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National Institute for Health Care Management

The Future of Health Care in America: The ACA and Beyond

Washington, D.C.

September 3, 2014
FACTORS SHAPING THE FUTURE OF U.S. HEALTH CARE

- Slower economic growth
- High cost of U.S. health care
- Tight government budgets
- Rising income inequality
I. THE HIGH COST OF U.S. HEALTH CARE
GROWTH OF REAL NATIONAL HEALTH INCOMES (NHE) AND REAL GDP, BOTH PER CAPITA, IN CONSTANT 2000 $s, 1965 = 100 (GDP Deflator)

During ’65-’09, real NHE per capita grew 6.8 fold.

During ’65-’09, real GDP per capita grew 2.3 fold.

True, there has been a marked slow-down in the annual growth of health spending in the U.S. – and in the rest of the OECD as well.

But we have had such slow-downs before, only to see health spending take off again later.

And the fact is that, recent slow-down notwithstanding, Americans spend roughly twice as much per capita on health care as do most other nations in the OECD.
PER-CAPITA HEALTH SPENDING IN PPP DOLLARS --
SELECTED OECD COUNTRIES, 1980-2011

Graph showing the per-capita health spending in PPP dollars for selected OECD countries from 1980 to 2011. The countries included are the US, Switzerland (SWIZ), Netherlands (NETH), Canada (CAN), Germany (GER), Sweden (SWE), and the UK. The spending is measured in PPP dollars on the y-axis, and the years from 1980 to 2011 are shown on the x-axis.

- The US has the highest spending, consistently showing a significant increase over the years.
- Switzerland also shows a steady increase, though at a slightly lower rate compared to the US.
- The Netherlands and Canada have a moderate increase, with the Netherlands showing a slightly steeper rise.
- Germany and Sweden have a more gradual increase, with Sweden showing a slightly steeper rise.
- The UK has the lowest spending among the countries shown, with a relatively flat line indicating a small increase over the period.

The graph illustrates the disparities in healthcare spending among these countries, with the US leading and the UK lagging in terms of PPP-adjusted spending.
The problem is not that Americans consume more health care per capita than do citizens of other countries.

The opposite is more nearly the truth.

The main reason Americans spend so much more per capita on health care than do other nations is that prices for virtually any health service of product are twice as high or higher in the U.S.
Higher health spending but lower use of health services adds up to much higher prices in the United States than in any other OECD country.
International Federation of Health Plans

2012 Comparative Price Report

Variation in Medical and Hospital Prices by Country
2012 Scanning and Imaging: MRI

($ USD)

- Argentina: $118
- Spain: $230
- Netherlands: $319
- United Kingdom: $335
- France: $363
- Chile: $502
- New Zealand: $554
- Switzerland: $928
- South Africa: $1,072
- United States: $2,871

Legend:
- USA 25th Percentile
- Average Price
- USA 95th Percentile
Lipitor is commonly prescribed for high cholesterol.
The actuarial firm Milliman annually calculated its so-called *Milliman Medical Index* of health spending by a typical American family covered by an employer-sponsored Preferred Provider Plan (PPO).

The index represents the sum of:

1. The employer’s contribution to the premium for the employee’s health insurance;
2. The employee’s own contribution to the premium;
3. The employee’s out-of-pocket spending for health care.
MILLIMAN MEDICAL INDEX (MMI)
Average Annual Medical Cost for a Typical Family of Four

How many American families could actually cover this cost out of their own resources, without explicit or hidden cross subsidies from others?
II. RISING INEQUALITY IN INCOME AND WEALTH
Median = $56,000
Top 25% > $85,000
Top 10% > $135,000
Top 4% > $200,000

Source: Sentier Research analysis of Labor Department data. Note that vertical axis does not start at zero to better show the change. Cited by Catherine Rampell, http://economix.blogs.nytimes.com/2013/03/28/median-household-income-down-7-3-since-start-of-recession/
Income, Poverty, and Health Insurance Coverage in the United States: 2012

Current Population Reports

By Carmen DeNavas-Walt, Bernadette D. Proctor, Jessica C. Smith
Issued September 2013
P60-245
### Mean (Average) Household Income by Quintile and Top 5%

<table>
<thead>
<tr>
<th>Household Segment</th>
<th>2012 Mean Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 5%</td>
<td>$318,052</td>
</tr>
<tr>
<td>Top Quintile</td>
<td>$181,905</td>
</tr>
<tr>
<td>2nd Quintile</td>
<td>$82,098</td>
</tr>
<tr>
<td>Middle Quintile</td>
<td>$51,179</td>
</tr>
<tr>
<td>4th Quintile</td>
<td>$29,696</td>
</tr>
<tr>
<td>Bottom Quintile</td>
<td>$11,490</td>
</tr>
</tbody>
</table>

