958 and 1959, other alternatives were suggested, e.g., tax deductions for medical expenses, subsidies for private insurers, etc. But none of the alternatives addressed the issue of expanding coverage, and as a result, these alternatives failed to gain steam.
The most monumental health policy accomplishment occurred in 1965 when Congress passed the Medicare and Medicaid Act during the presidency of Lyndon B. Johnson, which created government-run health insurance for the elderly, Medicare, and the government-run insurance for the impoverished, Medicaid. It was labeled the “three-layer cake” because it consisted of Medicare Part A (hospital insurance for the elderly), Medicare Part B (medical insurance for the elderly), and Medicaid (federal and state government subsidized insurance for the poor). In order to qualify for Medicare, citizens of the U.S. have to be of age 65, or under 65 with certain disabilities. Qualifying for Medicaid depends on states’ laws, but usually some combination of income, age, and disabilities determines Medicaid coverage. (Medicare General Information Overview).

The combination of coverage for the elderly, with the removal of risky people (older people who require more medical care) from insurance pools, helped Medicare and Medicaid Act win support from liberals, who favored the programs because they provided more citizens with coverage. Republicans were left fairly satisfied because it freed up insurance markets and allowed private insurance providers to choose from younger individuals. Although the Act brought coverage to fragments of the population (65 and older and the impoverished), the policy drastically added to the deficit and would later intensify the rise of inflationary pressures. It was during this time that the country was starting to take notice of the rising costs associated with health care.

In the 1970s, under President Richard Nixon, health reformers were torn between expanding coverage to all individuals or reigning in costs associated with health care. By trying to accomplish both of those goals, they came up with proposals to enact universal coverage, expand Medicare or Medicaid, mandate employment-based insurance, issue insurance vouchers,
and subsidize private insurance. What came out of all of these proposals was nothing more than a watered down expansion of insurance coverage called the Comprehensive Health Insurance Program (CHIP), which included a weak employer mandate and subsidized private insurance. This was the closest the country had ever come to reaching universal coverage.

But the most noteworthy accomplishment under the Nixon administration was their encouragement of Health Maintenance Organizations (HMOs). HMOs were celebrated as a solution to the rising health care cost problem. The HMO is a “managed care” network whose intent is to bring professionals and specialists under one roof, thereby streamlining costs and increasing efficiency. As a patient under “managed care,” all treatments, doctor’s visits, and hospital stays are accomplished under the umbrella of the single managed care provider. And specific guidelines, with an emphasis on cost control, regarding treatments and doctors visits, are followed by the health care provider. Initially, HMOs were considered a cure for the rise in health care costs, but at the same time, they were criticized for withholding care from patients and using exclusionary practices to “cherry pick” healthy patients. “Cherry picking” is a strategy used by insurance companies to choose the healthiest patients to insure in order to reduce the risks of paying out claims. Because an HMO was a network of health providers, financially it made the most sense to choose less risky or healthier patients to join the health maintenance organization. Many blamed HMOs for rationing care and preventing patients from seeking any and all medical treatments necessary.

As the HMO period stagnated, as a result of more people opting for traditional private insurance, President Regan in the U.S. and Margret Thatcher in the U.K. entered the 1980s with a new goal to privatize the economy even more, including in President Regan’s case, health care. The 1980s was slow period for health policy issues and very few of the proposals targeted the
The 1980s was a time of privatization of healthcare and an increase of for-profit insurers. This market-oriented approach tried to reduce expenses by using inherent market functions and increasing competition. Throughout the 1980s, health care inflation grew unabated. In fact, “between 1966 and 1990 per capita health spending (in 1990 dollars) ballooned from $700 to $2500, and national spending nearly doubled its share of net national product” (Gordon 38). During this period of increasing health care costs, Colin Gordon points out that “the central problem was the persistence of a fragmentary system that deferred health policy to private interests and squandered a quarter of its resources on the administrative task of sorting the insured from the uninsured” (Gordon 29). As health outcomes gradually worsened and expenditures increased, Republicans and Democrats turned back to HMOs to solve the problems of both rising costs and the lack of quality care.

Enter President Clinton and the Clinton Health Plan (CHP). The CHP sought to rein in costs while expanding coverage to millions of Americans by using managed care systems. The CHP’s central tenets included an employer mandate which would require employers to offer insurance to their employees, regional insurance purchasing cooperatives which sought to offer competitive plans for the employers to choose from, and global spending caps. But the proposal failed as a result of the contradictory elements within its initiatives: proposing an employer mandate appealed to insurance companies and medical providers because they would be receiving millions of more customers, but was opposed by employers because of the added cost of providing health insurance; cost control and regulation attracted employers because of the intended savings, but was objected to by health providers and drug companies for the reason that more regulation would mean less profitability. In the end the bill failed partially because it was
exclusively crafted by the White House and the Clinton Administration rather than giving the responsibility to Congress where more bi-partisan support might have been a possibility.

President Obama may have learned from President Clinton’s mistake when he delegated responsibility of the PPACA to Congress. President Obama hoped that passing responsibility to Congress would help gain bi-partisan support, but we soon found out that the legislation was mainly supported by Democrats. As a result, the life of the PPACA remains in question to this day as the Republicans gained majority in the House of Representatives in the November 2010 elections. Nevertheless, President Obama learned from President Clinton’s mistake and got health care reform passed.

