

CONTENTS

| | |
|--|-------|
| <i>Foreword by Paul Krugman</i> | ix |
| <i>Foreword by Senator William H. Frist, MD</i> | xv |
| <i>Prologue</i> | xxiii |
| Introduction | 1 |
| I A Visual Stroll through America's Health Care Wonderland | |
| 1 U.S. Health Spending and What Drives It | 13 |
| 2 Pricing Americans Out of Health Care | 41 |
| 3 Some Interesting or Curious Facts about Our Health Care System | 47 |
| 4 Who Actually Pays for Health Care? | 62 |
| 5 Value for the Money Spent on U.S. Health Care | 69 |
| II Ethical Perspectives on U.S. Health Care | |
| 6 The Social Role of Health Care | 81 |
| 7 The Mechanics of Commercial Health Insurance from an Ethical Perspective | 85 |
| 8 The Elephant in the Room and the Ethical Vision Baked into Health Reform Proposals | 99 |

| | | |
|----|---|-----|
| 9 | The Ethical Vision of the Affordable Care Act of 2010 (Obamacare) | 102 |
| 10 | The Ethical Vision of the Health Reform Proposals of 2017 | 110 |
| | Conclusion: A Novel (My Own) Reform Proposal | 135 |
| | <i>Epilogue by Tsung-Mei Cheng</i> | 139 |
| | <i>Acknowledgments by Tsung-Mei Cheng</i> | 169 |
| | <i>Notes</i> | 173 |
| | <i>Index</i> | 191 |



Introduction

Even twenty years ago, it should have been clear that the collision of two powerful, long-term trends in our economy would eventually drive the debate on U.S. health policy to the impasse it reached in 2017. Indeed, some of us had predicted it years ago. (See, for example, “Is There Hope for the Uninsured?,” *Health Affairs* [2003].¹)

The debate is conducted in the jargon of *economics* and *constitutional federal-state relations*. But it is not really about economics and the Constitution at all. Instead, at the heart of the debate is a long-simmering argument over the following question on distributive *social ethics*:

To what extent should the better-off members of society be made to be their poorer and sick brothers’ and sisters’ keepers in health care?

The two ominous long-term trends on which I based my dire prognosis on the uninsured are the following:

1. the rapid secular growth in the cost of American health care, in the face of
2. the growing inequality² in the distribution of income and wealth in this country.

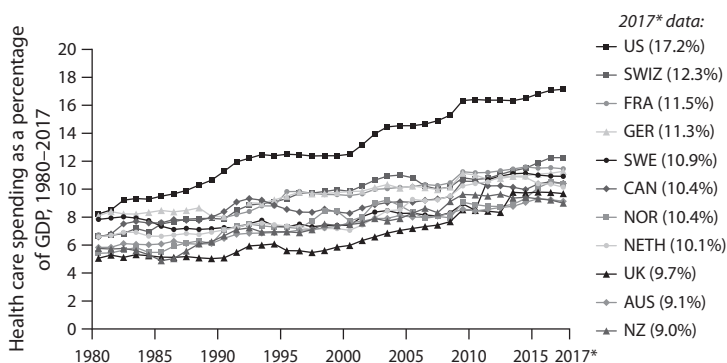


Figure I.1 Health Care Spending as a Percentage of GDP, 1980–2017 (Adjusted for Differences in Cost of Living). Current expenditures on health per capita, adjusted for current US\$ purchasing power parities (PPPs). Based on System of Health Accounts methodology, with some differences between country methodologies (data for Australia uses narrower definition for long-term care spending than other countries). *2017 data are provisional or estimated.

Source: Roosa Tikkanen, *Multinational Comparisons of Health Systems Data*, 2018 (Commonwealth Fund, Dec. 2018), <https://www.commonwealthfund.org/publications/publication/2018/dec/multinational-comparisons-health-systems-data-2018>.

Figures I.1 and I.2 give a sense of these two trends.

Over time, these two trends have combined to price a growing number of American families out of the high-quality or at least luxurious American health care that families in the higher strata of the nation's income distribution would like to have for themselves. We have now reached a pass where bestowing on a low-income American even standard medical procedures, such as a coronary bypass or a hip replacement, is the financial equivalent of bestowing on a poor patient a fully loaded Mercedes-Benz.

The American people's legendary apathy on such matters (see, for example, Uwe Reinhardt, "Taking Our Gaze away from Bread and Circus Games" [1995])³ has facilitated the unabated growth of these trends over time.⁴ The people's leaders, from

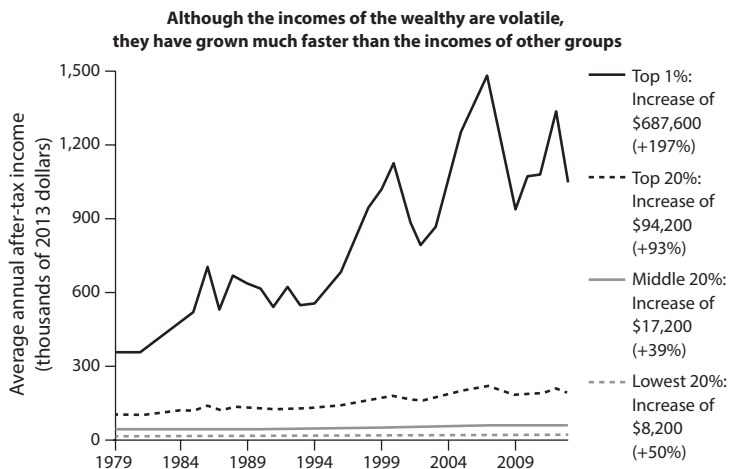


Figure I.2 Average Annual After-Tax Income (2013 Dollars). Increase calculated for 1980–2013.

