

Testimony of

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Hearing on
***“Making Health Care Work for American Families:
Ensuring Affordable Coverage”***

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My name is Uwe E. Reinhardt. I am a Professor of Economics and Public Affairs at Princeton University and have been engaged in research on health economics and health policies for several decades.

I would like to thank you, Mr. Chairman, for convening this hearing on an issue that is now uppermost in the mind of the American people. It is an honor to be invited to present a statement to your Committee.

My statement has three sections. In the first I present some data on the extraordinary and increasingly indefensible high cost of American health care. In the section I shall illustrate how these high and relentlessly growing costs are inexorably pricing American families in the lower half of the nation's income distribution out of health insurance and timely, efficient health care. The third section then offers some perspectives on how the nation might address this growing problem.

A. The High Cost of American Health Care

Over the past four decades the United States has constructed for itself a health system that is now the most expensive such system in the world.

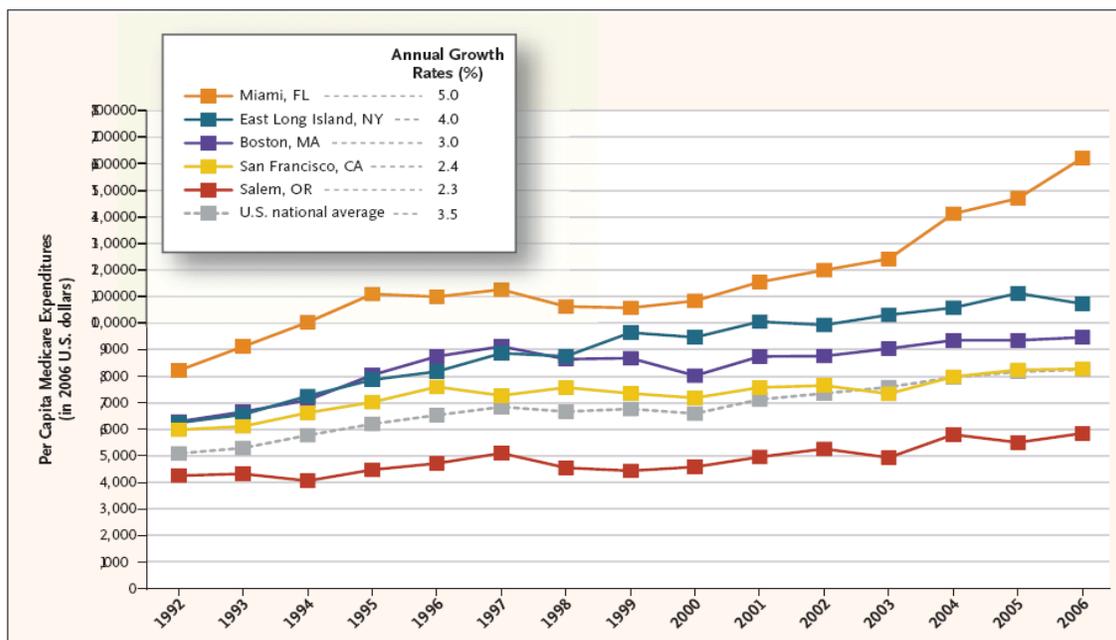
In 2006, the last year for which such data are available from the Organization of Economic Cooperation and Development (OECD), the U.S. spent 56% more per capita in Purchasing Power Parity Dollars (PPP\$) than did the second most expensive health system, Switzerland's, which is widely regarded as a well-endowed, high-quality with remarkably good health-status statistics. The U.S. spent 83% more per capita in PPP\$ than does neighboring Canada, whose health statistics also are as good and sometimes better than comparable American statistics although, unlike the Swiss or, say, Germans, Canadians do have to queue up from time to time for elective surgery and certain high-tech procedures, such as imaging.

For decades, Americans have viewed these sizeable cost differentials in health care with equanimity, on the unquestioned premise that the American health system is the best in the world. A growing volume of research in the past decade, however, has cast serious doubt on that premise. While at its best American health care undoubtedly has few, if any, rivals, on average the system does not appear to rank at the top of nations, and certainly not as high as its high health spending would seem to warrant.