In the 1990s, health costs were escalating to new levels and the expansion of managed care providers sought to control costs by rationing care. More emphasis was placed on controlling costs associated with Medicare and Medicaid, yet the piecemeal and fragmented health care system continued to hike up health care cost and decrease quality of care, as a result of the extremely high administrative costs associated with a multi-payer health systems. The American people were receiving less care than before but spending more money. The 2000s experienced severe rises in health care costs and presently health care exceeds over 18 percent of U.S. GDP (Staff of the Washington Post 64). President George W. Bush added his imprint to the national deficit by pushing Congress to pass Medicare Part D, and there were no provisions for funding Part D in the legislation. The addition of Medicare Part D added more drug coverage to Medicare beneficiaries but created the infamous “doughnut hole” where some beneficiaries were caught between spending thresholds and were forced to pay exorbitant amounts of money out of pocket.
As health care costs and the amount of uninsured U.S. citizens continued to rise in the first decade of the twenty-first century, health care reform was once again at the top of the agenda for the Democratic controlled Congress and the newly elected Democratic president Barack Obama. An arduous year and half of heated health care debates, filed with compromises, concessions, and false propaganda, finally concluded on March 23, 2010 with the passing of the Patient Protection and Affordable Care Act. This most recent and extensive health reform act extends coverage to millions of more Americans, over the course of six years, and attempts to cut back on frivolous health care spending. The legislation looks to integrate more than 32 million out of the 45 million uninsured over the course of 6 years and reduce the growth rate of health spending in conjunction with the national deficit (Staff of the Washington Post 65). Whether or not these goals are feasible (especially reducing health care costs) remains a legitimate question. In the subsequent paragraphs, I will dissect some the unique features of the legislation and uncover the cost saving measures that were created to reduce costs. But first, I will further explain why the U.S. health care system needs reform and illustrate the degree to which the U.S. health care system is floundering.

**Why Do Health Policy Issues Matter?**

Issues pertaining to health policy are pervasive because they affect everyone at some time or another. As the population ages in the U.S. and other parts of the world, older citizens, who spend the most money on medical care, are becoming a greater portion of the population. So logically, the older the population becomes, the greater the amount of medical care that will be needed to address their health concerns. With the increase in care, more financing will be needed to cover the increasing number of patients. As the government debt to GDP ratio approaches 1 to
1, and with Medicare and Medicaid being the top two government expenditures, reductions in medical spending will play a pivotal role in balancing the national budget.

For the amount of money spent on health care, the U.S. is not able to boast astounding positive health statistics. Evidence of this lies in the World Health Organization’s (WHO) health rankings. When the World Health Organization rated the national health care systems of “191 countries in terms of ‘fairness’ and [financing], the United States ranked fifty-fourth. That put the U.S. slightly ahead of Rwanda, but just behind Bangladesh” (Reid 30). Another shocking statistic is that the U.S. has the highest infant mortality rate and one of the lowest life expectancies among developed nations (Life Expectancy and Infant Mortality OECD). The fact of matter is the U.S. pays more for health care and receives less quality care. And just as disturbing is how health care has evolved into being able to keep people alive for long periods of time, but not being able to cure or prevent illnesses at an early age.

The search for cost containment without reducing quality care is the conundrum for current healthy policy experts to solve. For health economists, cost containment has been illusive because of the unique economic qualities of health care. Kenneth Arrow, in his 1963 article, “Uncertainty and the Welfare Economics of Medical Care,” argues that health care takes on special characteristics that differentiate it from other commodities (Arrow 948). One of those characteristics is the nature of its demand. Demand for medical care is unpredictable on a case-by-case basis. That is, people get ill at unpredictable times and are in search of a remedy as fast as possible. Consumers don’t have the time to research medical information when they get sick; yet even when consumers choose insurance plans, the complexity of the plans is overwhelming. The transparency between consumers and health care markets is cloudy at best. Consumers do not know how much each procedure costs, or how much each drug costs; they leave it up to the
insurers to handle the economics of the doctor-patient relationship. The consumer’s desire is quality care, not affordable care. As Daniel Callahan puts it, “you often cannot well compete for customers by offering fewer desired services or amenities in a market such as health care, where people want better not worse care.” (Callahan, Medicine and the Markets 50).

Generally, a typical good or product would see reductions in costs when technological advances occur within the industry, but quite the opposite has occurred in health care. Technological advances have led to an increase in costs because the advances in technology have not been met with increases in cured illnesses, increases in prevention, or increases in quality of care. Technology has done a great job at keeping people alive but not curing them. As strange as that may sound, it is true. The cost of treating the five most costly conditions “increased from $227 billion in 2000 to $311 billion in 2004,” proving that as a nation, technology is not reducing costs. (Callahan, Taming the Beloved Beast 22). The health care market’s unique qualities make it unsuitable to act as a typical commodity. The demand from consumers is for higher quality care, but for unlimited options when it comes to health care. With the lack of transparency and the complex structure of the system, the cost for health care will continue to rise.

Now that the health care cost issue has been framed, I turn to three crucial cost-containment measures that are addressed in the PPACA and that have been adopted by other countries, and which have for the most part been successful: comparative effectiveness research, prevention, and health information technologies. A large amount of global research has been poured into these initiatives, and some form of these three measures is highlighted in the PPACA. The following is an evaluation of these and their implications on health care costs.
Comparative Effectiveness Research

Within our current health care system, comparative effectiveness research studies (CER) play a very minor role in medical spending decisions. Initially, the scope of CER studies was not to reduce medical costs, but rather to provide evidence of a drug’s or treatment’s effectiveness. The emphasis of these studies was placed on quality, not cost-effectiveness. CER studies original aim was at providing the “current best evidence in making decisions about the care of individual patients” (Callahan, *Taming the Beloved Beast* 59). But with health care costs continuing to rise, CER studies are being used for a different reason: curbing health care costs. Peter Ubel, Professor of Marketing and Public Policy at Duke University, indicates that the purpose of the scientific research conducted for these studies is to provide “information on the relative effectiveness of common medical interventions, so that government payers, insurance companies, doctors and, patients can spend their health care dollars more wisely” (Ubel 1). Advocates for this scientific research would like to see CER have an expanded role in doctor’s decision-making, possibly creating guidelines that doctors are mandated to follow. This new vision proposed for CER studies stems from years of superfluous and wasteful spending on the part of patients, doctors, and insurance companies.