Source: Congressional Budget Office, *The Distribution of Household Income and Federal Taxes, 2013*, June 2016. Compiled by Peter G. Peterson Foundation, 2016. Reprinted with permission from PGPF.

every incumbent president down,⁵ simply told voters that we had the best macro economy in the world, and also the best health system in the world, bar none, and that was good enough for the general populace.

In the early postwar period and through the 1990s, the dream among health policy analysts and the policy makers they advised had been to construct for America a roughly egalitarian, universal health insurance and health care system.

That dream appears to be dead. We will examine the symptoms of its demise throughout the book. Just one example is the ceaseless talk about the economic “sustainability” of Medicare and Medicaid. That argument reflects efforts by some members of Congress and their advisers to construct for the United States an *officially* sanctioned, multi-tier health system in which the

quality of health insurance and of the health care experience of low-income and lower-middle-class Americans does not have to match the health care experience of families in the upper strata of the nation's income distribution. In effect, they seek a system in which health care is rationed by income class.

The argument that U.S. spending on Medicare for the elderly and Medicaid for the poor and disabled is not “affordable” or “economically sustainable” seems to have wide currency in the arena of public opinion; but it is a highly dubious argument that calls for quick comment.

Medicare

One should always challenge anyone who declares that a trend—any trend—is “unsustainable” or “not affordable” to explain exactly what he or she means by these words. Usually the response will be vague or plainly *political*, that is, not about economics at all.

To illustrate, figure 1-8 in a 2016 report⁶ by the prestigious Medicare Payment Advisory Commission (Medpac) shows that in some years Medicare spending rose faster than private health insurance spending, while in other years it was the other way around. These growth rates are reproduced in figure I.3.

If Medicare spending is not sustainable, is health spending sustainable under private health insurance, whose growth in per capita health spending in many years has exceeded the growth in Medicare spending per beneficiary?

The latest estimates by the Trustees of the Medicare program⁷ indicate that Medicare currently accounts for 3.6 percent of gross domestic product (GDP) and will claim 6 percent of GDP by 2050. For 2016, that comes to a claim of 2016 per capita GDP of \$2,088, leaving a non-Medicare GDP per capita of about \$56,000.

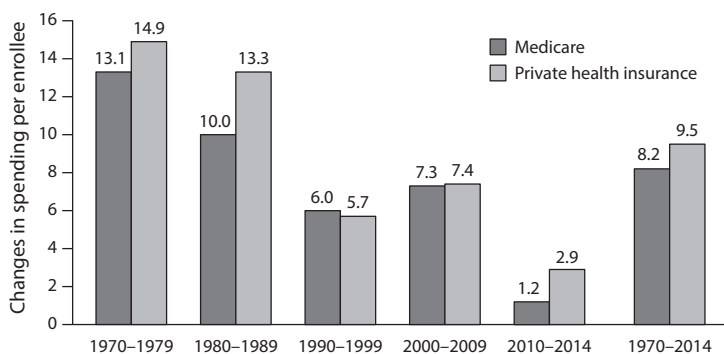


Figure I.3 Changes in Spending per Enrollee, Medicare and Private Health Insurance.

Source: Medicare Payment Advisory Commission (Medpac) Data Book “Health Care Spending and the Medicare Program,” June 2016, Figure 1-8.

According to the Congressional Budget Office (CBO), real GDP is expected to grow by only 1.9 percent per year for the foreseeable future (although that number may be higher if promises made by the Trump administration come true). If we subtract from the growth of real GDP the currently projected population growth of about 0.9 percent per year, we conclude that the CBO projects real GDP per capita to grow by about 1 percent. At an annual compound growth rate of 1 percent, real GDP (in 2017 prices) will be \$80,544 in 2050. After a claim of 6 percent, or \$4,833, for Medicare, that leaves the contemporaries living in 2050 with \$75,700 of non-Medicare GDP per capita. Thus, in 2050 the contemporaries living then will have 35 percent more real *non-Medicare GDP* per capita than we have today.⁸ Figure I.4 illustrates these numbers.

So, if we could afford to take care of our elderly in 2016 with a real GDP per capita of only \$58,000, why cannot the contemporaries living in 2050 take care of their elderly with a real GDP per capita of \$80,500? Put another way, what do pundits and

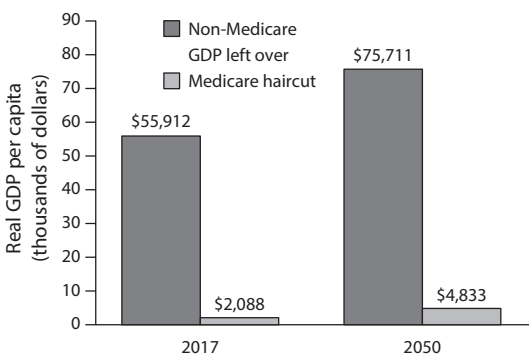


Figure I.4 Real GDP Per Capita after Medicare Haircut, 2017 and 2050.
Source: Congressional Budget Office, 2017.

politicians who proclaim that Medicare is “unsustainable” mean by that term?