Only last week, for example, the *Business Roundtable*, traditionally a staunch defender of this country's approach to health care, delivered itself of a doleful report which concludes that, in terms of value received per dollar spent on health care, the American health system exhibits a "23 percent value gap relative to five leading economic competitors – Canada, Japan, Germany, the United Kingdom and France."¹ Coming from that quarter, this is a quite remarkable statement.

¹ The Business Roundtable, *Health Care Value Comparability Study, Executive Summary*, available at <http://www.businessroundtable.org/sites/default/files/BRT%20exec%20sum%20FINAL%20FOR%20PRINT.pdf>

But one need not look across national boundaries to question what value Americans actually receive for their enormous health spending. Several weeks ago, researchers of the Dartmouth Medical School published in *The New England Journal of Medicine* their latest report in a long series of similar reports published in the literature and formally presented to the U.S. Congress during the past two decades.² The graph below, taken directly from the report, indicates that in 1992, Medicare spent about 33% more per Medicare beneficiary in Miami, Florida than it did for statistically similar beneficiaries in San Francisco, and close to twice as much than was spent on Salem, Oregon. By 2006, this spending gap had widened. In that year, Medicare spent twice as much per Medicare beneficiary in Miami than for similar beneficiaries in San Francisco and 2.7 times as much as it spent for Medicare beneficiaries in Salem Oregon. While Medicare spending over the period 1992-2006 per beneficiary rose at an annual compound rate of 5% in Miami, it rose by only 2.4% per year in San Francisco and only 2.3% per year in Salem Oregon.



Annual Growth Rates of per Capita Medicare Spending in Five U.S. Hospital-Referral Regions, 1992–2006.

Data are in 2006 dollars and were adjusted with the use of the gross domestic product implicit price deflator (from the Economic Report of the President, 2008) and for age, sex, and race. Data are from the Dartmouth Atlas Project.

I mention these international and intra-US variations in per capita health spending not to deflect us from the topic before this hearing, but to register an important point:

Sooner or later those who write most of the checks for health care in America – employers, Congress and state governments – must embrace the idea that, like any other sector, health care should be subjected to the rigorous cost-effectiveness analysis known elsewhere in the economy as “operations research.”

² Elliott S. Fisher et al., “Slowing the Growth of Health Care Costs – Lessons from Regional Variation,” *The New England Journal of Medicine* vol. 360, No. 9 (February 26, 2009): 849 - 52.

To the detached observer, for example, it seems incredible that, having been apprised for over two decades now of the huge geographic variations in Medicare spending per beneficiary, the U.S. Congress has never funded research to inquire whether the high spending levels in the high-cost states are really necessary.

The same, of course, can be said of private employers, who have done very little over the years to reign in the growth of health spending in this country and to extract greater cost-effectiveness and accountability from the supply-side of the health system.

Unfortunately, the term “**cost-effectiveness analysis**” remains as yet anathema in the halls of Congress, as we saw only recently in connection with the Economic Stimulus Bill. That is unfortunate, because more and more American taxpayers and families are now becoming the victims of a health system that has never been properly held to account for what it does with the enormous real and financial resources entrusted to it.

At the same time, of course, I am fully aware also that any attempt to wrestle the supply-side of our health sector down on the issue of **cost-effectiveness** is constrained by what I have facetiously called in earlier work

ALFRED E. NEUMAN’S COSMIC LAW OF HEALTH CARE

Every dollar of health spending = Someone else’s dollar of health care income, including fraud, waste and abuse.

As the members of this Committee know only too well, much economic and political power resides on the right-hand side of this equation. Indeed, even the legendary General David Petraeus might find daunting the legion of K-Street insurgents enlisted by that side.