Most health policy experts, doctors, and insurance companies support the research studies because “it provides decision makers with information...on how [they] can spend their health care dollars more wisely” (Ubel 1). Disagreements arise on how these studies should be applied. Peter Ubel identifies two purposes of CER: one “[to] evaluate the cost effectiveness of competing treatments” and “to estimate the relative impact that alternative treatments have on people’s quality and quantity of life (Ubel 2). The former use of CER incites the fear of rationing care in the minds of some health policy experts and the public-at-large.
During the passing of the health care reform legislation, policy experts offering alternatives to a market-oriented system, or health care economists criticizing the system for wasteful spending, were labeled as “rationists,” or attempting to withhold care from patients. Opponents of CER argue that restricting patient choice by discrediting some treatments because of their expense is a step toward socialized health care. This argument is similar to the one opponents use to attack managed care health systems. Pure market-oriented health care advocates galvanize support against new health care initiatives by calling them “rationed care.” Critics of CER arouse support by declaring CER studies a “threat to innovation” and a “threat to saving lives.” (Callahan, The Fine Line Between Waste and Marginal Benefits 8). On the other hand, supporters of CER studies attest to the cost-saving measures these studies provide, by effectively reducing how much money is spent on treatments and drugs that are not as efficacious.

CER studies were condemned for not allowing patients and doctor’s greater choice when it came to end-of-life care. The anecdote used to gather opposition support often cites a patient, ill with cancer, not having the ability to experiment with all possible treatments. Daniel Callahan believes opponents of CER studies do not believe medical decisions should be based on scientific research but rather doctor’s clinical experience. In an ideal world, doctors should base their decisions off of both scientific research and experience, but the fee-for-service incentive and defensive medicine practices creep into some doctor’s decision-making. Callahan points to the subjectivity of “marginal benefits” as a way of analyzing what types of treatments, drugs, and other medical technologies should be used on patients (Callahan, The Fine Line Between Waste and Marginal Benefits 7). Marginal benefits are difficult to quantify because for each individual person, what counts as a marginal benefit is different, which is why a combination of scientific
research and doctors’ intuitions should be used to make the decision for the patient. Here is an example; consider the cancer drug Erbitux. It costs $80,000 per year to administer (the cost is charged mostly to the patient’s insurance), but the result is 1.2 months of additional survival time. Is the marginal benefit of 1.2 months worth the cost of $80,000 to the health care system, and who should decide this?

Within the current health care system, the answer to the first question is most likely yes; the marginal benefit of living 1.2 months longer is worth the cost of 80,000. And the answer to the second question is the patient and the doctors are the ones who should decide. The current market-oriented health care system enables patient’s unlimited choice when it comes to medical testing and prescription drugs. As briefly stated in the introduction, unlimited patient choice is also fueled by the fee-for-service structure that influences doctor’s decision-making. If a patient wants a treatment or test administered, the doctor is encouraged to acquiesce to the patient’s request because the doctor receives reimbursements from running tests. The doctor is also able to protect him or herself from malpractice lawsuits by running more tests and is therefore able to please the patient. Unless the doctor firmly believes that the tests should not be administered, the incentive exists for the doctor to appease the patient. Moreover, there are no enforceable guidelines for doctors to follow in cases where the patient is seeking marginal benefits from a treatment or drug. Much more is needed in this gray area of decision-making and the Affordable Care Act mildly addresses this issue.

In the Patient Protection and Affordable Care Act, CER studies have a limited role in cost-reduction. The law creates a Patient-Centered Outcomes Research Institute (PCORI) to underwrite comparative effectiveness research (Staff of the Washington Post 236). The PCORI is a “non-profit organization [functioning] to assist patients, clinicians, purchasers, and policy-
makers in making informed health decisions by carrying out research projects that provide quality, relevant evidence on how diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed” (PCORI).

However, the institute cannot mandate any changes in pharmaceutical selections or treatment preferences. All the group can do is comment on the efficacy and cost-effectiveness of a drug, treatment, or procedure. The PPACA states that any “findings from comparative effectiveness research may not be construed as mandates, guidelines, or recommendations for payment, coverage or treatment or used to deny coverage” (Side By Side Comparison of Major Health Care Proposals 27). A study on the cost effectiveness of the Affordable Care Act, by the Centers for Medicare and Medicaid Services (CMS), concludes that “the magnitude of the potential savings varies widely depending upon the scope and influence of comparative effectiveness efforts” (Foster 13). The CMS study finds that if the CER is “consistent with a low degree of influence” assumption for health related decisions, the federal deficit will see a “$4 billion” reduction from 2010-2019 (Foster 13). Again, much of this prediction is conjecture because without any binding resolutions from the Research Institute, all guideline changes will have to be passed through Congress. And having guideline changes pass through Congress will greatly decrease the power, jurisdiction, cost-saving ability of the Institute.

**Prevention**

There is an old sports cliché that says the best offense is a good defense. In terms of health and medicine, does this same cliché hold true? Does an ounce of prevention exponentially benefit each person? More importantly, do preventive measures reduce the costs associated with
treating avoidable illness and diseases? The notion that preventive medicine decreases medical expenses faces debate among health policy experts.

Preventive medicine, the practice of preventing illnesses and diseases instead of treating them when they occur, is scrutinized because some researchers believe that the added costs (more tests, more doctors’ visits, more immunizations) increase health care spending. Doctors Joshua T. Cohen, Peter J. Neumann, and Milton C. Weinstein, point to studies that conclude that “preventing illness can in some cases save money, but in other cases add to health care costs” (Cohen et al 601-603). This point can easily be overlooked when thinking of prevention as a cost-saver in the long run. Logically, preventive measures should decrease medical spending in the long run by fostering healthier lifestyles, empowering patients to visit their primary care doctors, and even dissuading people from leading unhealthy lifestyles. A built-in incentive structure created by the Patient Protection and Affordable Care Act is designed to fulfill these needs.

