

A COMPARATIVE ANALYSIS OF COST CONTROL MEASURES AND HEALTHCARE SYSTEMS

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Abstract

This paper examines the issue of healthcare spending in the United States and analyzes different healthcare systems and cost-control measures present in other states and countries. Health care costs are and will continue to be a national priority in the United States and worldwide. The first chapter of the paper will examine the problem of rising healthcare costs in the US and the pro and cons of several cost-control measures in the Affordable Care Act (ACA). The focus of the second chapter is the Massachusetts health care reform law. It includes background on the law, outcomes, and comparisons to the ACA. Finally, the third chapter provides an overview of the healthcare systems in the United Kingdom and Germany. The analysis shows some cost-saving benefits for these methods, but also shortcomings.

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Introduction:

This paper will examine the issue of healthcare spending in the United States and analyze different healthcare systems and cost-control measures present in other states and countries. Health care costs are and will continue to be a national priority in the United States. The first chapter of the paper will examine the problem of rising healthcare costs in the US and the pro and cons of several cost-control measures in the Affordable Care Act (ACA). The focus of the second chapter is the Massachusetts health care reform law. It includes background on the law, outcomes, and comparisons to the ACA. Finally, the third chapter provides an overview of the healthcare systems in the United Kingdom and Germany.

Overview of Chapters:

The first chapter of this paper examines three potential cost-savings solutions for healthcare reform: accountable care organizations (ACOs), health insurance exchanges, and government negotiations of prices. The ACA contains a variety of measures meant to control healthcare costs including medical homes, comparative effectiveness research, pay for performance, health information technology and accountable care organizations. Two of the measures have been considered in the Affordable Care Act, and some have been tested already in healthcare settings across the country.

The reasons for the high cost of healthcare in the United States are varied; including “the rising costs of medical technology and prescription drugs... [and] high administrative costs”. According to Davis et al, “although the U.S. spends more on health care than any other country and has the highest rate of specialist physician’s per capita, survey findings indicate that from the patients’ perspective, the quality of American health care is less than optimal. The nation’s substantial investment in health care is not yielding returns in terms of public satisfaction with the health care system.”¹



The United States has by far the most expensive healthcare system in the world, based on health expenditures and total expenditures as a percentage of GDP. The United States spent more than \$8,000 per person on healthcare in 2010 –more than one and half times as other countries. The United States spends over 18 percent of its GDP on health, which is higher than that of any other country. Despite our high healthcare spending, Americans have a lower life expectancy than other developed countries.

The Commonwealth Fund is an organization whose mission is promoting a high-performing health care system. They accomplish this by supporting independent research on health care issues. Their report “Mirror, Mirror On The Wall: How the Performance of the U.S. Health Care System Compares Internationally”, ranked the U.S. 11th in overall out of the 11 countries studied on measures of health outcomes, quality,

¹ Davis, Karen et al. mirror, mirror on the wall: an international update on the comparative performance of American health care. The Commonwealth Fund, 2007.

and efficiency. Conversely, The United Kingdom ranks first and Germany ranks fifth. The figure below is taken from the same report.²

EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS												
Top 2*												
Middle												
Bottom 2*												
												
		AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)		4	10	9	5	5	7	7	3	2	1	11
Quality Care		2	9	8	7	5	4	11	10	3	1	5
Effective Care		4	7	9	6	5	2	11	10	8	1	3
Safe Care		3	10	2	6	7	9	11	5	4	1	7
Coordinated Care		4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care		5	8	10	7	3	6	11	9	2	1	4
Access		8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem		9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care		6	11	10	4	2	7	8	9	1	3	5
Efficiency		4	10	8	9	7	3	4	2	6	1	11
Equity		5	9	7	4	8	10	6	1	2	2	11
Healthy Lives		4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**		\$3,800	\$4,522	\$4,118	\$4,495	\$5,099	\$3,182	\$5,669	\$3,925	\$5,643	\$3,405	\$8,508

Notes: * Includes ties. ** Expenditures shown in \$US PPP (purchasing power parity); Australian \$ data are from 2010.
 Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011*; World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

Prior to the passage of the Patient Protection and Affordable Care Act (ACA), every other industrialized country provided universal healthcare except the United States. The ACA extends coverage to millions of previously uninsured individuals. Although some cost-controls are included in the ACA, the cost of healthcare in America

² "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally." The Commonwealth Fund. <http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror>.

is expected to continue to rise. Several solutions have been proposed as an option to lower costs, including healthcare delivery system reform accountable care organizations (ACO), the health insurance exchanges and government negotiation of prescription drug prices. Although rising healthcare costs are not a new problem, increased spending on health care, combined with the country's economic challenges, makes the need to control health care spending a national priority. Accountable Care Organizations (ACOs) are groups of physicians, hospitals and other healthcare providers that share responsibility for improving the quality of care for its patients while reducing costs. The health insurance exchanges are web-based markets that individuals can use to purchase health insurance plans. Finally, only Medicare and the Department of Veterans Affairs can set or negotiate the prices for the health services that they provide. In some countries, health insurance is provided to everyone, and the government sets prices or oversees price negotiation to keep costs down. Maryland is only state in the U.S. that sets rates for hospitals, with the government deciding what every hospital can charge for a given procedure.

The second chapter compares the Massachusetts health care reform law passed in 2006 to the ACA. There are similarities between the Affordable Care Act and the MA health reform law. The MA law is considered a blueprint for the ACA. Both have state-based insurance exchanges, subsidies for lower-income individuals and mandates on individuals and businesses. Examining the MA law and its outcomes will provide insight into the potential universal coverage and healthcare costs associated with the ACA.

The insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) are modeled after the Massachusetts law's major provisions: expanded Medicaid eligibility, new subsidized coverage options for people with low and moderate incomes, insurance exchanges through which individuals and small businesses can purchase health coverage, and new individual and employer mandates.

Healthcare is a priority and source of concern worldwide. Health systems can vary by country. The third chapter will compare the health care systems of the United Kingdom and Germany compared to the United States. Both countries rank higher in studies than the US in quality, access, and efficiency. Researching the MA law will provide insight into potential outcomes for the ACA, which has only been fully implanted since January 1, 2014. The German system is multi-payer health care system with two main types of health insurance: workers choose a sickness fund that is paid for with joint employer-employee contributions. The UK has a single-payer system funded by taxes. The first part of the chapter will focus on the description of the four models of healthcare systems and the U.S. healthcare system. The second part will provide an overview of the healthcare systems in the United Kingdom and Germany and any potential policy recommendations for the United States.

Chapter 1: Examination of Healthcare Prices in the United States and Potential Cost-Control Measures

The Patient Protection and Affordable Care Act (ACA) was signed into law in 2010. The ACA established universal health insurance coverage for a majority of Americans.³ The ACA extends coverage to millions of previously uninsured individuals. The expansion in coverage was achieved through several means including: an individual mandate, a requirement for insurance companies to provide coverage regardless of pre-existing conditions, subsidies to individuals who cannot afford insurance and state-based healthcare exchanges where individuals can compare healthcare plans.^{1, 4} Despite the fact that cost-controls are included in the ACA, the cost of healthcare in America is expected to continue to rise. Several solutions have been proposed as an option to lower costs, including accountable care organizations (ACO), the health insurance exchanges and government negotiation of prescription drug prices.

Although high healthcare costs are not a new problem, spending on health care, combined with the country's fiscal challenges, makes the need to contain health care costs a national priority. This chapter will examine the current high cost of the U.S. health care system and proposed cost-control measures and their effect on controlling healthcare costs.

³ Patient Protection and Affordable Care Act Pub L. No. 111-148, HR 3590.