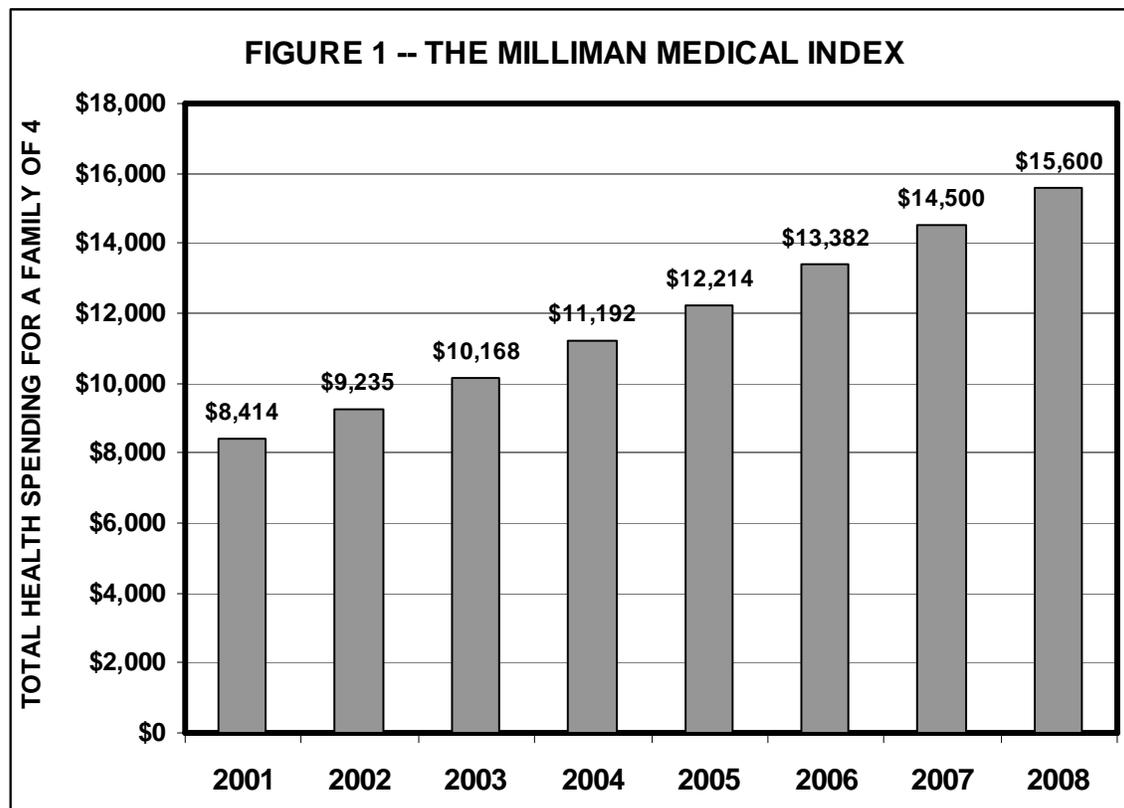
For that reason, I would never advocate a frequently proposed policy of controlling health care cost first, before helping Americans currently priced out of the health system to gain access to timely, good-quality health care, without pushing them to the brink of personal bankruptcy. Eliminating the value gap of which the Business Roundtable speaks will take decades of concerted effort by an alliance of payers and health-services researchers. Congress must ask itself whether America’s growing number of families without health insurance should be made to wait that long.

A. Pricing Americans out of Health Care

During the past four decades, real (inflation-adjusted) health spending in the United States has, on average, grown 2½ percentage points faster than the rest of real GDP. This differential was not constant year by year and is not true for every component of national health spending, But, over the longer run and for total national health spending, it has been remarkably stable over the decades.

If this differential persisted for another four decades, then health care would absorb close to 40% of the GDP by 2050.³ It would severely stress the budgets of governments, of employers and of households across the United States, most of all those of families in the lower half of the nation's income distribution.

Household spending on health care: Figure 1 below shows data from the Milliman Medical Index published annually by Milliman, Inc., a benefits consulting firm. The index shows the average annual health spending for a privately insured hypothetical American family of four, averaged over a very large, nationwide data base of families covered by a private Preferred Provider health insurance plan (PPO).⁴



³ See, for example, Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November, 2007; Figure 4, p. 13.

⁴ Milliman, Inc., *2008 Milliman Medical Index*, <http://www.milliman.com/expertise/healthcare/products-tools/mmi/pdfs/milliman-medical-index-2008.pdf>

The virtue of the Milliman Medical index is that it includes not only the premium for the family's employment-based health insurance, but also the family's out-of-pocket spending for health care. Many other surveys capture only the premium component, which can be treacherous when benefit packages change over time and deductibles and coinsurance as well as exclusions rise over time.