Medicaid

Total Medicaid spending is determined by the number of Americans who are eligible for Medicaid coverage and the amount of spending *per Medicaid enrollee*.

The growth in Medicaid enrollment is driven primarily by the growing income inequality in this country, which tends to increase the number of low-income Americans and with it enrollment in Medicaid, especially during recessions. Indeed, there is now a debate about how long this growing income inequality is politically sustainable, not only in the United States but also in other modern democracies.⁹

The *level* of Medicaid spending *per enrollee* is determined in part (1) by the high cost of U.S. health care in general¹⁰ and (2) by the fact that the Medicaid population tends to be sicker and

is more disabled than is the low-income, privately insured population. After a careful review of the literature on Medicaid spending, the Kaiser Family Foundation¹¹ concluded:

Spending *per enrollee* is lower for Medicaid compared to private insurance after controlling for differences in socio-demographic and health characteristics between the two groups. Given the significant health and disability differences between Medicaid enrollees and those who are privately insured, the most rigorous research examining differences in *per-enrollee* spending has focused primarily on regression-adjusted comparisons that control for these underlying differences in the need for health care. (Italics added.)

There are no proposals to impose *global* budgets on per capita U.S. health spending in general. In the Congressional Republican reform proposals of 2017, on the other hand, spending on the poor and disabled in Medicaid is to be constrained by converting the current federal assistance to Medicaid, Federal Medical Assistance Percentages (FMAP),¹² into a block grant or per capita cap arrangement whose future growth is to be constrained to the growth merely of the urban Consumer Price Index. That index, however, has always risen more slowly over time than overall per capita health spending in the United States, as figure I.5 shows.

An argument often made by the proponents of constraining Medicaid spending in this way is that actually we are not talking about real cuts, but merely cuts from some imaginary projected future spending path. First, the argument goes, the data are already adjusted for future growth in Medicaid enrollment, because future Medicaid spending is anchored in a block grant. Second, the argument continues, general price inflation (as measured

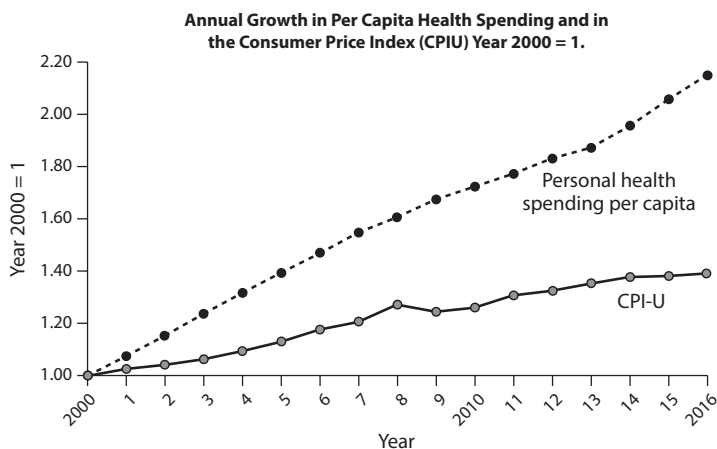


Figure I.5 Annual Growth in Per Capita Health Spending and in the Consumer Price Index (CPI-U) Year 2000 = 1.

Sources: For health spending, Department of Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), “National Health Expenditure Accounts,” available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>. For the inflation rate, Inflation Data.com, Tim McMahon, “Historical Consumer Price Index (CPI-U),” October 13, 2017. https://inflationdata.com/Inflation/Consumer_Price_Index/HistoricalCPI.aspx?reloaded=true. Last viewed October 20, 2017.

by the CPI-U) always does rise, and therefore so will future Medicaid spending per capita. In a nutshell, the argument concludes, there will be no future *cuts* to the Medicaid program.

An interesting experiment here would be to see how members of Congress themselves would react if the tough constraints proposed for future per capita Medicaid spending were to be applied also to the public subsidies the federal government routinely grants health insurance for members of Congress and their staff.

Because even after a lively debate on the matter, we will never be able to reach a political consensus on the fundamental question raised above—to what extent we should become our

poorer brothers' and sisters' keepers when they fall ill. All that is left for health policy makers is the construction of an administratively more stable multi-tier health care system that facilitates rationing by income class. Chapters 9 and 10 of this book, which examines the various health reform plans debated during the summer of 2017, shed further light on this issue.

That is the long and short of it.

In the rest of the book, I begin with an overview of U.S. health spending and the factors that drive our high health spending. I argue that these spending trends already are pricing more and more American families in the lower part of the nation's income distribution out of health insurance and health care as families in the upper half of the distribution know it. I then focus on a number of bizarre quirks in our health system that are unique to the United States, explain who actually pays for health care in the United States, and explore the question whether from an international perspective Americans get adequate value for their high health spending.