⁴ Shaffer, Ellen R. "The Affordable Care Act: The Value of Systemic Disruption." *American Journal of Public Health* 103, no. 6 (2013): 969-972.

The Problem:

According to the Centers for Medicare and Medicaid Services (CMS), the United States spent more than \$8,000 per person on healthcare in 2010 –more than one and half times as other countries.⁵ Comparatively, Canada spent \$4,808 and France spent \$3,978. The United States spends more on health care than any other countries in the Organization for Economic Co-operation and Development (OECD), an international economic organization of thirty-four countries, without providing more services than the other countries, suggesting that the difference in spending costs is mostly attributable to higher priced services.⁶

The United States spends over 18 percent of its GDP on health, which is higher than any other country. Annual per capita health spending in the U.S. is the highest in the world—\$8,508 in 2011. Total health care spending in the United States is expected to reach \$4.8 trillion in 2021, up from \$2.6trillion in 2010 and \$75 billion in 1970. Health care spending will account for nearly 20 percent of GDP, or one-fifth of the U.S. economy, by 2021.⁷ Despite our high healthcare spending, Americans have a lower life

⁵ Allen, Frederick. "Fixing Our Healthcare System: We Spend More Money per Patient Than Any Other Country, Yet We Are Less Healthy by Far. How Did Our Healthcare System Become Such a Wreck? and What Is to Be Done?." The Saturday Evening Post, September 1, 2012.

⁶ Klein, Ezra. "High health care costs: It's all in the pricing." Washington Post. http://articles.washingtonpost.com/2012-03-02/business/35449534_1_higher-prices-health-care-services-health-care-costs.

⁷ "National Health Expenditures Projections 2011-2021." Centers for Medicare and Medicaid Services. <http://www.cms.gov/Research-Statistics-data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf>.

expectancy than other developed countries.⁴ According to the United Nations the U.S. ranks 46th (78.5) in life expectancy at birth. Comparatively, Japan ranks 1st (83.5 years), Germany 25th (80.5 years) and the U.K. 34th (80 years).⁸

During the 2009-2010 ACA health reform debate, Secretary of Health and Human Services, Kathleen Sebelius, asserted, “every cost-cutting idea that every health economist has brought to the table is in this bill.” The ACA does contain a variety of measures meant to control healthcare costs including medical homes, comparative effectiveness research, pay for performance, health information technology and accountable care organizations.⁹

There are several factors cited for contributing to the high cost of health care; including high prices, administrative costs and a large number of uninsured Americans. This chapter will examine and evaluate three potential cost-savings solutions for health care reform: accountable care organizations (ACOs), health insurance exchanges, and government negotiations of prices. Two have been considered in the Affordable Care Act, and some have been tested already in healthcare settings across the country. This analysis will share the cost-saving benefits of these methods, but also highlight shortcomings and obstacles for each for each method.

⁸ "United Nations Statistics Division - Demographic and Social Statistics." United Nations Statistics Division - Demographic and Social Statistics. <http://unstats.un.org/unsd/demographic/products/socind/>.

⁹ Oberlander, J.. "Throwing Darts: Americans' Elusive Search for Health Care Cost Control." Journal of Health Politics, Policy and Law 36, no. 3 (2011): 477-484.

Proposed Solutions:

Accountable Care Organizations:

Accountable Care Organizations (ACOs) are groups of physicians, hospitals and other healthcare providers that share responsibility for improving the quality of care for its patients while reducing costs.¹⁰ The American Society of Health-System Pharmacists describes ACOs as an “integrated patient care model that emphasizes for quality of care instead of quantity of care (i.e. pay for performance instead of a fee for service model)”.¹¹

ACOs are partnerships of health care providers — including primary care doctors, specialists, and sometimes hospitals — that agree to a set budget for serving all of the health and long-term care needs of a defined group of patients. The ACOs have incentives to keep patients healthy and treat them efficiently. If costs are below a set budget, ACOs share in the profits. However, if an ACO’s costs exceeds the budget, some

¹⁰ "Accountable Care Organizations (ACO)." - Centers for Medicare & Medicaid Services. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/>. "Report of the 2012 ASHP Task Force on Accountable Care Organizations." American Journal of Health-System Pharmacy 70, no. 1 (2012): 66-76.

⁸ Emanuel, Ezekiel , and Jeffrey Liebman. "The End of Health Insurance Companies." Opinionator The End of Health Insurance Companies Comments. <http://opinionator.blogs.nytimes.com/2012/01/30/the-end-of-health-insurance-companies/?scp=3&sq=health%20insurance&st=cse>.

ACOs may share in the losses. The budgets are set based on the health of the population served and the payments are tied to quality measures.¹²

Care coordination allows healthcare systems and health professionals to achieve significant quality improvements. The promotion of preventive medicine avoids costly acute care.¹³ The current healthcare system is fragmented. Patients see primary care physicians, specialists, and receive tests at different location. An ACO brings all the components in the healthcare system together. In an ACO, if you need a specialist, lab work or medication, it will come from the same treatment team. ACOs also change how doctors and hospitals are paid.

ACOs make providers mutually accountable for the health of their patients, giving them incentives to collaborate and save money by avoiding unnecessary tests and procedures. The traditional fee-for-service payment system pays doctors and hospitals by the test and procedure. ACOs would not end the fee-for-service system, but create savings incentives by offering bonuses when providers keep costs down and meet specific quality benchmarks. The focus will be on prevention.

Dr. Ezekiel Emanuel, former advisor to the Obama Administration, has suggested that by 2020 health insurance companies will be extinct and will have been replaced by

¹² Vestal, Christine . "KHN: Kaiser Health News." Accountable Care Explained: An Experiment in State Health Policy. <http://www.kaiserhealthnews.org/stories/2012/october/18/aco-accountable-care-organization-states-medicaid.aspx?referrer=search>.

¹³ "Two differing perspectives on accountable care organizations." <http://medcitynews.com/2011/10/two-differing-perspectives-on-accountable-care-organizations/>.

accountable care organizations. The ACOs will provide better and more efficient and increase competition in the healthcare markets.¹⁴

Another advocate for accountable care organizations is Atul Gawande. Gawande is a surgeon, writer, and public-health researcher. He has argued that high costs are not an indicator of high-quality care. His examination focused on the town of McAllen, Texas that, in 2009, was one of the nation's most expensive places for healthcare. In 2006, Medicare spent \$15,000 per enrollee, almost twice the national average. The income in McAllen was only \$12,000 per capita. The findings show that patients in McAllen are often given unnecessary tests, procedures, and prescriptions with the excess money going to physicians.¹⁵

Gawande also looked at systems that have managed to increase the quality of care while keeping costs low. The first system he examined was the Mayo Clinic in Rochester, MN; one of the highest quality, lowest-cost health systems in the country. While the Mayo Clinic is not technically an ACO, there are qualities about its system and organization that approximate an ACO and in this sense; it can serve as a model for how ACOs can offer high-quality health care at lower costs.

The core tenant at the Mayo Clinic is that the "needs of the patient come first." To accomplish this, Mayo began combining all the money received by the hospitals and

¹⁵ Gawande, Atul. "The Cost Conundrum - The New Yorker." The New Yorker. <http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum?currentPage=all>.

doctors and paying everyone a salary, so that the doctors' goal is the patients' care not increasing their income.⁷

The Mayo Clinic's collaborative practice has been expanded to satellite campuses in Florida and Arizona that have also achieved the same high-quality, low-cost results as in Rochester. The system created by the Mayo Clinic is a highly coordinated care organization, very similar to an ACO. Mayo is a group practice where physicians have a salary and less incentive to perform unnecessary procedures than physicians paid on a fee for service basis.