It is seen that over the past 7 years the average total outlay on health care for a family – from all sources – nearly doubled. The overall average annual compound growth rate in the series is 8.9%, although on a year-t-year basis that growth rate had declined from 10% in the earlier years to 7.6% in between 2007 and 2008.

To put the data in Figure 1 in perspective, it may be noted that according to the U.S. Bureau of the Census, median household income in the United States in 2007 was about \$51,000⁵. That figure is not likely to grow much in the near future and only sluggishly over the next decade. For the 50% of households falling below this median, it will be increasing difficult to finance the household's health insurance premiums and out-of-pocket spending with its own resources.

Household spending on health care and the wage base: An important point to note in connection with Figure 1 is that the total spending contributions to employment-based health insurance or contributed by employers toward the family's health insurance, must be borne by what one may call the "gross wage base" of this family's income earner or earners combined.

This conception of the "gross wage base" is so important that it merits some further explanation. Economists think of the "gross wage base" of an employee as the total price an employer pays for labor per employee. In accounting parlance, it is the sum of all of the debits an employer makes to the account PAYROLL EXPENSE for an employee.

Thus, the gross wage base includes not only the gross amount shown on the employee's paycheck, prior to withholdings from that sum for taxes owed by the employee or the employee's contributions to his or her health insurance and pension. The gross wage base also includes any mandated contributions the employer makes to the employee's Social Security and Unemployment Insurance payments, along with the voluntary contributions the employer makes to the employee's pension and health insurance plans, the cost of vacation and sick pay, and so on.

The idea that an employee's gross wage base must support all of the health spending of the employee and his or her family tends to confuse people who believe the employer's contribution to an employee's health insurance is paid by shareholders and not the employee him- or herself. That myth that has long bedeviled the role of employment-based health insurance in health policy. Most economists are convinced, by dint of their and empirical research, that over the longer run, employers are able to shift the cost of their contributions to the employee's fringe benefits back to employees by lowering take-home pay.

⁵ U.S. Census Bureau, Quick facts from the U.S. census Bureau, <http://quickfacts.census.gov/qfd/states/00000.html>.

The fact that the employee's gross wage base must support all of a family's health spending, including its out-of-pocket spending, also confuses the many people who argue that reducing the premiums for health insurance through higher deductible and coinsurance solves the health-care cost problem. It certainly does not. For the most part, high-deductible health insurance merely shifts spending out of the insurer's accounts into the family's accounts. It is not a solution to the American health-care cost problem.

Health spending as a percentage of the gross wage base: Consider a family supported by a gross wage base, as defined above, of \$50,000. It could be a family with one or two breadwinners. Suppose that wage base grew at an annual rate of about 3%, the long-run average growth rate of average weekly earnings during the past two decades.⁶ It would then be \$67,200 by 2018. Suppose next that the total annual health spending of the family grew at an annual compound growth rate of 8% during the next decade, from \$15,600 in 2008 to \$33,700 by 2018.