Part II of the book is devoted to the ethical questions that the current situation in the United States raises for health policy makers. I explain the different distributive ethics different nations impose on their health care systems and how the United States is different from the majority of the rich nations in Europe and Asia in that it has never been able to reach a politically dominant consensus on a distributive ethic for American health care. This is followed by an explanation, from an ethical perspective, of the mechanics of commercial health insurance, which accounts for over a third of the total health spending in the United States. I then turn to focus on health reforms and the ethical precepts that underlay the reforms in recent years. The book ends with a brief novel proposal of my own for the next health reform in the United States.

INDEX

NOTE: Page numbers in *italics* refer to figures and tables. Note information is indicated by n and note number following the page reference.

- Aaron, Henry, 32
- ACA (Affordable Care Act).
See Obamacare
- actuarially fair insurance premiums:
ethical perspective on, 85, 88–92,
89–90, 93, 95, 96–97, 97; reform
proposals on, 111, 132, 135–37
- administrative overhead: Congress
as driver of, 38–40; drug-related,
32–38, 33–36; growth of adminis-
trative workforce, 27–28, 28;
health care costs driven by, 16,
23–40; health care providers and
hospitals incurring, 29–30, 30;
insurance-related, 23–26, 25–26,
28–30; medical underwriting
raising, 91; patients incurring, 30,
30–32; reduction of, 158, 164–65;
value chain and, 26–27, 26–27
- adverse risk selection, 97, 97, 125, 133
- Affordable Care Act (ACA).
See Obamacare
- aging population: health care costs
among, 17–21, 18–20; insurance
for, 25, 45, 46 (*see also* Medicare);
reform proposals' effects on, 110–11,
113, 114, 123, 124, 128–29, 131
- AHCA. *See* American Health Care Act
- AHIP (American Health Insurance
Plans) data, 28–29, 53, 54–56
- Alexander, Lamar, 142
- all-payer systems, 50–51, 158–60
- Altman, Drew, 118, 144–45
- American Health Care Act (AHCA):
actuarially fair insurance premiums
under, 111; CBO analysis of, 83,
112, 113, 114, 115, 116, 130;
community-rated insurance
premiums under, 111; essential
health benefits under, 111; ethical
perspectives on, 83, 95, 110–17,
112, 114, 116–17; insurance
premiums under, 95, 110–17; job
creation or depletion under, 58;
Medicaid changes under, 112, 116,
130; summary of, 110; tax changes
under, 110–11, 112–13, 114,
116–17, 130; waivers under, 111

- American Health Insurance Plans (AHIP) data, 28–29, 53, 54–56
- Arrow, Kenneth, 77
- Australia: demographics of, 21; health care costs in, 2, 14, 15, 17; health care prices in, 23–24; health status indicators in, 72; self-rationing of health care in, 71
- Austria: health care costs in, 14
- BCRA. *See* Better Care Reconciliation Act
- Belgium: social health insurance system in, 93
- Better Care Reconciliation Act (BCRA): actuarially fair premiums under, 132; administrative overhead under, 29; CBO analysis of, 83, 122, 125–27, 126, 128–30; community-rated premiums under, 121–22, 124–25; Cruz Amendment to, 132–33; ethical perspectives on, 83, 95, 118–34, 120, 123, 126, 128–30; insurance premiums under, 95, 118–34, 123; job creation or depletion under, 58; mandated coverage under, 121, 124–25; Medicaid changes under, 118–21, 127, 130; out-of-pocket expense percentages under, 122, 123, 124; subsidized individuals under, 121, 124, 125, 128–29, 131; tax changes under, 121, 124, 125, 128–30, 131; waivers under, 124, 185n26
- Bismarck, Otto von, 93, 140
- Bismarckian model, 93
- boutique medicine, 25, 45, 164
- Brill, Steven, 49
- Brooks, David, 40, 131
- Brooks, Mo, 94
- Canada: administrative overhead in, 30; demographics of, 21; health care costs in, 2, 14, 15, 17, 30; health status indicators in, 72, 75; private insurance in, 81–82; self-rationing of health care in, 71; single-payer system in, 30, 63–64, 81, 154–55, 179n1; social health insurance system in, 30, 63–64, 65, 81–82, 154–55, 179n1; social role of health care in, 81, 82; timeliness of services in, 70; value for health care spending in, 70, 71, 72, 75, 77
- cancer, 74–75, 75
- Cassidy, Bill, 101
- CBO. *See* Congressional Budget Office
- Centers for Disease Control and Prevention (CDC): obesity and diabetes metrics, 72, 73
- Centers for Medicare and Medicaid Services (CMS): drug payment proposal by, 38; health spending data, 14, 146, 175n1; Innovation Center of, 14, 160. *See also* Medicaid; Medicare
- Cheng, Tsung-Mei, 111, 139
- children and adolescents. *See* younger population