One carrot and stick method used by some employers to motivate their employees to stay healthy is pegging employee’s premiums to their health status. Under section 2795 of the PPACA, the government grants explicit power to employers to use health related tests in determining the premium for each employee. Before the legislation was passed, employers were restricted from increasing or decreasing an employee’s premium by more than 20 percent. After passage, the new ceiling is 30 percent and will rise to 50 percent in 2014. (H.R. 3590-Patient Protection and Affordable Care Act). Of course there is a darker side to this incentive structure. Companies may abuse the premium requirement by using health tests to raise premiums, which is the opposite intention Congress had in mind. So long as companies use this method as a carrot
and reduce premiums for healthy individuals instead of increasing premiums for unhealthy employees, this may create an even greater incentive to stay healthy and seek out primary care.

Another expanded incentive structure designed by Congress to ward off expensive just-in-time care is Medicare’s preventive services programs. Medicare recipients will be relieved of co-payments for annual physicals, testing related to cancer, cholesterol, bone density, diabetes and other medical issues. Similarly, the UK and their National HealthCare System (NHS) take a similar approach but go a step further; they prohibit insurers from charging co-payments for primary care visits. (Reid 112). The intended consequence is to encourage citizens to visit their primary care physician when they have an ailment, illness, or other symptoms; frequent visits will hopefully thwart off visits from patients when the illness has progressed into something more severe, consequently needing more extensive and expensive treatments to cure the problem.

Dr. Steven Miles contends that the lack of prevention with the U.S. health care system is the leading contributor to the increases in health care spending. According to Dr. Miles, Americans’ low number of visits to their primary care doctor is at the heart of the problem. Whether the small number visits is a result of primary care doctors being too expensive, patients being uninsured or underinsured, people living hectic busy lives, patients living in a geographical regions where doctors are scarce, or the patient’s inability to get an appointment in the immediate future is unclear. But what the data does suggest is that prescriptions are not being filled, visits to the doctor when sick are declining, and treatments are being skipped (Miles Interview). All of these point to a lack of primary care. No doubt the high cost, in the form of co-pays and deductibles, deter patients from seeking out the primary care physicians. However, Dr Miles believes that the emphasis should not be on what causes these primary care barriers, but
rather what can be done to remove them. Other studies suggest that the problem emanates from
the lack of primary physicians. The Commonwealth Fund International found that only “80
percent of U.S. citizens” have a regular doctor that they visit. (Miles Interview). Part of this
problem is from being uninsured or being underinsured, but some of it is a result of a decrease in
primary care physicians. The Dartmouth studies show, as mentioned earlier, disproportioned
amounts of care through geographical regions. The proximity of physicians to patients varies
from region to region. The Affordable Care Act includes several provisions that encourage
medical students to become primary care physicians. First, the law “increases Medicare
reimbursements for ‘evaluations’ and ‘management’ services, it provides loan-forgiveness
incentives to medical school graduates who practice primary care in underserved areas, and it
distributes hospital residency slots to programs that produce primary-care doctors” (Staff of the
Washington Post 138-139). If these incentives prove successful, a rise in primary care doctors
may result in increases in preventive medicine, and therefore, better health.

Health Information Technology

So far I have addressed the importance of comparative effectiveness research and
preventive care in reducing health care cost, but other areas, in particular health system
infrastructure, is being targeted as a cost saving area. Over the last decade, new improvements in
health technology systems were thought to be the panacea for rising health care costs. Both the
American Reinvestment and Recovery Act, and the Patient Protection Affordable Care Act,
propose improvements in health information technologies (HIT), and I will examine these
upgrades in the following paragraphs. But first, I want to demonstrate the upside HIT
improvements have on reducing costs and improving care by studying some global health care systems.

Internationally, several countries have effectively implemented high tech systems into their health care infrastructure, and one such country is France. The French health care system has their version of an electronic health record (EHR). Each citizen above the age of 15 is required to carry a green plastic credit card called carte vitale, or card of life. This card contains medical records including all imaging, testing, treatments, and drug prescriptions along with entries as to how much the doctor, patient, and insurance company have been billed for each of those visits or procedures. This innovative medical technology helps the French control costs in two ways: first, it centralizes a patient’s medical history, mitigating redundancy errors and illegible writing errors; and second, the card provides an automated system of payment that drastically cuts down on administrative errors. “The expensive layer of administrative workers and paper handlers found in every corner of American medicine doesn’t exist in France. (Reid 59.) All of the administrative charges tagged on to the U.S. insurance system costs a significant amount of money. From the billing of medical providers, to denying claims and issuing statements of payments, the fragmented health care system inherently costs the patients and the insured more to maintain. The automated system in France “makes French hospitals, public and private, easier to run” (Reid 59).

The reason upgrading health systems have failed to gain momentum in the U.S. is attributed to the expensive implementation costs associated with health technology. As with any new infrastructure, there is an initial capital investment required and then a cost associated with maintaining the systems. The problem with installing new medical information technology is that the U.S. health care system is so complicated and intertwined. Doctors and other medical
professionals would have an arduous time connecting insurance companies to medical care networks, to hospitals, and incorporating Medicare and Medicaid patients. Part of the implementation cost is managing new technology systems and paying new employees to transfer medical records and update the new systems. In particular, paying new employees to update systems would be very costly for small medical practices. With “46 percent of clinicians working in practices of one to three doctors and…less than 20 percent in practices of more than 11 doctors,” hiring more employees to manage their new systems may be financially imprudent. (Staff of the Washington Post 142). But on other hand, adding new systems could be seen as a job creator (although costly at some levels), requiring new labor to setup and manage the new health systems.

Additionally, the new systems are forcing doctors to consolidate and form larger practices, and the transition from smaller practices to larger ones is facilitating in the creation of accountable care networks. Accountable care organizations (ACO) are a one stop shop; they are a network consisting of doctors and hospitals that all share responsibility for the patients’ health. Many components are included in the network of care created by ACOs, e.g., specialists, primary care physicians, and home care. ACOs are thought to coordinate care more efficiently and streamline costs. In subsequent paragraphs, PPACA’s implementation of accountable care organizations will be explained more in depth.