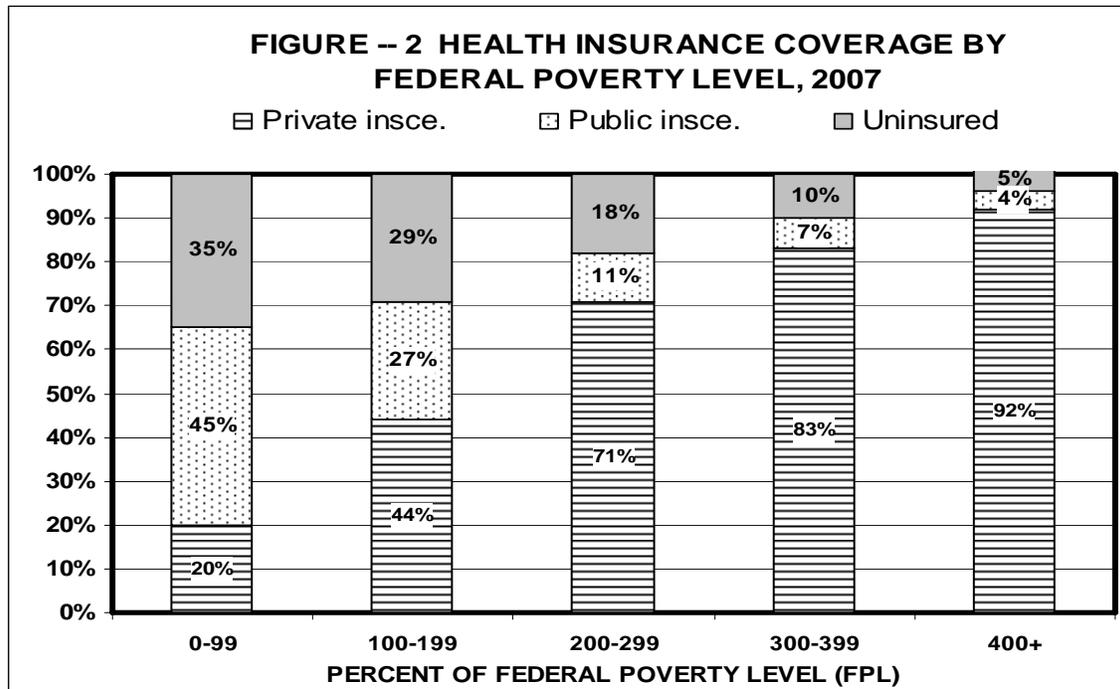
It follows that the family's total health spending in 2018, which must be supported by its gross wage base as defined above, would absorb half that wage base before it could support any other of the family's spending, including its tax obligations. Table 1 repeats this calculation for other combinations of growth in the wage base and in health spending. It is seen that even if health spending grew only at 4% per year and wages by 5% -- both highly optimistic assumptions -- 29% of the wage base in 2018 would be chewed up by health care.

TABLE 1 -- RATIO OF FAMILY'S HEALTH SPENDING TO ITS WAGE BASE, 2018

Annual Growth in Wage Base	- Assumed Annual Growth in Family Health Spending -				
	4%	6%	8%	10%	12%
1%	42%	51%	62%	74%	89%
2%	38%	46%	56%	67%	81%
3%	35%	42%	51%	61%	73%
4%	32%	38%	46%	55%	66%
5%	29%	35%	42%	50%	60%

Figure 2 shows that being uninsured is strongly related to income levels. If the average health spending from all sources for American continues to grow in the next decade as it has in the past, an increasing number of families with incomes 200% of the Federal Poverty level and above will find themselves among the uninsured and unable to finance their health care with their own resources.

⁶ See Economic Report of the President to the Congress 2008, Table B47, <http://www.gpoaccess.gov/eop/2008/B47.xls>.



SOURCE: Kaiser Family Foundation, *The Uninsured: A Primer*, October, 2008; Figure 3.

This circumstance will confront American voters and their representatives in the political arena with the following choice:

Either the households in the top half of the income distribution must pay higher taxes to help subsidize the health care of households in the lower half of the income distribution,

or

The American health-insurance and health-care systems will gradually be restructured into a two- or mi- or multi-tiered system that rations health care by income class, perhaps by means of reference pricing.

By “reference pricing” is meant an insurance system that covers patients full or near fully only at low cost hospitals and medical practices and for low-cost medical devices and pharmaceutical products, forcing the patient to pay out of pocket the whole difference between the cost of the low-cost facility or product and a higher priced option. We see this form of pricing already in drug therapy. Quite possibly it will be extended in the next decade to other segments of the health care sector.

C. Providing American Families with Secure Health Insurance

In formulating their thoughts on the goals for reforming the nation’s health system, American might begin their contemplating by thinking about the following questions:

1. Do you want to live in a society were a family, already financially stricken when one or both of the family's breadwinners loses their job, the family also loses the financial security of health insurance?
2. Do you want to live in a society in which access to health care is rationed by income class?
3. Do you want to live in a society in which your offspring, who may be starting their work-life in a small business firm -- perhaps one of their own creation -- or many other self-employed entrepreneurs cannot get health insurance because the insurance industry does not serve small business firms well?
4. Do you want to live in a society in families are can easily face bankruptcy when one of its members is stricken by serious illness?

If the answer to these questions were "Yes" in every case, the present system would be found perfectly acceptable. If the answers were "No," then this list furnishes the minimal benchmarks a sound health-reform program ought to achieve.