- China: demographics of, 21. *See also* Taiwan
- citizen engagement, in health care, 142–43
- CMS. *See* Centers for Medicare and Medicaid Services
- coinsurance, 37, 52, 70, 103, 122, 131, 145
- community-rated insurance premiums: ethical perspective on, 85, 91–95, 97–98, 97; income redistribution via, 45, 46; under Obamacare, 46, 86, 92, 93, 108, 109; reform proposals on, 111, 121–22, 124–25, 135–37
- Congress: as administrative overhead driver, 38–40; insurance for, 8, 46; reform proposals of (*see* reform proposals)
- Congressional Budget Office (CBO): on real GDP, 5, 6, 146; reform proposal analysis by, 83, 101, 112, 113, 114, 115, 116, 122, 125–27, 126, 128–30, 151
- Consumer Price Index for All Urban Consumers (CPI-U): health care cost growth relative to, 8, 119–20, 120; Medicaid constraints based on, 7–8, 119–21
- Cooper, Zachary, 47
- costs of health care. *See* health care costs; prices
- CPI-U. *See* Consumer Price Index for All Urban Consumers
- Cruz, Ted, 132
- Cruz Amendment, 132–33
- deductibles, insurance, 52, 70, 103, 122, 131, 145
- demographics: health care costs effects of, 17–21, 18–20; insurance availability based on, 24–25, 25
- Denmark: health care costs in, 2, 14, 15, 17
- diabetes, 71–72, 73
- doctors. *See* health care providers and hospitals
- Douthat, Ross, 131
- drugs: distribution system, 32–38, 35–36; income distribution and ability to pay for, 44; prices of, 21, 22, 32–38, 33–34, 36, 145, 150; rebates on, 37
- economic perspectives: on commercial health insurance, 85–98; GDP figures (*see* gross domestic product); on health care costs (*see* health care costs; prices); on income distribution (*see* income distribution); on Medicaid and Medicare, 3–9, 5, 6, 8, 66, 175n10, 175n12; per capita figures (*see* per capita figures); on prices (*see* prices)
- elderly adults. *See* aging population
- employment: growth of health care workforce, 27–28, 28; health care job creation or depletion, 57–59, 58; insurance provided via, 25,

- employment (cont.)
25–26, 37, 42, 62, 66–68, 93,
157, 165
- ethical perspectives: on commercial
health insurance, 85–98; distribu-
tive social ethics, 1, 81–84, 151; on
Obamacare, 102–9; on reform
proposals, 9, 81–84, 95, 99–101,
110–34, 139–67; social good
perspective, 100–101, 102; on social
role of health care, 81–84, 82
- Flack, Roberta, 120
- Flexible Spending Accounts (FSAs),
39, 177n24
- Frakt, Austin, 60
- France: health care costs in, 2, 14, 15,
17; health care prices in, 50–51;
health status indicators in, 72, 75,
76; self-rationing of health care in,
71; social health insurance system
in, 93; value for health care
spending in, 71, 72, 75, 76, 77
- FSAs (Flexible Spending Accounts),
39, 177n24
- Gaba, Charles, 105
- GDP. *See* gross domestic product
- Germany: administrative overhead in,
30, 31–32; all-payer system in, 159;
demographics of, 19; health care
costs in, 2, 14, 15, 17, 19, 30,
31–32; health care prices in, 50–51,
159; health status indicators in, 75,
76; private insurance in, 81, 156,
181n2; risk-adjustment mecha-
nisms in, 156; self-rationing of
health care in, 71; social health
insurance system in, 65, 81, 93,
139–40, 144, 155, 156, 159, 181n2;
social role of health care in, 81;
value for health care spending in,
71, 75, 76, 77
- Goethe, Johann Wolfgang von, 139,
143–44
- Gorman, Linda, 111
- Graham, Lindsey, 101
- gross domestic product (GDP):
growth of real, 5, 6; health care
costs as percentage of, 3, 13, 14, 14,
60–61, 146, 159; health care costs
growth exceeding growth of, 146;
Medicare costs as percentage of,
4–5, 6; per capita, and ability to
pay, 16, 17; personal income *vs.*, 61
- health care: boutique, 25, 45, 164;
citizen engagement in, 142–43;
costs of (*see* health care costs;
prices); curious facts about U.S.,
47–61; economic perspectives
on (*see* economic perspectives);
ethical perspectives on (*see* ethical
perspectives); income in relation to
(*see* income distribution); insurance
for (*see* insurance); job creation or
depletion, 57–59, 58; multi-tiered
system, 162–64, 166–67; payers of
(*see* payers); pre-Obamacare status
of, 161–62; providers of (*see* health

- care providers and hospitals); reform (*see* reform proposals); as social good, 100–101, 102; social role of, 81–84, 82; as tax system, 59–61, 61, 69; transformation of, 162–66
- health care costs: ability to pay for, 16, 17, 43–44, 110, 125, 131, 149–50, 177n1; administrative overhead, 16, 23–40, 91, 158, 164–65; concentration of spending on, 86–87, 87, 148; control of, 158–60; demographic structure affecting, 17–21, 18–20; drivers of high, 15–40, 145, 158, 164–65; as GDP percentage, 3, 13, 14, 14, 60–61, 146, 159; growth of, 1, 2, 8, 13, 146–47; high prices driving, 21–23, 22–24, 30, 32–38, 33–34, 36, 145; insurance coverage of (*see* insurance); international comparisons, 2, 14, 14–15, 15, 175n1; of Medicaid, 3–4, 6–9, 8; medical bills for (*see* medical bills); of Medicare, 3–6, 5, 6; Milliman Medical Index of, 41–43, 42; payers of (*see* payers); per capita, 4, 5, 7, 8, 14–15, 17, 17–19, 18–19, 23, 30, 31, 42, 119–21, 120; value for spending on, 69–77; waste from excess, 76–77, 77
- health care providers and hospitals: administrative overhead of, 29–30, 30; growth of workforce, 27–28, 28; prices of, 21–22, 23, 23–24, 30, 45, 46, 47–53, 48–49, 51, 60, 150–51, 158–60, 161–62, 163; shortage of, 150; surprise bills from out-of-network, 53, 54–56, 60, 61; in value chain, 26–27, 26–27
- Health Datapalooza, 165
- health information technology (HIT), 24, 165
- Health Savings Accounts (HSAs), 39
- health status indicators: for cancer, 74–75, 75; concentration of health care spending reflecting, 86–87, 87, 148; insurance premiums based on, 85, 88–92, 89–90, 93, 95–97, 97, 111, 132, 135–37; life expectancy as, 73–74, 74, 180n9; for mortality amenable to health care, 75, 76; for obesity and diabetes, 71–72, 72–73; personal *vs.* social responsibility for, 94–95; preexisting conditions, 95–96; value of health care and, 70–75, 72–76
- HIT (health information technology), 24, 165
- Hlatshwayo, Sandile, 57
- Hogan, Larry, 160
- hospitals. *See* health care providers and hospitals
- H.R. 1628: House of Representatives draft (*see* American Health Care Act); Senate draft (*see* Better Care Reconciliation Act)
- HSAs (Health Savings Accounts), 39