Some experts disagree about the Mayo Clinic model could be expanded to the rest of the country stating, "Mayo's patients are wealthier, healthier, and less racially diverse than those elsewhere in the country. It has few poor patients."¹⁶ According to the Washington Post, in the town of Rochester, where Mayo is located "Mayo serves a higher-income echelon than the town's other hospital, Olmsted Medical Center. Just 5 percent of Mayo's hospital patients receive Medicaid, an exceptionally low figure, compared with 29 percent at Olmsted...."¹³ Mayo officials have dismissed those claims, stating, "there is no distinction between Medicaid patients and other patients" when it comes to providing care.¹⁷

¹⁶ MacGillis, Alec, and Rob Stein. "Is the Mayo Clinic a Model Or a Mirage? Jury Is Still Out." The Washington Post. http://articles.washingtonpost.com/2009-09-20/politics/36859325_1_mayo-clinic-poor-patients-public-option/2.

¹⁷ Mahar, Maggie. "What Makes Minnesota's Mayo Clinic Different?." Health Beat by Maggie Mahar. <http://www.healthbeatblog.com/2008/10/what-makes-minn>.

Similar systems to the Mayo Clinic have been adopted in other places as well: the Geisinger Health System in Danville, PA; the Marshfield Clinic, in Marshfield, WI; International Healthcare, in Salt Lake City; and Kaiser Permanente in CA. All have produced higher-quality healthcare with lower-costs than the average American town.⁷

Effect on controlling costs:

The language in the ACA called for a “shared savings program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs.”¹⁸ The Center for Medicare and Medicaid Services (CMS) created ACOs as a response.¹⁹ ACOs are shared savings programs meant to solve the problem of wasteful and poor quality healthcare. The shared savings in ACOs come from keeping patients healthy and by avoiding unnecessary tests and procedures. The ACOs are paid a fixed amount and receive bonuses for achieving quality targets.¹²

Prior to the passage of the ACA, CMS conducted a demonstration project on ACOs from 2005-2009 called the Medicare Physician Group Project. The demonstration focused on ten medical groups that covered 220,000 Medicare beneficiaries.^{12,13}

¹⁸ "Health Policy Brief: Next Steps for ACOS." Health Affairs January (2012): 1-6.

¹⁹ Correia, Edward W. "Accountable Care Organizations: The Proposed Regulations and the Prospects for Success." *American Journal Of Managed Care* 17, no. 8 (August 2011): 560-568.

Of the ten groups that participated in the demonstration, three did not receive a savings bonus. The annual bonus was for \$5.4 million. At the end of five years, the program did not significantly reduce spending growth.¹²

The pilot program saved Medicare \$26.6 million or approximately \$121 per beneficiary per year.¹² The program did produce improvements in quality from ten measures in the first year to thirty-two measures in the fifth year. These measures included diabetes, coronary artery disease, congestive heart failure, and hypertension and cancer screens. There has been some debate if the project caused any of the favorable results in the project.²⁰ According to CMS, the Medicare Savings Program will generate up to \$940 million in savings within its first four years.¹² However, this is a small fraction of the total program costs.¹⁶

ACOs are not limited to the public sector. Private health insurance plans have ACO arrangements with healthcare providers using a shared risk payment model.¹² One example is the Collaborative Accountable Care Initiative launched in 2008 by health insurance company, Cigna. Cigna's initiative was a shared savings program that used registered nurses as care coordinators to use patient and performance reports to improve quality of care and reduce costs. The initiative included practices in Arizona, New Hampshire, and Texas. Although its results were not statistically significant, the results did reveal favorable trends in the areas of total medical costs and quality of

²⁰ Burns, L. R., and M. V. Pauly. "Accountable Care Organizations May Have Difficulty Avoiding The Failures Of Integrated Delivery Networks Of The 1990s." *Health Affairs* 31, no. 11 (2012): 2407-2416.

care.²¹ Currently, there are 428 ACOs now existing in 48 states. California, Florida, and Texas have the highest amount of ACOs with 46, 42, and 33 ACOs respectively.²²

Some have criticized the provisions in the ACA for cost-containment, including ACOs.^{23, 24} ACOs have been compared to integrated delivery networks introduced in the 1990s. However, the networks failed because of large financial losses that hospitals incurred. Both systems develop a continuum of care, emphasize care coordination, and focus on primary care providers. Both systems are also encouraged by federal legislation to pursue the “Triple Aim” of “improved quality of care, improved population health, and reduced costs.”

However, unlike the integrated delivery networks, ACOs rely heavily on health information technology, data analytics, and shared savings. There is some evidence to suggest that ACOs will have a limited impact on cost savings and will provide little support for the idea that better care coordination will lower Medicare’s rate of spending growth.¹⁴

²¹ Munev, Alan. "A Collaborative Accountable Care Model In Three Practices Showed Promising Early Results On Costs And Quality Of Care." *Health Affairs* 31, no. 11 (November 2012): 2379-2387.

²² Muhlestein, David. "Continued Growth Of Public And Private Accountable Care Organizations." Health Affairs Blog Continued Growth Of Public And Private Accountable Care Organizations Comments. <http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/>.

²³ Marmor, Theodore, and Jonathan Oberlander. "From HMOs to ACOs: The Quest for the Holy Grail in U.S. Health Policy." *Journal of General Internal Medicine* 27, no. 9 (2012): 1215-1218.

²⁴ Oberlander, J. "Throwing Darts: Americans' Elusive Search for Health Care Cost Control." *Journal of Health Politics, Policy and Law* 36, no. 3 (2011): 477-484.

Rita Numerof, of the Heritage Foundation, points out that ACOs could lead to greater consolidation of healthcare providers in the industry. This could lead to some providers charging more for services. Numerof also points out that ACOs have the potential to concentrate more power into fewer organizations, allowing them to become “too large to fail.”²⁵

Health Insurance Exchanges:

One of the main features of the ACA is the health insurance exchanges. Exchanges are structured web-based markets that individuals can use to purchase health insurance plans. States can choose to let the federal government create and run the exchanges, or can establish and operate the exchanges themselves. States that opt-out of setting up a state-based exchange will instead be created and managed by the federal government. The federal government will run twenty-six of the state health exchanges. The government will also collaborate with seven states, where state and federal officials take joint responsibility for the exchange. Seventeen states and the District of Columbia will manage the exchange themselves.

Effect on controlling costs:

Exchanges have the potential to produce savings by lowering the costs of administering a health plan—particularly costs related to marketing and sales—and by

²⁵ Numerof, Rita. "Why Accountable Care Organizations Won't Deliver Better Health Care-and Market Innovation Will." The Heritage Foundation. <http://www.heritage.org/research/reports/2011/04/why-accountable-care-organizations-wont-deliver-better-health-care-and-market-innovation-will>.

creating an environment in which plans can compete for enrollees only by offering low-cost, high-quality products. The exchanges would eliminate insurance companies' ability to 'cherry pick' patients with the lowest risk, individuals who are young and healthy. States can choose to let the federal government create and run the exchanges, or can establish and operate the exchanges themselves. According to an analysis by Bloomberg Government, competition among health insurance providers offering coverage through the federal exchanges is driving down the premiums charged in the new marketplaces by as much as one third. In an analysis of rates for individual policies in the 36 states where the federal government will run or largely run the exchanges:²⁶

The larger the number of insurers operating in a given market, the lower the price of coverage. The health law requires insurers that sell through exchanges to offer plans that cover the same broad set of medical benefits at a few preset levels of cost. "Bronze" plans cover 60 percent of expected medical costs and so on, up to "platinum" at 90 percent. The Bloomberg Government analysis looked at the monthly premiums that insurers will charge in more than 400 rating areas or sub-state zones where carriers are allowed to adjust their prices based on such variables as the cost of medical care, across the 36 states where the federal government will be largely responsible for operating exchanges.