Most citizens in the industrialized world have long enjoyed the mental and financial security of permanent, life-cycle health insurance that is portable from job to job and from employment into the status of unemployment or retirement.

In the United States, this state of security is enjoyed only by Medicare beneficiaries, who do have permanent, portable, life-cycle insurance for life starting at age 65. The rest of society could be said to be more "unsured" than "insured," because insurance coverage can be lost for a number of reasons, job loss most prominent among them.

To the outsider, the question is why Americans have been content with this inherently brittle health insurance system for so long and for how long they wish to continue it.

The employment-based health insurance system: It can be doubted that any health-policy analyst given the luxury of starting from scratch would ever think of making the current American employment-based health insurance system a major corner stone of the American health system. Not only is that form of coverage ephemeral and, thus, brittle, but it also entails huge administrative costs all around.⁷

In the eyes of many, however, a major advantage of employment-based health insurance within the American health system, however, is it is based on usually wide risk pools that are not segregated by risk class. As already noted, these systems can be viewed as a form of private social health insurance.

It can be predicted that the fraction of the American population covered by employment-based system – now still over 60% of the non-elderly population – will

⁷ In this connection, see U E Reinhardt, "Employer-based health insurance: a balance sheet," *Health Affairs*, November/December 1999; 18(6): 124-132.

shrink gradually in the decade ahead, especially among smaller enterprises, unless employers are directly subsidized publicly for continuing that form of coverage.

Therefore, this is a propitious time to develop a robust alternative track to the employment-based system based either on a reformed market for individually purchased health insurance or a public insurance program for the non-elderly or both.

A strengthened market for individual health insurance: Volumes have been written on the merits and shortcomings of the market for individually purchased health insurance and how to strengthen that market. There are two options.

One extreme option would be to permit this market to segregate itself by risk classes through medical underwriting and then to subsidize individual families buying coverage in this market so that their total annual outlay on health care plus health insurance does not exceed a legislated fraction of discretionary income (i.e., income after covering basic necessities such as food, utilities, housing, etc). In theory, economists find this the most attractive model, as it permits efficient competition among private insurers without having to worry about the problem of creating broad risk pools for individually purchased health insurance. In practice, of course, this approach would require a whole new bureaucracy to determine and pay out the customized public subsidies to individual families in this market.

At the other extreme are arrangements such as the German statutory health insurance system under which private, non-profit sickness funds compete for enrollees, but subject to guaranteed issue, community-rating for each insurer and even uniform fee schedules for paying the providers of health care.

In between these extremes are countless alternative arrangements leaning to one or the other of the extremes. One can find a good sampling of such arrangements on *eHealthInsurance.com*.

These arrangements always come with several problems.

First, there is the well-known problem that a major chief instrument of competition in these markets will be judicious cherry picking among insured risks – especially if insurers are subject to community rating.

Second, if insurer's competing in the individual health insurance market are subject to guaranteed issue and community-rated premiums, but households are free to insure or not to insure, there will be adverse risk selection on the part of consumers who will go without insurance when they are healthy but then have the privilege of throwing themselves on community-rated premiums when they fall ill. It is well known that community-rating and guaranteed issue coupled with voluntary insurance tends to lead to a death spiral of individual insurance. The State of New Jersey, which introduced this arrangement some years ago, furnishes a clear example of this tendency.⁸

⁸ See, for example, Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberley S. Fox, "Community Rating And Sustainable Individual Health Insurance Markets In New Jersey," *Health Affairs*, July/August 2004; 23(4): 167-175.

Third, there is the expectation that insurers will compete in part on their ability to pay the providers low prices for health care. It is not at all clear, however, that the price discrimination on the part of providers this competition engenders works to the advantage of society. As William Porter and Elizabeth Olmsted Teisberg remark on this issue in their *Redefining Health Care*, correctly in my view:

The dysfunctional competition that has been created by price discrimination far outweighs any short-term advantages that individual system participants gain from it, even for those participants who currently enjoy the biggest discounts.⁹

Fourth, it is not clear to me how the market for individual health insurance, any more than employment-based insurance, can offer Americans what citizens in any other nation take for granted: stable, permanent, life-cycle insurance, if that is what some or many Americans actually would like to have. In Germany, private commercial insurers must offer permanent, life-cycle insurance policies; but that is achieved only with very heavy handed federal regulation. To create such policies in American private insurance would require similarly heavy regulation of insurers.