One way health care technology can improve patient care and potentially reduce costs is through the use of electronic health records. Incentives for EHR implementation were created by the American Recovery and Reinvestment Act and the PPACA. President Obama’s stimulus included a 1.1 billion dollar budget item for HIT which included the creation of the “Health Information Technology for Economic and Clinical Health (HITECH) Act,” which establishes a
framework for HIT, and includes provisions that amend Medicare and Medicaid “to incentivize qualifying health care professionals to become meaningful users of certified (EHR) technology.” (Burke et al 26). The financial incentives created under the Recovery Act “consist of bonus Medicare payments for up to five years, followed by Medicare penalties for providers who fail to become meaningful EHR user[s]” (Burke et al 26). The new legislation establishes the Center to Research Health Care Quality Practices which will expand HIT projects and look to improve the use of HIT. It also subsidizes the use of HIT in very minor ways. The result is a diluted version of health information technologies that assumes doctors will implement EHR and other technologies because of the benefits they provide.

The benefits of EHR are very important in providing quality health care. Electronic health records can decrease medical errors, increase preventive measures, and decrease paperwork, all of which can increase the quality of care and/or decrease overhead costs. Daniel Callahan describes three ways in which HIT can improve patient care and decrease the costs associated with health care. These three ways include “reducing potential adverse reactions to pharmaceuticals, reducing hospital visits, and scanning of patients records for needed preventive efforts” (Callahan, Taming the Beloved Beast 60). A more recent study on HIT demonstrates how “electronically generated data can support multiple policy initiatives, including performance feedback to clinicians and providers, enabling consumers to make informed choices about where to seek care, and policies…to improve outcomes while lowering costs.” (Roski et al 59). All these benefits of HIT sound promising, but without quantitative evidence, support for HIT wavers. In order to capture quantitative data explaining the effectiveness of HIT applications, a 2005 study by the Rand Institute estimated the total HIT savings on overall health spending. The study concluded that “if 90% of doctors and hospitals adopted and used IT well, the savings
could come to $77 billion a year, with an additional $4 billion saved in prescription errors.” (Rand Corporation). This study demonstrated that proper adoption can reduce medical spending, but the key to the reduction is in implementation. As of 2009, “20.5 percent of physicians have adopted EHR, and 2.7 percent of hospitals adopted comprehensive EHR” (Miralles and DesRoches 12). The U.S. is still a ways off from the 90 percent adoption goal, and until that threshold is reached, the effectiveness of HIT will be hindered.

To encourage implementations, both the PPACA and American Recovery and Reinvestment Act put in place an incentive structure, and in some cases subsidized the use of HIT. The PPACA put into place “penalties for doctors who don’t report [quality related measures]” (Staff of the Washington Post 142). Particularly in Medicaid, if physicians, medical providers, or hospitals fail to adopt EHR measures, they may be subject to reduced reimbursement rates starting in 2015. This gives practices and hospitals four years to adopt new information systems. The main impact of health technology in the new law is felt by Medicare and Medicaid. New program initiatives follow closely many of the cost-saving and quality factors Daniel Callahan and other studies have endorsed. These include financial incentives for “accountable provider groups that assume responsibility for the continuum of a patient’s care, pay-for-performance incentives for Medicare providers, and profiling medical care providers on the basis of cost and quality, making that data available to consumers and insurance plans, and providing relatively low-quality, high-cost providers with financial incentives to improve their care” (Cutler et al 4). Although many other HIT initiatives exist, I would like to focus on accountable care organizations in the paragraphs to follow.

As mentioned earlier, one integral part of health technologies resides in accountable care organizations. ACOs streamline medical care by creating better coordination between doctors,
hospitals, and providers. Better coordination occurs as a result of these three entities grouping together and sharing the responsibility of bettering the patient’s health. Sally Pipes, author of *The Truth about Obamacare*, says that in order to combat the fee-for-service structure, where providers make more money when they provide more care, ACOs were created to give less money to the providers the more care they provide (Pipes 1). More formally, ACOs are thought to reduce volume-based rewards (fee-for-service) and increase value-based rewards (savings if patients are kept healthy). The purpose of ACOs is to reduce the unnecessary readmissions into hospitals and extraneous doctor’s visits. A study by the Center for Studying Health System Change published a report that found “20 percent of Medicare beneficiaries discharged from the hospitals were readmitted within 30 days” (Staff of the Washington Post 141). Half of those patients were discharged in shaky health conditions, or they were taking new higher dosed medications and did not visit a doctor during the 30 day period. In some cases, Medicare patients are rushed out of the hospitals because the reimbursements from the government are less than what hospitals could receive from privately insured patients. To eliminate some of these readmissions hospitals, physicians, and other professionals could join together and form an integrated medical service which would lessen costs through the streamlined service.

The health reform act also helps facilitate ACO creations by establishing “a Center for Medicare and Medicaid Innovation [that] provides incentives for doctors, other professionals, hospitals, clinics, imaging centers, diagnostic labs etc., to band together into accountable care organizations” (Staff of the Washington Post 141). The thought is that if Medicare gives these banded groups bundled payments, that is a lump sum payment per patient, the ACOs will be motivated to keep patients healthy and out of the hospitals. It is in the best interest of the ACOs to keep patients from being readmitted because they will not be compensated by Medicare if a
patient is readmitted, under the new legislation. Consequently, the ACO will pocket the extra savings that Medicare paid them, that is, if they keep patients healthy and out of the emergency room. In order to encourage the formation of these ACOs, the PPACA includes a provision stating that if the ACOs “achieve savings (that is if ACOs retain some of their bundled payment) greater than the annual minimal savings level established by the State… [they] shall receive an incentive payment of the amount of such excess savings” (H.R. 3590 Patient Protection and Affordable Care Act). Ultimately, the ACO structure works based on incentives and it promotes efficiency by rewarding quality care. The Congressional Budget Office (CBO) estimates have shown ACOs to save Medicare 4.9 billion dollars, and if successful, ACOs could expand to other private insurer networks. (Gold 1).