On October 1, 2013, the healthcare exchanges opened for the public to enroll in health insurance plans. The beginning of the open-enrollment period on the federally run exchange website was plagued with technical glitches and functionality issues,

²⁶ Gosselin, Peter. "Bloomberg Government." Exchange Competition Cuts Health Insurance Costs: BGOV Insight. <http://about.bgov.com/2013-10-08/exchange-competition-cuts-health-insurance-costs-bgov-insight>.

mostly because of overwhelming traffic.²⁷ The initial website problems caused difficulties for those trying to purchase insurance plans in the insurance marketplace's first month of operation. According to the Obama Administration, the initial technical problems have been solved, and one million individuals have enrolled in insurance plans in the exchange marketplace. Based on the Administration's projections, seven million individuals are expected to enroll in insurance plans by the end of the open enrollment period on March 31, 2014.²⁸ By April 2014, 8,019,763 individuals had selected a plan via the exchanges according to the U.S. Department of Health and Human Services.²⁹

Government Negotiation of Prices:

Another solution suggested for controlling healthcare costs has been to authorize the government to negotiate prices with healthcare providers.² Currently, only Medicare and the Department of Veterans Affairs can set or negotiate the prices for the

²⁷ Timothy, Lee. "Here's everything you need to know about Obamacare's error-plagued websites." Washington Post. <http://www.washingtonpost.com/blogs/the-switch/wp/2013/10/09/heres-everything-you-need-to-know-about-obamacares-error-plagued-web-sites>.

²⁸ Cornwell, Susan. "Obamacare Draws Last-minute Shoppers; Site Gets Nearly 2 Million Visits." NBC News. <http://www.nbcnews.com/health/obamacare-draws-last-minute-shoppers-site-gets-nearly-2-million-2D11792117>.

²⁹ CNN. "Obamacare: Enrollment numbers and Medicaid expansion." CNN. <http://www.cnn.com/interactive/2013/09/health/map-obamacare/>.

health services that they provide.³⁰ In some countries, health insurance is provided to everyone, and the government sets prices or oversees price negotiation to keep costs down.

The United States relies on for-profit insurance companies to pay for healthcare. Twenty cents of every dollar spent on healthcare goes to “marketing, underwriting, administration, and profit.”^{31,32} According to T.R. Reid, “in a system where government doesn’t negotiate prices down, prices will be higher. In a system where for-profit companies need profit margins and advertising, prices will be higher.”¹⁹ The ACA does contain some options for wider-scale cost negotiations through the administration of the healthcare exchanges, the expansion of Medicaid and the option for state experimentation beginning after 2017.²

Americans pay significantly more for healthcare compared to other countries. The prices for prescription drugs, hospital stays, and medical procedures can vary widely from individual to individual based on their insurance.^{33,34} There is no corresponding

³⁰ Frakt, Austin B., Steven D. Pizer, and Ann M. Hendricks. "Controlling Prescription Drug Costs: Regulation and the Role of Interest Groups in Medicare and the Veterans Health Administration." *Journal Of Health Politics, Policy & Law* 33, no. 6 (December 2008): 1079-1106.

³¹ Reid, T.R. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care* (Penguin Books, 2010)

³² “Thompson, Derek. "Why Is American Health Care So Ridiculously Expensive?." *The Atlantic*. <http://www.theatlantic.com/business/archive/2013/03/why-is-american-health-care-so-ridiculously-expensive/274425/>.

³³ "That CT scan costs how much?." *Consumer Reports*, July 2012.

³⁴ “What Is Driving U.S. Health Care Spending? America’s Unsustainable Health Care Cost Growth”. *The Bipartisan Policy Center*, September 2012.

improvement in outcomes even if health status and wealth differences are taken into account.

The hospital charge master or charge description master (CDM) lists the prices for hospital-provided health care products and services. The true prices paid for various procedures and products are not publicly available. The amounts are the result of private negotiations between insurers and providers and they are usually kept secret. Some policy analysts have speculated that better price transparency, when combined with information on quality, could lead to cost-lowering competition in the marketplace.³⁵

Medicare and Medicaid negotiate prices on behalf of beneficiaries, which results in substantially lower costs compared to private insurance.⁴ Sarah Kliff, of the Washington Post, has stated “what sets our really expensive health-care system apart from most others isn’t necessarily the fact it’s not single-payer or universal. It’s that the federal government does not regulate the prices that health-care providers can charge.”³⁶

³⁵ "Addressing Rising Health Care Costs: A Guide for Consumer Advocates." RWJF. <http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/11/addressing-rising-health-care-costs.html>.

³⁶ Kliff, Sarah. "Steven Brill's 26,000-word health-care story, in one sentence." Washington Post. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/23/steven-brills-26000-word-health-care-story-in-one-sentence/>.

Steven Brill examined the disparity in costs that are paid by Americans, in an article in *Time Magazine*. The chargemaster, the list of prices used by hospitals for everything it does, dictates the prices that are paid by patients. According to Brill, “no hospital's chargemaster prices are consistent with those of any other hospital, nor do they seem to be based on anything objective -- like cost -- that any hospital executive I spoke with was able to explain.”

Some examples of the prices charged to patients include: \$1.50 for one acetaminophen tablet, when a bottle for 100 can bought on Amazon for \$1.49 and \$283 for a chest X-ray compared to the \$20.44 Medicare pays. In other countries, the federal governments set rates for what both private and public plans can charge for various procedures and so that differences noted by Brill are not present. Those countries have tended to see much lower growth in health-care costs.³⁷ The difference in cost between the Canada and America on healthcare is mostly explained by prices and administrative costs.¹⁶

Effect on controlling costs:

Maryland is only state in the U.S. that sets rates for hospitals, with the government deciding what every hospital can charge for a given procedure. In other states, hospitals negotiate with insurers individually, leading to drastically different

³⁷ Brill, Steven. "Bitter Pill: Why Medical Bills Are Killing Us." *Time*. <http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/>.

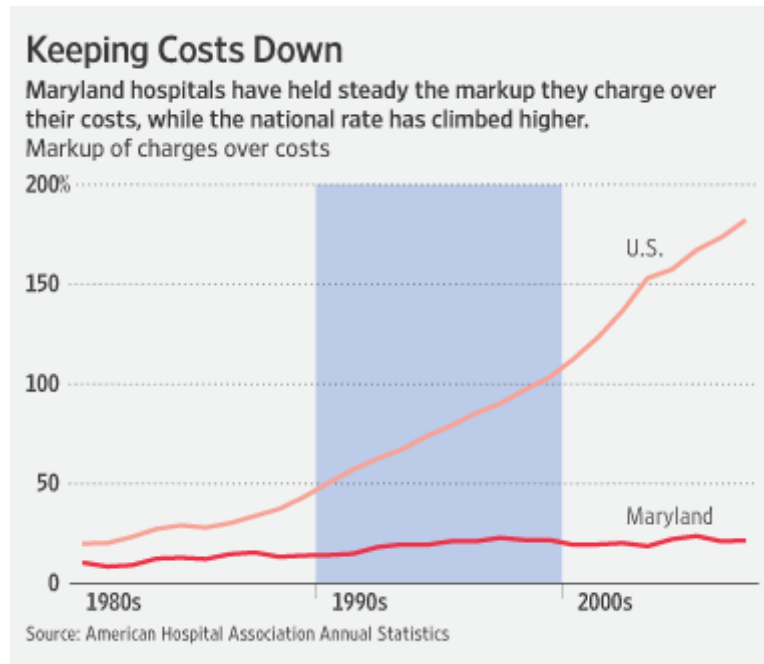
rates. As a result, Maryland has succeeded in controlling costs. The Maryland system started in 1976, when their hospital costs were 26 percent higher than the rest of the country for the same procedures. Maryland established a commission that directly set the rates for procedures in all of the state's hospitals. Hospitals and insurers "embraced the system because they knew exactly what to expect."