Source: Census Bureau

Data from 1967-2011

SHARES OF HOUSEHOLD INCOME BY QUINTILES, 2012

- **Top 5%**: 22.3%
- **Highest quintile**: 51.0%
- **Fourth quintile**: 23.0%
- **Third quintile**: 14.4%
- **Second quintile**: 8.3%
- **Lowest quintile**: 3.2%

Most Americans seem blissfully unaware of these income-distribution statistics.
Source: Michael Norton and Dan Ariely,
DISTRIBUTION OF MONEY INCOME BY HOUSEHOLDS, ALL RACES, 2012

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percent of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200,000 and more</td>
<td>4.5%</td>
</tr>
<tr>
<td>$150,000 - $199,999</td>
<td>5.0%</td>
</tr>
<tr>
<td>$100,000 - $149,999</td>
<td>13.0%</td>
</tr>
<tr>
<td>$75,000 - $99,999</td>
<td>11.7%</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>17.5%</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>13.6%</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>10.7%</td>
</tr>
<tr>
<td>$15,000 - $24,999</td>
<td>11.7%</td>
</tr>
<tr>
<td>less than $15,000</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

Median: $51,017

### Distribution of Money Income by Households, Blacks Alone, 2012

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percent of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200,000 and more</td>
<td>1.5%</td>
</tr>
<tr>
<td>$150,000 - $199,999</td>
<td>2.1%</td>
</tr>
<tr>
<td>$100,000 - $149,999</td>
<td>7.3%</td>
</tr>
<tr>
<td>$75,000 - $99,999</td>
<td>8.5%</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>15.0%</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>14.3%</td>
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<tr>
<td>$25,000 - $34,999</td>
<td>12.0%</td>
</tr>
<tr>
<td>$15,000 - $24,999</td>
<td>15.5%</td>
</tr>
<tr>
<td>Less than $15,000</td>
<td>24.0%</td>
</tr>
</tbody>
</table>

**Median:** $33,321

Household income at upper limit of percentiles, 2012

MILLIMAN MEDICAL INDEX (MMI)
Average Annual Medical Cost for a Typical Family of Four

III. SO WHAT ARE OUR OPTIONS?
1. Above all, cut out the waste.
Best Care at Lower Cost
The Path to Continuously Learning Health Care in America
<table>
<thead>
<tr>
<th>Source</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary services</td>
<td>$210 billion</td>
</tr>
<tr>
<td>Inefficiently delivered care</td>
<td>$130 billion</td>
</tr>
<tr>
<td>Excess administrative costs</td>
<td>$190 billion</td>
</tr>
<tr>
<td>Excessively high prices</td>
<td>$105 billion</td>
</tr>
<tr>
<td>Missed prevention opportunities</td>
<td>$55 billion</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 billion</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$765 billion</strong></td>
</tr>
</tbody>
</table>

SOURCE: Institute of Medicine, Best Care at Lower Cost (2013) Table 3-1.
Alas, in health care one person’s efficiency gain is another person’s income loss.

Waste in health care has powerful defenders on K-Street and in Congress.
1. Above all, cut out the waste.

2. Raise taxes on households in the top third of the income distribution and subsidize health care for the bottom half.
All taxes as percent of GDP, selected OECD countries, 2012

1. Above all, cut out the waste.

2. Raise taxes on households in the top third of the income distribution and subsidize health care for the bottom half.

3. Move to a three-tier strategy
1. Public hospitals and public clinics for publicly insured Americans, especially the poor, but perhaps also for a restructured Medicare. It allows politicians to ration care without ever having to admit it.

2. For the employed middle class, a mixed system, tiered by cost through tiered reference pricing (now used mainly for prescription drugs) or defined-contributions in the employment-based system. That approach also permits rationing of some health care by income class without anyone having to say so openly.

3. For the upper-income groups, boutique medicine, which is already growing in the U.S. Here the sky will be the limit.
1. Above all, cut out the waste.

2. Raise taxes on households in the top third of the income distribution and subsidize health care for the bottom half.

3. Move to a three-tier strategy

4. Turn our backs to the problem and ignore it
Medicaid Expansions Break Conservative Principles

Nina Owcharenko, Director, Center for Health Policy Studies, Heritage Foundation

June 19, 2014
It is time to stop, take a breath and ask some basic questions about health care: Do we want to see greater government control over health care dollars and decisions, or less? Do we favor more federal spending, taxes and debt, or less? Are we in favor of a surrender to, or a decisive victory over, Obamacare?

Look at the big picture. Get out of the weeds. Go back to basic principles. Expanding government control over health care financing and delivery, the central objective of Obamacare, is incompatible with conservative principles.
Thank you for listening.