Steve Pearlstein of The Washington Post outlines the positive view of ACOs when he says, “the best way to deliver affordable quality care is through organizations such as the Mayo Clinic, which coordinates physicians and hospital services under one roof…and these organizations tend to rely on salaried doctors, extensive use of electronic medical records, and evidence based research” (Pearlstein 1). The effect of ACOs can be enhanced through the use of CER and the EHR. This demonstrates the synergistic savings power of these three programs on the health care system.

The effect that HIT programs, specifically ACOs, have on medical savings depends on how aggressively they are pursued and enforced. The Office of Actuary estimates only “2 billion in savings” while David Cutler, Professor of Applied Economics at Harvard University, and Melissa Beeuwkes-Butin, Senior Health Economist at Rand Health, predict that if a more aggressive approach is taken towards implementing and monitoring health technology modernizations, more than “$700 billion in a 10-year window could be saved” through the
reform’s measures (Cutler et al 4). The savings calculated by Beeuwkes-Butin and Cutler would occur through reducing administrative expenses from providers as “electronic medical records, and incentives to use them appropriately, are widely disseminated” (Cutler et al 4). Additional savings could be had by “preventing certain illnesses from recurring through better coordination of care and by rationalizing what is done when a person becomes sick by bundling payments… and sharing savings with accountable provider organizations” (Cutler et al 4).

A good example of ACO implementation lies within the state of Massachusetts’s newly modified health care system, or what many call “Romneycare.” Romneycare, named after the state’s former Republican governor Mitt Romney, has been the blueprint for the PPACA, as the state put into place similar health provisions that were included in the PPACA. Washington is keeping a curious eye on how Massachusetts adjusts to similar cost-savings measures, including ACOs. Recently, Massachusetts has created a pilot project called Alternative Quality Contract (AQC). This project is similar to an accountable care organization with the “global budgeting and financial performance incentives it has in place” (Gillick 1). The ACOs are near replicas of HMOs except for the added financial performance incentives.

The results of the pilot program show impressive improvements in quality of care and cost. In the area of quality, “the AQC participants showed improvement in both the ambulatory and hospital settings in preventive services and management of chronic diseases….and in the area of cost the groups are on target to achieve their goal of reducing by more than half the rate of rise of health care costs in five years” (Gillick 2). The accountable care organization has been effective in both of those areas but having more states adopt these organizations will be tough in an economic environment where budget cuts are next on the state and federal government’s docket.
Just like most new initiatives, opponents who resist the implementation of ACOs raise legitimate concerns. One concern is that to establish ACOs, hospitals and doctors have to consolidate their practices. By combining practices with other medical care providers, more market share is given to these ACOs and this trend of consolidation is already occurring with hospitals buying physician practices. Unfortunately, less competition will remain for doctors, hospitals, and other health care providers. On one hand, more market share is a benefit to patients because a conglomerate of medical services can negotiate better prices for their recipients. But on the other hand, a consolidation of power may lead to less competition and possibly higher costs, which many market proponents oppose. Opponents contend that “little evidence exists that hospital organizations would voluntarily pass those savings on in the form of lower premiums” (Pearlstein 2). Moreover, the format of ACOs resembles health maintenance organizations of the 1970s and 1990s, the only difference being that ACOs provide performance incentives for the providers. Whether there is enough incentive for these organizations to form and whether they can be effective at reducing costs remains uncertain. Yet, the PPACA and other health policy experts are placing a lot faith in these organizations.

Electronic health records and accountable care organizations are two of the many ways health information technologies can reduce costs and increase the quality of care. Another upcoming application of HIT is a data collection system that gathers regional data and then analyzes that data to determine various health indicators. If this data collection system comes to fruition, medical technicians could import the data into electronic health records. The collection of data could be analyzed to determine demographic health data, including which populations are at risk the most. Thus, the data gives our health system more accurate information than gathering the data from surveys. The hope is that one day EHR will evolve so clinical information,
patient-reported data, performance indicators, and the population’s health can be accurately collected and analyzed. According to Hellen Burstin, Director of the Agency for Healthcare Research and Quality Center for Primary Care Research (AHRQ), and John Eisenberg, Director of the AHRQ, a practical use of EHR would be “the calculation of BMI (body mass index) or cardiac risk assessments” (Burstin et al 70 -76). If HIT possessed those capabilities, it could build in “trigger alerts and activate guidelines to enable providers with the right information, at the right time, for the right patient” (Burstin et al 78) All of the applications mentioned are feasible but would require more labor, capital, collaboration, and cooperation between hospitals, doctors, insurance providers and the government. The capabilities could possibly be accomplished with paper records, but HIT adoption of data collection and EHR would drastically cut down time and thereby prevent later, more costly diagnoses.

The compounding benefits of each of the three cost-saving factors (CER, Prevention, and HIT) are a boon to the health care system as a whole. Another study of HIT by Robert Wood Johnson Foundation describes an additional synergy created by implementing both HIT and effectiveness research. By developing data collection systems “that are aligned with policy goals such as comparative effectiveness,…affords additional opportunities to reduce the overall burden and administrative costs by…efficiently collecting data once and using it multiple times to support multiple purposes” (Roski et al 68). It is important to understand that if these proposed savings come to fruition within Medicare, eventually private insurance companies will lean to this bundled payment structure when paying for care because private insurance often follows changes in Medicare.
What Will This Look Like in the End?

It is difficult to say how effective the Patient and Protection and Affordable Care Act will be at reducing health care costs, lowering the national deficit, and including more of the current uninsured population. Many barriers still exist: Republican criticism of the legislation and the threat of repealing the reform; proper enactment of the reform, that is spreading awareness and making sure citizens understand the scope of the reform and how it affects them; and most importantly, implementation of the legislation’s new health measures. All of the new initiatives and cost saving changes are contingent on health insurers, hospitals, doctors, and other providers understanding the new rules, abiding by the new rules, and implementing these measures successfully.

Theoretically, the reform act will decrease the national deficit by “$143 billion from 2010-2019” and by “$1.5 trillion from 2020-2029” (Holahan 1). Although there are many assumptions built into the cost savings (proper implementation of technologies, and medical provider’s willingness to take on large upfront cost in order to save in the future), the end result should be a marginally less expensive health care system that covers more people.