In 2008, the average cost for a hospital admission in Maryland was down to national levels. Researchers estimate the system has saved \$45 billion for consumers over four decades and prices have grown more slowly in the state.³⁸ A report by the National Governor's Association highlights that hospital rate setting "worked in Maryland in part because the size, culture, and politics were right...but also we had hospital support."³⁹

According to the Washington Post, "from 1997 through 2008, Maryland hospitals experienced the lowest cumulative growth in cost per adjusted admission of any state in the nation."²³

³⁸ The Washington Post. "Maryland already sets hospitals prices. Now it wants to cap their spending.." Washington Post. <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/05/25/maryland-already-sets-hospitals-prices-now-it-wants-to-cap-their-spending/>.

³⁹ National Governor's Association . "Cost Containment and Quality Improvement: Maryland Hospital Rate Setting System." State Health Policy Options. <http://statepolicyoptions.nga.org/casestudy/cost-containment-and-quality-improvement-maryland-hospital-rate-setting-system>.



The chart above shows that Maryland hospitals that rate-set have kept markup costs down compared to the national rate, which has continued to rise.

A report by the Robert Wood Johnson Foundation showed that “Maryland has consistently had the lowest markup of charges over cost of any state, but extra steps needed to be taken to control the volume of admissions.” According to the same report, rate setting can be successful in lowering costs²²:

Several meta-analyses suggest this can be an effective strategy.

Several researchers have concluded that rate setting can be successful in controlling the rate of increase in hospital costs. However, its success depends on the way in which rate setting is carried out, as well as regulators’ ability to enforce the rates and impose penalties for noncompliance. Hospital care represents 31 percent of overall national health care spending. Even a modest decrease in hospital expenditures – on the order of five percent, a level that was met or exceeded in most

states adopting hospital rate regulation – would achieve an annual savings of \$35 billion, based on 2007 expenditures.

Conclusion:

Although there is disagreement among policy makers about what solutions will succeed in reining in costs and by how much, most agree that some action must be taken. Rising healthcare costs will affect the long-term financial stability of the United States if solutions are not enacted. The three potential cost-savings solutions examined in the chapter all show evidence of potentially lowering costs, to varying degrees.

The evidence for the success of accountable care organizations lowering healthcare costs is mixed. Although several systems have experienced improvement in quality and lower costs, other systems, including the Medicare pilot have not produced significant savings. In a few years, more examples of ACOs will have been created and more evidence will be available to examine their effect on long-term healthcare costs.

Because the healthcare exchanges have only been open for the public to purchase insurance for a few months, data on their effect on lowering costs is limited. However, based on preliminary analysis, there is evidence that the exchanges will result in lower costs for insurance; especially in states with a large number of insurance options in the healthcare marketplace. However, technical glitches and low-enrollment numbers, may hinder the results.

The government negotiation of prices for healthcare has much stronger evidence that it will reduce costs. Many other countries utilize price-setting has an effective method to keep healthcare prices considerably lower than in America. Based on the research, government negotiation of prices would be an appropriate cost-control method in the U.S. and should be examined further.

Chapter 2: A Comparison of the Affordable Care Act and the Massachusetts Health Reform Law

Introduction

The Patient Protection and Affordable Care Act (ACA) contains the most significant changes to America's health care system since the passage of Medicare and Medicaid. Major elements of the national reform are based on Massachusetts' health care reform law; both laws have the central goal of ensuring access to affordable health care coverage for nearly all residents.

The Massachusetts health reform law is considered a blueprint for the ACA. Both have state-based insurance exchanges, subsidies for lower-income individuals and mandates on individuals and businesses. However, there are some differences, mainly the size and scope of both laws. While successful in increasing coverage to nearly all of its citizens, the Massachusetts legislature has only started to focus on cost-saving measures in recent years.

The MA law only applies to a population of 6 million whereas the ACA covers over 300 million people in 50 diverse states. Since the MA law was passed in 2006, it could provide evidence for potential cost-savings to similar measures included in the ACA. Health care costs are and will continue to be a national priority. Researching the MA law will provide insight into potential outcomes for the ACA, which has only been

fully implanted since January 1, 2014. Some think that the potential cost-controls do not go far enough. This chapter will examine the MA health reform law, any impact of cost-savings and access to care, and whether the MA law's success or failures can be applied to the ACA. The individual mandate and the expansion of coverage are two major similarities between both laws and provide the most opportunity for comparison.

The Patient Protection and Affordable Care Act was signed into law in 2010. The law established universal health insurance coverage for a majority of Americans.⁴⁰ The ACA extends coverage to the millions of previously uninsured individuals. The expansion in coverage was achieved through several means including: an individual mandate, a requirement for insurance companies to sell insurance regardless of pre-existing conditions, subsidies to individuals who cannot afford insurance and state-based healthcare exchanges where individuals can compare healthcare plans.^{1, 41}

The template for the ACA was passed several years earlier in Massachusetts. In April 2006 the Massachusetts health care reform law, titled "An Act Providing Access to Affordable, Quality, Accountable Health Care" (Chapter 58 of the Acts of 2006), was enacted. President Obama stated on October 30, 2013, "...the worst predictions about health care reform in Massachusetts never came true. They are the same arguments that you are hearing now... and it is because you guys had a proven model that we built

⁴⁰ Patient Protection and Affordable Care Act Pub L. No. 111-148, HR 3590.

⁴¹Shaffer, Ellen R. "The Affordable Care Act: The Value of Systemic Disruption." *American Journal of Public Health* 103, no. 6 (2013): 969-972.

the Affordable Care Act on this template of proven, bipartisan success. Your law was the model for the nation's law." ⁴²

Theoretical Framework and the Role of Government

The phrase "laboratories of democracy" was popularized by U.S. Supreme Court Justice Louis Brandeis in the case of *New State Ice Co. v. Liebmann* in 1932 to describe how a "state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." This concept explains how within the federal framework, there exists a system of filtration where state and local governments act as "laboratories," where law is created and enacted from the lowest level of the democratic system, up to the top level. ⁴³

The Tenth Amendment of the United States Constitution makes all "powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." This is a basis for the laboratories of democracy concept, because the Tenth Amendment gives a number of responsibilities to state and local governments. Policy is experimented on the state level

⁴² Bazerghi, Alice. "Obama Visits Boston, Defends Healthcare Website." *The Daily Free Press*. 31 Oct. 2013. <http://dailyfreepress.com/2013/10/31/obama-visits-boston-defends-healthcare-website/>

⁴³"FindLaw | Cases and Codes." *NEW STATE ICE CO. v. LIEBMANN, 285 U.S.* U.S. Supreme Court. <http://caselaw.lp.findlaw.com/scripts/getcase.pl?navby=CASE&court=US&vol=285&page=262>.

first, before it is on the national level. We can see what works on local and state levels first before expanding policies to the national level. The Massachusetts healthcare law serves as a perfect example of this idea.