- income distribution: ability to pay for health care and, 16, 17, 43–44, 110, 125, 131, 149–51, 177n1; health care prices and, 22–23, 45, 46; health care rationed by, 2, 4, 45, 70, 71, 100–101, 110, 125, 131, 148, 149–51; healthy policy choices reflecting, 44–46; inequality of, 1–2, 3, 6, 43–44, 43–46; insurance availability and, 24–25, 25; insurance premiums and, 45, 46, 87–98, 102–9, 110–34; Medicaid eligibility and (*see* Medicaid); multi-tiered health care system reflecting, 162–64, 166–67; Obamacare applicability by, 102–9; redistribution options, 44, 45–46, 92, 131; statistics on U.S. wealth and, 43–44, 43–44, 177n1
- Institute of Medicine study, 73, 75, 76, 77, 164
- insurance: actuarially fair premiums for, 85, 88–92, 89–90, 93, 95, 97–99, 97, 111, 132, 135–37; administrative overhead of, 23–26, 25–26, 28–30; adverse risk selection for, 97, 97, 125, 133; coinsurance with, 37, 52, 70, 103, 122, 131, 145; community-rated premiums for, 45, 46, 85, 91–95, 96–98, 97, 108, 109, 111, 121–22, 135–37; death spiral of, 98, 104, 125, 133; deductibles, 52, 70, 103, 122, 131, 145; demographics of coverage, 24–25, 25; economic perspectives on, 85–98; employment-based, 25, 25–26, 37, 42, 62, 66–68, 93, 157, 165; ethical perspectives on, 85–98 (*see also under* Obamacare; reform proposals); mandates for, 85, 98, 104, 109, 125, 135, 149, 182n7; medically underwritten premiums for, 85, 88–92, 89–90, 93, 95, 96–97, 97, 111, 132, 135–37; Obamacare regulation of (*see* Obamacare); out-of-network lack of coverage, 53, 54–56; as payers for health care, 62–68, 63, 64; for preexisting conditions, 95–96, 162; prices paid by, 48, 48, 49–50, 158–60, 161–62; prices paid for, 45, 46, 85, 87–98, 102–9, 110–34; private, 4, 5, 23–26, 25–26, 28–29, 37, 42–43, 48, 48, 49–50, 62, 66–68, 81–82, 85–98, 155–58, 181nn2–3; reform proposals on (*see* reform proposals); risk pools, 87–92, 89–90, 95–96, 132–33, 148, 156–57; social (*see* Medicaid; Medicare; social insurance); tax credits for, 110–11, 113, 114, 116–17, 121, 128–30; tax-financed subsidies for, 39–40, 67–68, 102–3, 105, 106–8, 107, 109, 121, 124, 125, 128–29, 131, 176n21, 179–80n7, 183n9; in value chain, 26, 26
- international comparisons of health care costs, 2, 14, 14–15, 15, 175n1. *See also specific countries*

- International Federation of Health Plans, price comparisons, 21, 22–24, 37, 160
- Italy: health care costs in, 14; health status indicators in, 72, 75
- Japan: administrative overhead in, 30; all-payer system in, 159; demographics of, 18–19, 19, 21; health care costs in, 2, 14, 15, 17, 18–19, 19, 30; health status indicators in, 75; social health insurance system in, 65, 93, 159; value for health care spending in, 75, 77
- Kaiser Family Foundation, 7, 31, 73, 84, 102, 110, 113, 115, 118, 144
- Kimmel, Jimmy, 94
- Klein, Ezra, 153
- Kliff, Sarah, 52
- Kocher, Robert, 27–28
- Korea: administrative overhead in, 30; demographics of, 19, 21; health care costs in, 14, 15, 17, 19, 30; health status indicators in, 72; single-payer system in, 63; social health insurance system in, 63, 65
- Libertarians, reform proposal suiting, 135–37
- life expectancy, 73–74, 74, 180n9
- Luxembourg: health care costs in, 19
- maternity and neo-natal care, 111–12
- McDermott, Jim, 155–57
- McKinsey Global Institute study, 21, 27, 31
- Medicaid: demographics of coverage, 25; economic sustainability of, 3–4, 6–9, 8, 66, 175n10, 175n12; financing of, 175n12; as payer for health care, 63, 161–62; prices paid by, 161–62; reform proposals changes to, 112, 116, 118–21, 127, 130, 137, 184n18; taxes and transfers for, 45
- medical bills: administrative overhead and, 16, 29, 31; billing clerks for, 29; billing consultants for, 31; lack of price transparency on, 52–53, 60; surprise, 53, 54–56, 60, 61
- medically underwritten insurance premiums: ethical perspective on, 85, 88–92, 89–90, 93, 95, 96–97, 97; reform proposals on, 111, 132, 135–37
- Medicare: community-rated premiums under, 93; demographics of coverage, 25; drug costs for, 37–38; economic sustainability of, 3–6, 5, 6, 66; Medicare Advantage program, 64–65, 93; Medicare-for-all system, 152–58; as payer for health care, 62, 63–66, 152–58; prices paid by, 37–38, 48, 50, 158, 160, 175n10; taxes and transfers for, 45
- Medicare Payment Advisory Commission (Medpac), 4, 38