However, if you dig deeper, past all the theory I described, you find that these three cost-saving initiatives (CER, HIT, and preventive measures) are barely band-aids on a more systemic and deeper wound. The cause of the deeper wound is the health consumer’s demand for the best possible treatments, most efficacious drugs, and a variety of choices and alternatives when making these decisions. Yet while desiring all of these options, the American consumer does not want to pay the price associated with them. Part of the reason the U.S. health care system has successfully been able to meet the demand from the consumer is by hiding the costs. The current market system resembles a shell game where costs are being hidden or pushed onto other
fragmented areas of our system: hospitals may soak up some costs when uninsured patients are treated in the emergency rooms; doctor’s and practices may eat some of the costs when they treat Medicare patients and receive reimbursements less than what they would have received from treating patients in private plans; and employers may switch to higher deductible insurance plans in order to save costs, even though some employees may pay more out of pocket as a result of the changed plans. In all of these instances costs are being shifted around and being absorbed by different segments of the U.S. health care system.

The expenditures are hidden from the consumer, enabling the consumer to demand the highest quality health care products and services without realizing the costs associated with their demand. To put this in perspective, here are some statistics regarding how much employees and employers pay towards health insurance. In 2009, according to the Employee Benefit Research Institute (EBRI), the “average premium paid out to private health insurers for a family four was $13,375” (EBRI). The employer paid “$9,860 or 73% of the premium while the household premium was $3,515, or 27% of the cost” (EBRI). Undoubtedly, that number has increased within the past two years and will continue to grow in the near future. That amount may surprise some people, but it reflects a high consumer demand, high administrative expenses, and general inefficiency in the health care system. How do these numbers compare with other countries? Japan, for example, is home to the number one health care system based on life expectancy, spending $2,578 per person on health insurance, drastically less than the U.S. (Staff of the Washington Post 67). Although the comparison is not apples to apples because the U.S. health care system is primarily employer-based, the comparison shows the large gap in spending versus health outcomes.
Consumer demand is pushing up health care costs along with others factors that I have mentioned: defensive doctor practices, lack of preventive care, and fee-for-service arrangements. My solution to mitigate these problems is a stronger government role in health care. The one thing that all of the best health care systems have in common is some type of government intervention. Ideally, switching to more of a federally run health care system tomorrow would start saving the U.S. health care system money because of less overhead expenses, no for-profit practices, and economies of scale. I realize the bureaucratic elements in our political system would make that nearly impossible, so an incremental approach to government intervention in health care would be necessary.

Just to be clear, government influenced health care does not mean “socialized medicine” or even universal care. Germany, France, and Japan, all of which are far better than the U.S. in holding down costs and providing better care, do not have a universal government run system. Germany, for example, has non-profit entities called sickness funds (similar to U.S. non-profit insurers) that provide a variety of different plans at much more affordable prices comparatively. Germany actually has quite a market structure where many “sickness funds” compete for insurance carriers. (Callahan, Medicine and the Market 100-101).

In order to sustain an affordable and efficacious U.S. health care system, several things have to be done. First, a universal insurance mandate is necessary. Through all of my research and interviews, this one facet of health care is included in each of the systems. The PPACA includes an employer mandate that requires employers to offer adequate insurance coverage or purchase insurance (which may be more affordable) through regional insurance exchanges (Staff of the Washington Post 85). Individuals will also be able to purchase insurance through the
exchanges. The reform legislation is attempting to move more policy-holders to these insurance exchanges which will be comprised of insurance plans that must meet certain criteria.

I understand what the reform act is trying to accomplish. The act is attempting to provide “managed competition.” That is an arena (insurance exchanges) where insurance companies will compete with each other for consumers, but they will be subject to more stringent government health insurance rules in the exchanges. The Affordable Care Act’s underlying goal is to shift the majority of patients to these insurance exchanges, de facto, as the exchanges become more affordable than other private insurance companies’ policies. The result, if these exchanges succeed, may be the demise of private insurers, if the majority of people switch over to the exchanges. If this occurred a majority of the insured would be placed under the purview of managed government health care. In my opinion, this is one large hypothetical scenario with no guarantee of success.

The quickest way to accomplish the PPACA’s underlying goal of reducing costs, and the second change I would make to the U.S. health care system, would be to pass a law requiring limits on the amount insurance companies could charge for medical premiums and how much hospitals and doctors could charge insurance companies. This would accomplish the goal of providing more affordable coverage without having the government run health care. The government would only place a ceiling on costs, and the government would not need to touch drug costs because health insurers would compete on the basis of attracting consumers through plan affordability, trying to negotiate the lowest prices possible for drugs. What should happen, as seen in other countries, is a reduction in for-profit insurers because they would be at a competitive disadvantage by having to payout certain amounts to shareholders, for marketing costs and bonuses. Managing health care so insurers compete on the basis of costs rather than
finding the healthiest people to insure would provide more coverage to people and more affordability. By competing on costs, administrative costs would also be lowered. Administrative costs such as bonuses for insurance executives, marketing costs, payouts to shareholders, insurance claim compilers, and other non-value added costs account for more than 20 cents out of every premium dollar paid to the insurance company (Reid 37). This would be the most simplistic and effective way to accomplish affordability while still maintaining a quasi-market structure.

The last key to sustaining a cost-effective and high quality health care system is to increase consumer awareness on health care costs and encourage and facilitate a better doctor-patient relationship. Consumer awareness is often times inhibited by the fragmented U.S. health care system. There are too many different health care models within our health care system that confuse patients, doctors, and health care providers and ultimately add to the cost of the U.S. health system. These health models include: Medicare for the elderly, Medicaid for the low-income earners, private employer-insurance for most employed individuals in large companies or organizations, the Veterans Administration for military veterans or current personnel, the Indian Health Service for Native Americans or Alaska Natives, and finally, the out-of-pocket model for the 46 million Americans who are uninsured.