State/Federal Responsibilities in Healthcare

Federalism allocates powers and responsibilities between the states and the federal government. Some powers may be exclusively handled at the federal or state level, and some may be shared. One of the main areas that federal health policy influences states is Medicaid. Medicaid is the health program for families and individuals with low income. Medicaid currently covers over 62 million Americans, more than Medicare or any single private insurer. Medicaid is not completely funded at the federal level. States provide up to half of the funding for the Medicaid program. In some states, counties also contribute funds.

The ACA will expand Medicaid eligibility starting in 2014. The law shifts the Medicaid power sharing significantly in favor of the federal government. The Medicaid expansion permits all individuals under age 65 with incomes up to 133 percent of the federal poverty level to enroll. Under this expansion, the federal government will pay 100 percent of the anticipated cost through 2016, with funding gradually declining to 90 percent by 2020 and beyond.

In every state, this expansion represents an increase in reimbursement levels and a large increase in the number of people who will be eligible for Medicaid. The increase in

federal funding is accompanied by a uniform set of eligibility requirements and benefits that will replace the highly variable set of provisions crafted by individual state governments.⁴⁴

Under the law as it was written by Congress, states that wished to continue to participate in the Medicaid program would be required to allow people with income up to 133% of the poverty line to qualify for coverage, including adults without dependent children. After the ACA was signed, several states filed litigation against the law. The challenges were based on the question of whether it is within the constitutional powers of Congress to legislate for a minimum coverage requirement and how far Congress can compel the states to carry out its coverage expansion.⁴⁵

Twenty-six states opposed the expansion of Medicaid eligibility. They argued that the provision is coercive under the Constitution's Spending Clause: states that fail to comply stand to lose some or all of their federal Medicaid funding. The U.S. Department of Health and Human Services (HHS) argued that previous Supreme Court rulings have stated that the federal government has the right to attach conditions when states receive federal grants and aid programs.⁶

⁴⁴Patient Protection and Affordable Care Act Pub L. No. 111-148, HR 3590.

⁴⁵ Scott, Dylan. "Health Ruling Sets Up Potential Fallout for Federalism." Health Ruling Sets Up Potential Fallout for Federalism. 29 June 2012. <http://www.governing.com/blogs/fedwatch/gov-supreme-court-ruling-potential-fallout-for-federalism.html>.

The government argued that the minimum coverage provision is well within Congress' power due to the Commerce Clause. The Commerce Clause gives Congress the power to regulate interstate commerce; the Necessary and Proper Clause gives Congress the power to make all laws necessary and proper for this regulation. Their argument was that health insurance is interstate commerce.

Opponents argued against this, asserting that the obligation to buy something regulates "inactivity" and not "activity," and only activity can count as commerce. According to them, Congress is creating commerce first in order to regulate it, and that exceeds Congress's power. The government's response is that everyone, at some point, has to use medical care, so whether they are insured or not, they are participating in the market.⁴⁶

The opponents raised two types of federalism claims in their cases. First, they argued that the Medicaid expansion violates the 10th Amendment and its related federalism principles by compelling the states to accept the expansion. They say that the expansion is compulsion and upsets the balance between federal and state power. They also argued that universal coverage mandate intrudes into an area that was traditional under state control.

⁴⁶Elhauge, Einer. "The Broccoli Test." The New York Times. 15 Nov. 2011.
<http://www.nytimes.com/2011/11/16/opinion/health-insurance-and-the-broccoli-test.html>.

When the Supreme Court ruled that states did not have to accept the Medicaid, it created a gap in the universal coverage goal that Congress had hoped for when the ACA was written. Several states with legislatures controlled by Republicans have opted to reject the expanded Medicaid coverage provided. Over half of the nation's uninsured live in those states. They include Texas, Florida, Kansas, Georgia, Louisiana, Alabama, and Mississippi. In states that do not expand Medicaid, some of the neediest people will not get coverage.⁴⁷ It remains to be seen what the long-term effect of the Supreme Court's ruling will be on federal and state relations involving healthcare.

Similarities between the ACA and Massachusetts law

There several similarities between the ACA and the Massachusetts law. The Massachusetts law, like the ACA, includes health insurance exchanges for individuals and small businesses; insurance market reforms; a mandate that individuals obtain insurance; and a requirement that employers contribute toward health insurance premiums for their workers or face a penalty.⁴⁸

Both laws create exchanges charged with operating health insurance marketplaces. The exchanges for both laws function the same way, they are internet websites where individuals may compare and buy private insurance policies. The

⁴⁷Where Each State Stands on ACA's Medicaid Expansion." The Advisory Board Company. The Advisory Board Company. <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>.

⁴⁸"Session Laws." CHAPTER 58 of the Acts of 2006. <https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58>.

objective of the exchanges is to “drive down premium costs by increasing competition, and provide policies with similar levels of coverage for ease of comparison.”⁴⁹ Subsidies for low-income individuals are another similarity between the laws. Although the amounts of the subsidies differ, both laws provide assistance to make health insurance more affordable.

Lastly, both laws have individual and business mandates. It is a requirement that any one that can afford insurance must purchase it or pay a financial penalty. The Massachusetts law initially required businesses with more than ten employees to provide health benefits to their workers or pay a penalty. However, it was “repealed in July 2013 in anticipation of the ACA business mandate. Under the ACA, businesses with 50 or more full-time employees must offer health insurance or pay a \$2,000 per employee penalty, which excludes the first 30 employees. The ACA employer mandate takes effect January 1, 2015.”⁴⁵

Individual mandate

The individual mandate is a component present in both the Massachusetts health law and the ACA. The politically conservative Heritage Foundation initially proposed the individual mandate as an alternative to a single-payer health care system.

⁴⁹Burdett, Gillian . "Romneycare Vs. Obamacare: Key Similarities & Differences." CBS Boston. <http://boston.cbslocal.com/2013/11/13/romneycare-vs-obamacare-key-similarities-differences/>.

⁵⁰ Sarah Kliff and Ezra Klein of the Washington Post describe the reasoning for including an individual mandate as follows:

...with no penalty for not purchasing health insurance, but a requirement for insurers to accept anyone who wants insurance, many expected the costs of insurance would increase as the healthy hung back from the system and the sick flooded it. Some states learned this from experience: Kentucky, for example, attempted to eliminate pre-existing conditions in 1994 without the mandated purchase of insurance and saw its premiums spike. Its law was repealed in 2004. Health care economists expect this would happen if federal health reform did not include a mandate, either: They project that premiums would go up anywhere from 2 to 40 percent.⁵¹

Republican politicians embraced the individual mandate as a free-market approach to health-care reform. The individual mandate also aligned with conservative principles of individual responsibility. Following the adoption of an individual mandate as a central component of the Affordable Care Act in 2009, Republicans began to oppose the mandate including Mitt Romney, whose reform was the blueprint for the ACA, became a critic of the mandate in the ACA. The Attorney Generals of several states questioned the constitutionality of the individual mandate. They argued that the federal mandate was not a proper use of Congress's power to regulate commerce. The separate

⁵⁰Cooper, Michael. "Conservatives Sowed Idea of Health Care Mandate, Only to Spurn It Later." The New York Times. http://www.nytimes.com/2012/02/15/health/policy/health-care-mandate-was-first-backed-by-conservatives.html?_r=0.

⁵¹Kliff, Sarah, and Ezra Klein. "Individual mandate 101: What it is, why it matters." Washington Post. http://www.washingtonpost.com/blogs/wonkblog/post/individual-mandate-101-what-it-is-why-it-matters/2011/08/25/gIQAhPzCeS_blog.html.

cases filed were merged into a single case titled *National Federation of Independent Business v. Sebelius*. The Court's decision came on June 28, 2012.