- Medicare Prescription Drug, Improvement, and Modernization Act (2003), 64
- medications. *See* drugs
- Medpac (Medicare Payment Advisory Commission), 4, 38
- mental health care, 111
- Mexico: health status indicators in, 72
- Meyer, Harris, 152
- military health care, 45, 63. *See also* Veterans Administration (VA) health care
- Milliman Medical Index, 41–43, 42
- mortality amenable to health care, 75, 76
- Mulligan, Casey B., 57
- Mulvaney, Mick, 94
- National Academy of Medicine (formerly Institute of Medicine) study, 73, 75, 76, 77
- Netherlands: health care costs in, 2, 14; risk-adjustment mechanisms in, 156; self-rationing of health care in, 71; social health insurance system in, 93, 155, 156
- Neuman, Alfred E., 57
- New Zealand: health care costs in, 2; health care prices in, 23–24; health status indicators in, 71, 72; self-rationing of health care in, 71
- Norway: demographics of, 19; health care costs in, 2, 14, 19; self-rationing of health care in, 71
- Obamacare: administrative overhead under, 28–29; common misconceptions about, 147–48; community-rated insurance premiums under, 46, 85, 92, 93, 108, 109; debate on repealing and replacing, 83, 100, 147 (*see also* reform proposals); deductibles and coinsurance under, 145; ethical perspectives on, 102–9; fixing, 109; job creation or depletion under, 57–58; mandates for insurance under, 85–86, 98, 104, 109, 149; middle class neglected in, 104–5, 105; penalties for noncoverage under, 104, 108, 109; poor population provisions of, 102–4; pre-implementation status of health care, 161–62; subsidized individuals under, 67–68, 102–3, 105, 106–8, 107, 109, 183n9; summary of, 102; tax-financed subsidies under, 67–68, 102–3, 105, 106–8, 107, 109, 183n9; unsubsidized individuals under, 103–4, 105, 108–9; waivers under, 185n26
- obesity and overweight, 71–72, 72–73
- older adults. *See* aging population
- Organizations for Economic Cooperation and Development (OECD) countries: demographics of, 18–19, 19; health care spending in, 13–15, 14, 15, 17, 18–19, 19, 175n1. *See also specific countries*
- overhead costs. *See* administrative overhead

- patients: administrative overhead incurred by, 30, 30–32; in value chain, 26
- Pauly, Mark, 21
- payers: all-payer systems, 50–51, 158–60; identifying, 62–68, 63, 64; price variations depending on, 47–51, 48–49, 51, 60, 158, 161–62, 175n10; single-payer systems, 30, 63–65, 81, 152–55, 179n1; with socialized medicine, 65–66
- per capita figures: administrative overhead, 23, 30, 31; GDP, and ability to pay, 16, 17; health care spending, 4, 5, 7, 8, 14–15, 17, 17–19, 18–19, 23, 30, 31, 42, 119–21, 120; Medicaid, 8, 119–21; Medicare *vs.* private health insurance, 4–5, 5; real GDP growth, 5, 6
- Peterson Institute, 73
- pharmaceuticals. *See* drugs
- physicians. *See* health care providers and hospitals
- preexisting conditions, 95–96, 162
- prices: discriminatory, for income redistribution, 45, 46; health care costs driven by, 21–23, 22–24, 30, 32–38, 33–34, 36, 145; for insurance premiums, 45, 46, 85, 87–98, 102–9, 110–34; lack of transparency, 51–53, 60, 158, 160; reference, 148, 150–51, 163; uniform, 23–24, 45, 50–51, 64, 158–60; variations and differentials in, 47–51, 48–49, 51, 60, 158, 161–62, 175n10. *See also* health care costs
- public health insurance. *See* social insurance
- rebates, drug, 37
- reference pricing, 148, 150–51, 163
- reform proposals: administrative overhead increases with, 29, 38–40; American Health Care Act as, 58, 83, 95, 110–17, 112, 114, 116–17, 130; author's recommendations for, 135–37, 141–67; Better Care Reconciliation Act as, 29, 58, 83, 95, 118–34, 120, 123, 126, 128–30, 185n26; CBO analysis of, 83, 101, 112, 113, 114, 115, 116, 122, 125–27, 126, 128–30, 151; comparisons of, 83–84; complexity of system as challenge for, 24–25; Cruz Amendment to, 132–33; demise of, 133–34; for drug distribution, 38; employment effects of, 57–58; ethical perspectives on, 9, 81–84, 95, 99–101, 110–34, 139–67; future prospects for, 151–52; insurance premiums in, 95, 110–34; Medicaid under, 112, 116, 118–21, 127, 130, 137, 184n18; on social role of health care, 81–84; tax changes under, 67, 110–11, 112–13, 114, 116–17, 121, 124, 125, 128–30, 131, 148, 186n3; uninsured population under, 101, 112, 125–26, 126, 135–37. *See also* Obamacare