The result of multiple health care models is an administrative nightmare for doctors, hospitals, and insurance providers. The hundreds of payment schedule possibilities that arise from all of the insurance plans cost all players in the system time and money. Most of the time, patients do not know how much a treatment, doctor’s visit, or prescription drug is costing them. And some of the time even the doctor’s themselves do not know how much money it costs to run tests, procedures, and prescribe medicines. Part of this can be reduced by the government setting
the rates private insurers, doctors, and hospitals can charge. Furthermore, the myriad number of insurance plans hurt the consumer because if, for example, Medicare decides to cut reimbursement payments to hospitals or doctors, the hospitals or doctors may decide to shift that cost to other insurance providers (Reid 42). If the numerous amounts of payment plans were condensed, patients would be able to visibly see and understand how much they are paying for a service.

A practical example of this is seen in France, where doctors post fee schedules on their walls and require patients to pay the full amount of their visit each time. The amount the patient pays may range from $20 to $60, but soon after the payment is made, the patient will receive a reimbursement from their insurance providers in the mail. Often times the provider will reimburse the patient for most, if not all, of the costs for the doctor’s visit. So why does this meaningless transaction take place? Well, it occurs because “it is important to convey that something of value is exchanged” when the patient visits the doctor (Reid 61). I believe implementing this type of payment strategy would help the patient understand the importance of acquiring care. If a patient in the U.S. had to make a transaction each time he or she made a visit, and moreover, a breakdown of the portion the insurance provider would pay was posted for the patient to see, this would create greater transparency in the cost structure of health care. Also, the government, similar to other countries, could make preventive care visits to the doctor’s office i.e., annual physicals, free of any co-pays. That way, patients would realize the benefits of being pro-active with their health, and there would be no financial barriers to seeking out preventive care.

Paramount to patients making better health decisions is the relationship formed between the doctor and patient. Anecdotally, patients on occasion will dictate what they want done as a
result of a diagnosis. Most people know someone who has requested or they themselves have requested a treatment or procedure to be administered without the doctor suggesting it first. More has to be done so that doctors do not feel obligated to honor the patient’s request. One way this can be accomplished is through comparative effectiveness studies. As mentioned above, the Patient Center Outcomes Research Institute recommends to doctors best practices on the basis of efficacy and cost-effectiveness. The key word being “recommends.” In order to bear the intended results from CER, cost-effectiveness research should analyze cost factors in administering a drug, treatment, or procedure and the conclusion from the research should be more than just recommended; it should be mandated.

The bottom line is that the patient-doctor relationship needs to be reformed, costs need to be made more visible to the patients, the government has to take on a bigger role and a simplification of the health care system is necessary in order to contain costs, increase quality of care, and extend coverage to the uninsured.

As the 2012 presidential election approaches and as the Affordable Care Act remains unpopular among Republicans, the legislation will no doubt be a focal point for debate. In months to come, there is no telling if and how the Republican controlled House of Representatives will amend, repeal, or underfund the legislation. The bottom line is that the health reform act reduces the deficit in the long-term and may provide a spring-board for more substantial reform in years to come. With the U.S. deficit accruing more than 1 trillion dollars each year, with Medicare and Medicaid being the two largest debt items, with spending on health care projected to be over 20 percent of GDP in the near future, and with an aging population, health care reform needs serious consideration and cooperation from both parties, if cost-containment is to be successful.
Addendum

While writing this paper on the U.S. health care system and discussing some of the cost-saving mechanisms imbedded in the legislation, I have experienced economic ambivalence and acquired a newly found perspective on economic issues. Let me explain. In college I majored in Economics and Finance, and for those four years, I learned about the benefits of free markets, deregulation, and the Classical Liberalism approach. To supplement that free market economic perspective, I was shown the shortcomings of government regulation in industries, the inefficiencies government brings to the markets, and the lack of incentives for producers when government steps in. For these four years I believed that a deregulated and perfectly competitive playing field for firms was paramount for industry to grow and products to be affordable. I thought the exception to the rule was in areas like national defense or education where some form of government intervention is necessary. I never considered health care to fall into the “exception” category.

As I read more and more health care literature and interviewed health care experts, Dr. Steven Miles of the Bioethics Center at University of Minnesota and Daniel Callahan of the Hastings Center, I found that the U.S. health care system’s private insurance (and in some cases for-profit insurance) model was not working. Kenneth Arrow’s article, “Uncertainty and the Welfare Economics of Medical Care,” brought in a new perspective for me to consider, one that acknowledges market failures and demonstrates health care as one of those failures. Market failures occur when incentives are not aligned with the intended outcome, or when transparency within an industry, particularly visibility of price, fails to exist. After researching U.S. health policy, it is clear that the incentives within the health system, i.e., fee-for-service payments, defensive medicine practices, for-profit insurance, do not yield affordable health care for the
populous, and the lack of price transparency in medical care does not encourage patients to consider price when they are making a medical decision.

After reading the myriad number of criticisms for U.S. health policy, I was struck with economic ambivalence. I wanted to believe that U.S. health care could work under a market-oriented system because privatized industries and deregulated markets usually deliver the best results. But in health policy, it does not seem to work.

If I had to point to a book that transformed my opinion the most, it would be T.R. Reid’s, *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*. His comparison of foreign health care systems and the U.S. health care system highlighted the shortcomings and underlying problems with U.S. healthy policy. Along with the global comparison of health care policies, the low scores in many health care metrics solidified my opinion that the U.S. health care system needs to be reformed.

The most important part of the researching and writing processes for a thesis are the new skills you acquire throughout the process. I have developed a new perspective for analyzing problems, one that enables me to acknowledge market failures and look to other countries for examples of how to improve healthy policy. In the end, the culmination of all of research has given me valuable knowledge of a topic that is highly debated and misunderstood at times. This thesis could prove to be a springboard to future endeavors. I at least hope my writing has illuminated the problem with U.S. policy in an area that will always affect everyone financially and physiologically, and I hope that my writing has motivated you to probe and question the status quo, and think of other areas that we need to improve.
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