A public health insurance program for the non-elderly: It seems clear that a well functioning market for individually purchased health insurance ought to be based on some form of farmer's market for insurance that brings order to the transactions and makes sure that they are reliable.

Electronic farmers markets such as *eHealthInsurance.com* go a long way of providing such a farmers market, but they are mainly passive organizers of listings of different insurance products. They lack regulatory power.

A more powerful alternative would be the National Insurance Exchange proposed by President Obama, which, at the blueprint stage, seems to be a compound of the Massachusetts Insurance Connector and the Federal Employee Health Benefit (FEHB) system. In the 1990s, these organizations went by the name of "Health Insurance Purchasing Cooperatives" or "Health Insurance Alliances."

Whatever their name, these types of more powerful farmers markets for health insurance would have to be endowed with regulatory powers to supervise and enforce the reputability of the products being offered on these markets and perhaps even to develop standard contracts whose fine print does not have to be studied every time an insured buys insurance. Policymakers might also look to these farmers markets to organize larger risk pools and to limit, if not altogether eliminate, cherry picking on the part of insurers and adverse risk selection on the part of the insured.

Whatever the eventual shape of such an organized market would be, it would presumably offer consumers a menu of choices among different health insurance products. The question then arises whether among these products should be a public insurance program for the non-elderly as well.

⁹ Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, 2006: 66.

In his presidential campaign, President Obama promised to provide Americans such a public, Medicare-like health insurance plan, which American desirous to enroll in such a plan could chose if they preferred it to rival private insurance offerings. A similar provision is included in Senator Baucus white paper *Call to Action: Health Reform 2009*.¹⁰

On its face, this idea should not appear controversial to anyone who believes that choice among insurance products and carriers should be a hallmark of a reformed American health insurance system. Remarkably, however, this idea now seems to have become the proverbial third rail in the current health reform debate.

The arguments against offering non-elderly American citizens the choice of a public plan, enrollment in which would be entirely voluntary, is that such a plan would have an “unfair” advantage over private insurers.¹¹ That argument, however, requires careful and convincing explication: “unfair” in what respect?

It may well be that, after having seen their private savings eroded and promised retiree health benefits disappear, and after seeing hallowed American business firms such as GM, AIG, Lehman Brothers, Citigroup sliding into bankruptcy or hanging on to life only on life support from the taxpayer, many American citizens might well look upon a government-run health insurance program as a more stable option that could, in principle, offer the insured permanent, fully portable, life-cycle financial protection against the financial inroads of illness. In the present economic turmoil, and after the truly disappointing performance of so many executives in the private sector, that feature of a public plan could become a decided advantage in the market for health insurance; but I am not sure that one could call it an “unfair” advantage.

Another candidate for an “unfair” advantage might be the ability of a public insurance plan to obtain exceptionally low prices from providers by virtue of its market power. For example, if the new public plan simply piggy-backed itself onto the existing Medicare payment system and paid the same rates, which are unilaterally set (albeit after some indirect negotiation with providers in the political arena), then the public plan would have a comparative advantage *vis a vis* private insurers in the market for health insurance that could be called “unfair.”

On the other hand, if the new public plan had to negotiate its own prices, then it would not have a competitive advantage any more “unfair” than is the ability of large insurers – such as Aetna or Wellpoint – to negotiate lower prices with hospitals and physicians than these providers charge smaller insurers. For some reason, not one has ever called this form of price discrimination “unfair,” although,

¹⁰ <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>

¹¹ It is more than a bit ironic that commentators who make this argument so no “unfair” advantage in having taxpayers by private insurers an average of 14% more per Medicare beneficiary choosing a private insurance option than that beneficiary would have cost taxpayers in traditional Medicare.

as Porter and Teisberg have pointed out¹², it is difficult to defend it on grounds of economic efficiency.

It will be fascinating to see whether, in the coming months, how the debate over the proposed public health plan will evolve – whether in the end it will be debated and decided upon on the basis purely of its economic merit, or whether it will be disposed of as part of political horse trading.

¹² Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, 2006: 66.