A 5-4 majority upheld the ACA. The court declared that the individual mandate and Medicaid expansion were constitutional. The Court upheld the individual mandate component of the ACA as a valid exercise of Congress's power to "lay and collect taxes" Chief Justice John Roberts, writing for the Court, explained: "The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."⁵²

Differences between the Laws

The laws differ in several ways. The most significant differences are in the Medicaid expansion and the size and scope of both laws. The ACA expanded Medicaid eligibility starting in 2014. The Medicaid expansion permits all individuals under age 65 with incomes up to 133 percent of the federal poverty level to enroll. However, the Medicaid expansion in Massachusetts was only applied to children, parents, pregnant women and the long-term unemployed. The ACA covers a population of over 300 million citizens, whereas the Massachusetts law only applies to the 6.5 million residents of that

⁵²Scott, Dylan. "Supreme Court Upholds Health-Care Law with Mandate." Supreme Court Upholds Health-Care Law with Mandate.<http://www.governing.com/news/state/gov-health-care-ruling-full-affordable-care-act-coverage.html>.

state. When Massachusetts was beginning its reform efforts, the rate of uninsured was half that of the rest of the United States.⁷

Impact of Massachusetts Health Reform and Implications for the Affordable Care Act

Long, Stockley and Nordahl assessed the potential impacts for the country under the ACA based on Massachusetts' results. They examined the impacts of Massachusetts' health reform effort on insurance coverage, access of care, and affordability for individuals since 2006.⁵³ The researchers' findings were based on the Massachusetts Health Reform Survey (MHRS), a comprehensive survey of adults in Massachusetts. Based on the survey, they found that health insurance coverage expanded significantly in Massachusetts under reform, increasing from 86.6% of adults in 2006. The researchers also found evidence of gains in the affordability of health care for adults in Massachusetts under the reform. There was a reduction in out-of-pocket health care spending and less unmet need for care because of costs.

However, not all of the findings were favorable. Health care costs in Massachusetts are rising. When the initial legislation was passed in 2006, a decision was made to focus on coverage and defer addressing costs. As a result, "between 2004 and 2009, personal health care spending per capita in Massachusetts increased by an average of 5.8% per year, to \$9,278 in 2009, as compared to an average increase of

⁵³Long, Sharon , Karen Stockley, and Kate Willrich Nordahl. "Coverage, Access, and Affordability under Health Reform: Learning from the Massachusetts Model." *Inquiry* 49 (2013): 303-316.

4.7%, to \$6,815, for the nation as a whole as health care spending per capita in Massachusetts, already the highest in the country, is projected to nearly double between 2010 and 2020".⁸

A study by the Veterans Affairs Boston Healthcare System analyzed hospital costs under the Massachusetts law. The results showed that the reform did not cause hospital use or costs to increase.⁵⁴ Before the reform, "from 2004 to 2006, average quarterly admissions for each hospital numbered 1502. After reform (2008-2010), the average was 1557. That represents a 3.6% increase vs a 3.3% increase in the study comparison states of New York, New Jersey, and Pennsylvania, states that did not reform their healthcare systems."⁹ According to the author, it is difficult to say whether health care costs would rise nationwide once most. He states that

Even prior to Massachusetts' reform, Massachusetts had a pretty low rate of uninsured (8.4% in 2006 for those aged 18-64), and that is not true for many other states," Also, after reform, the Massachusetts legislature closely monitored how costs were rising for the same type of care among hospitals and that monitoring may have played a role in keeping costs down.... In addition, he said that it is easier to compare Massachusetts with the 3 control states or Northeastern states, where the numbers of people without insurance are similar to that of pre-reform Massachusetts.

The Blue Cross Blue Shield of Massachusetts Foundation's 2011 five-year progress report on the Massachusetts reform, the percent of uninsured in the state has dropped

⁵⁴Frellick, Marcia . "Mass. Health Reform Didn't Increase Hospital Costs, Study Finds." Medscape . <http://www.medscape.com/viewarticle/804670>.

to less than two percent. During the same period, the average rate of uninsured in the nation rose to more than 16 percent.⁵⁵

The Urban Institute examined the evidence from the Massachusetts law and concluded that access to and use of health care in the state improved under health reform. They also found that the burden of health care costs was reduced under health reform, particularly for lower-income individuals. There was also a reduction in out-of-pocket spending on care and fewer individuals reported going without care because of costs.⁵⁶

Cost containment is an element in both laws, but the provisions in each in law is different. The ACA includes several measures intended to control health care costs, including collaborative health care systems called “accountable care organizations” (ACOs). ACOs are groups of physicians, hospitals and other healthcare providers that share responsibility for improving the quality of care for its patients while reducing costs.⁵⁷ There is not similar system included in the Massachusetts law.

⁵⁵Raymond, Alan. "Health Reform Implementation In Massachusetts 5 Year Progress Report." Blue Cross Foundation.<http://bluecrossmafoundation.org/sites/default/files/Health%20Reform%20Implementation%20Massachusetts%20Health%20Reform%205%20Year%20Progress%20Report.pdf>.

⁵⁶Long , Sharon. "What Is the Evidence on Health Reform in Massachusetts and How Might the Lessons from Massachusetts Apply to National Health Reform?". <http://www.urban.org/uploadedpdf/412118-massachusetts-national-health-reform.pdf>.

⁵⁷ "Accountable Care Organizations (ACO)." - Centers for Medicare & Medicaid Services. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco/>.

In 2006, Massachusetts made the decision to focus health reform on expanding insurance coverage not on controlling health costs. In 2008, additional health reform legislation was passed to initiate cost containment and delivery system improvements. The new legislation “included new requirements on statewide adoption of electronic medical records by 2015; a standard for uniform billing and coding among health care providers and insurers; a ban on gifts to physicians from pharmaceutical companies; a ban on payment to providers for “never events”; and implementation of a program educating providers on the cost-effective utilization of prescription drugs. The legislation also required annual public hearings with providers to investigate cost drivers and recommend cost-reduction mechanisms.”⁵⁸

The Massachusetts legislature created a Special Commission on the Health Care Payment System. The Commission released final recommendations in 2009. They called for the “development of a transparent payment methodology and endorsed a shift away from a fee-for-service system where providers are paid per visit and procedure, to a global payment system where providers work together to share the responsibility for the patient’s care.”¹⁴

According to the Sharon Long of the Urban Institute,

⁵⁸ Kaiser Family Foundation. "Kaiser Family Foundation." Massachusetts Health Care Reform: Six Years Later. <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8311.pdf>.

the strategies being debated in Massachusetts parallel those being debated nationally: shifting away from fee-for-service to an episode-based payment system, creating incentives for more efficient and high-quality care, addressing inequities in market power that are driving up health care costs (perhaps through a single-payer rate-setting system), and expanding the adoption of health information technology, among other things.

In 2010 the Massachusetts legislature enacted measures related to health care costs and quality including the development of uniform coding and billing standards and “prohibitions against hospitals seeking payment for preventable complications from medical errors, all of which helped add to costs.”⁵⁹

Health care expenditures in the Massachusetts are increasing more than wages and income. According to Kenneth Rapoza, “the relative difference in premiums between Massachusetts and the U.S. has increased over time. By 2007, health care expenditures were estimated to account for 15.2% of GDP in Massachusetts compared to 13.7% for the nation as a whole. By 2018, if current trends continue, health care in Massachusetts is projected to cost \$16,000 per person, \$3,000 more than the projected national average. But that’s not because of healthcare reform.”⁶⁰

Although similar in design, the political and demographic realities faced by the MA law and the ACA were very different. Massachusetts had several advantages as it implemented health reform, including a relatively high percentage of the population

⁵⁹ Rapoza, Kenneth. "If ObamaCare Is So Bad, How Does RomneyCare Survive?." Forbes. <http://www.forbes.com/sites/kenrapoza/2012/01/20/romney-care-massachusetts-healthcare-reform/>.