- Reinhardt, Uwe: education of, 140–41; health care for, 139–40, 144; professional standing of, 141, 143–44; reform recommendations of, 135–37, 141–67
- risk: adverse risk selection, 97, 97, 125, 133; risk-adjustment mechanisms, 156–57; risk corridors, 148; risk pools, 87–92, 89–90, 95–96, 132–33, 148, 156–57
- Rosenthal, Elisabeth, 31, 49
- Roy, Avik, 111, 115, 131
- Sanders, Bernie, 152
- Scott, Dylan, 131
- Shimkus, John, 111
- single-payer systems, 30, 63–65, 81, 152–55, 179n1
- social good perspective, 100–101, 102
- social insurance: administrative overhead of, 23–26, 29; demographics of coverage, 25; as payer for health care, 62, 63–66, 152–58; private insurance industry impacts from, 155–58; public option for, 155–58; social role of health care and, 81–82; universal health coverage through, 144–45, 148–49, 155, 164; in value chain, 26, 26. *See also* Medicaid; Medicare
- socialized medicine, 65–66
- social role of health care, 81–84, 82
- South Africa: health care prices in, 22–24
- Spain: health care costs in, 14; health care prices in, 22–24; health status indicators in, 72
- Spence, Michael, 57
- Starr, Paul, 135
- substance abuse services, 111
- Sweden: health care costs in, 2, 14, 15; self-rationing of health care in, 71
- Switzerland: all-payer system in, 159; demographics of, 19; health care costs in, 2, 14, 14–15, 15, 17, 19; health care prices in, 22–24, 50–51, 159; health status indicators in, 72; risk-adjustment mechanisms in, 156; self-rationing of health care in, 71; social health insurance system in, 93, 155, 156, 159
- Taiwan: administrative overhead in, 30; demographics of, 21; health care costs in, 17, 30; single-payer system in, 63, 81, 152; social health insurance system in, 63, 65, 81, 152; social role of health care in, 81
- taxes: health system as tax system, 59–61, 61, 69; income redistribution via, 45–46; reform proposals on, 67, 110–11, 112–13, 114, 116–17, 121, 124, 125, 128–30, 131, 148, 186n3; social insurance paid via, 62; tax credits, 110–11, 113, 114, 116–17, 121, 128–30; tax-financed subsidies, 39–40, 67–68, 102–3, 105, 106–8, 107,

- 109, 121, 124, 125, 128–29, 131, 179–80n7, 183n9, 186n3
- technology, 24, 165
- Tobin, James, 141
- Tricare, 45, 63
- Trump administration: on health care reform proposals, 94, 101, 115, 147; Medicaid spending proposal of, 7; on Obamacare, 108, 147; on pharmaceutical industry, 32; pressing health care issues facing, 145
- UHC (universal health coverage), 3, 139, 144–45, 148–49, 155, 164
- undocumented aliens, 162
- uninsured population: demographics of coverage, 25; growth of, 149; income distribution among, 1; insurance availability for, 162; multi-tiered health care coverage of, 166–67; Obamacare effects on, 103, 109, 149; Obamacare penalties for noncoverage, 104, 108, 109; pressing health care issues including, 145; prices paid by, 48, 49; reform proposals' effects on, 101, 112, 125–26, 126, 135–37; self-rationing of health care among, 70, 71, 150
- United Hospital Fund of New York study, 33
- United Kingdom: demographics of, 19; health care costs in, 2, 14, 15, 17, 19; health care prices in, 22–24; health status indicators in, 71, 72, 75, 76; self-rationing of health care in, 71; socialized medicine in, 65; timeliness of services in, 70; value for health care spending in, 70, 71, 71, 72, 75, 76, 77
- United States: demographics of, 17–21, 18–20, 24–25, 25; GDP of (*see* gross domestic product); health care in (*see* health care; health care costs)
- universal health coverage (UHC), 3, 139, 144–45, 148–49, 155, 164
- value: administrative overhead and, 26–27, 26–27; for health care spending, 69–77; health status indicators and, 70–75, 72–76; self-rationing of care diluting, 70, 71; value gap, 77; waste in health system depleting, 76–77, 77
- Veterans Administration (VA) health care: as payer for health care, 63, 65–66; as socialized medicine, 65–66; taxes and transfers for, 46
- waste in health system, 76–77, 77
- wealth and income statistics, 43–44, 43–44, 177n1. *See also* income distribution
- younger population: health care costs among, 17–18, 18; insurance for, 25, 45, 97, 104, 106, 156; reform proposals' effects on, 111, 123, 124, 125–26, 126, 128–29, 131