⁶⁰ Rapoza, Kenneth. "If ObamaCare Is So Bad, How Does RomneyCare Survive?." Forbes. <http://www.forbes.com/sites/kenrapoza/2012/01/20/romney-care-massachusetts-healthcare-reform/>.

that already had coverage, an uncompensated care pool that could be converted to dollars for coverage, and the ability of a Republican governor and a Democratic legislature to work constructively together.

According to an analysis by The Blue Cross Blue Shield of Massachusetts Foundation examining the implementation of the Massachusetts health law, Massachusetts started implementation in a favorable political environment for expanding coverage. This included a relatively low rate of uninsured residents (about 10 percent) and high levels of employer-sponsored coverage. In addition, insurance market reforms were already in place; the Uncompensated Care Pool supported safety-net care. Furthermore, much of the motivation behind passage of the Massachusetts law came from health care, business, and consumer groups that helped push through the bipartisan legislation⁶¹

Conclusion

The insurance coverage provisions of the Patient Protection and Affordable Care Act (ACA) were modeled after the Massachusetts law's key provisions— expanded Medicaid eligibility, new subsidized coverage options for people with low and moderate incomes, insurance exchanges through which individuals and small businesses can purchase health coverage, and new individual and employer mandates. Massachusetts has

⁶¹ Raymond, Alan. "Lessons from the Implementation of Massachusetts Health Reform." BCBS of Massachusetts Foundation. <http://bluecrossmafoundation.org/sites/default/files/Lessons%20from%20the%20Implementation%20of%20MA%20Health%20Reform.pdf>.

achieved nearly universal coverage and greatly improved residents' access to needed care. Universal coverage was the primary objective of the health reform law. Based on the evidence, in terms of increasing universal coverage, which is one of the goals of the ACA, the MA law provides encouraging results. However, Massachusetts has continued to experience some of the highest health-care costs in the nation, making affordability the next priority for the state. Further research is needed, after the ACA has been fully implemented, to know whether the measures will result in consistent cost- savings.

Chapter 3: A Comparison of Healthcare Systems in the United Kingdom and Germany

Health systems can vary from country to country. Regardless of the structure of every country faces challenges with quality, delivery, and the cost of services. This chapter will compare the health care systems of the United Kingdom and Germany. The first part of the chapter will focus on descriptions of the four models of healthcare systems and the U.S. healthcare system. The second part will compare and analyze the systems of the U.K. and Germany. Researching the countries healthcare systems will provide insight into potential measures the United States may consider in future health reform legislation.

Germany and the U.K. were chosen for analysis because they are highly advanced, industrialized countries. Although countries like Sweden and Switzerland are rated highly for their healthcare systems; they are too small and not diverse enough to be a model for the U.S. Germany (81.89 million Population) and the UK (63.23 million) are larger countries, although smaller than the US (313.9 million).⁶² Both countries healthcare systems contain elements that are familiar to U.S. citizens, Medicare and the Veteran's Health system are similar to the U.K.'s single-payer system, and Germany's employer-paid health insurance is similar to the employer paid health insurance millions of American's receive.

⁶² World Bank. "Population (Total)." Data. <http://data.worldbank.org/indicator/SP.POP.TOTL>.

Models of Healthcare Systems

There are four basic models of healthcare systems. Although there are variations among countries health care systems tend to follow general patterns:

The Beveridge Model

The Beveridge Model is named after Lord William Beveridge, who designed Britain's National Health Service. In this system, health care is provided and financed by the government through taxes. The government owns the hospitals and clinics, and some doctors are government employees. The Beveridge Model tend to have low costs per capita, because the government controls what procedures doctors can do and what they can charge. Countries that use the Beveridge plan or variations of it include Great Britain, Spain, most of Scandinavia and New Zealand. Cuba has "the extreme application of the Beveridge approach; it is probably the world's purest example of total government control."⁶³

The Bismarck Model

The Bismarck Model is named for the Prussian Chancellor Otto von Bismarck. It uses an insurance system financed jointly by employers and employees through payroll

63 "Health Care Systems - Four Basic Models." Physicians for a National Health Program. <http://www.pnhp.org/resources/health-care-systems-four-basic-models>.

deductions. Bismarck health insurance plans have to cover everyone, and do not make a profit. Doctors and hospitals tend to be private in Bismarck countries. Although it is a multi-payer model, strict regulation gives the government much of the cost-control power that the Beveridge Model provides. The Bismarck model is found in Germany, France, Belgium, the Netherlands, Japan, and Switzerland.⁵⁹

The National Health Insurance Model

The National Health Insurance Model contains elements of both the Beveridge and Bismarck models. It uses private-sector providers, but payment comes from a government-run insurance program that every citizen pays into. Since “there is no need for marketing and no financial motive to deny claims and no profit; these programs tend to be cheaper and much simpler to administer than for-profit insurance.” The single-payer has considerable market power to negotiate for lower prices. National Health Insurance plans also control costs by limiting the medical services paid for or having longer wait times for procedures. The classic NHI system is found in Canada; Taiwan and South Korea.⁵⁹

The Out-of-Pocket Model

The out-of-pocket model is found in the majority of the world. Only developed, industrialized countries, 40 out of 200 countries, have an established health care system.

The out-of-pocket model exists in countries that are “too poor or disorganized to provide any kind of national health care system.” In these countries, only those that can afford to pay out-of-pocket for healthcare receive it.⁵⁹

U.S. Healthcare System Overview

The American system has elements of all of all four models. As T.R. Reid, author of *The Healing of America: A Global Quest for Better, Cheaper and Fairer Health Care states*

“when it comes to treating veterans, we’re Britain or Cuba. For Americans over the age of 65 on Medicare, we’re Canada. For working Americans who get insurance on the job, we’re Germany. For the 15 percent of the population who have no health insurance, the United States is Cambodia or Burkina Faso or rural India, with access to a doctor available if you can pay the bill out-of-pocket at the time of treatment or if you’re sick enough to be admitted to the emergency ward at the public hospital. The United States is unlike every other country because it maintains so many separate systems for separate classes of people. All the other countries have settled on one model for everybody. This is much simpler than the U.S. system; it’s fairer and cheaper, too.”⁶⁴

Reid points out “the US health care system has elements of each of the 4 models and provides different types of care and coverage for different sectors of the population, making it disjointed and costly.”

Health insurance is mainly provided through the private sector with most Americans getting insurance from their employer. Programs such as Medicare,

⁶⁴ Reid, T. R.. *The healing of America a global quest for better, cheaper, and fairer health care*. New York: Penguin Books, 2014.

Medicaid, and the Veterans Health Administration (the military healthcare system) are provided by the government, but they are not free like the NHS.

Most Americans receive health insurance from their employers. Less than 10 percent of the population purchases individual health insurance plans. Most employers provided healthcare is provided through managed care organizations which include health maintenance organizations (HMOs) and Preferred Provider Organizations (PPOs). The main objective HMOs is “reducing the overall cost of health care while also aiming to improve or maintain the quality of that care for members”. One practice that HMOs have come under scrutiny for is “[achieving] cost savings for itself and members by first determining what procedures and it will pay for...” With this practice “elective or experimental procedures are almost never included”.⁶⁵ PPOs function the same as HMOs, but individuals have the option to go outside the network of approved healthcare providers, but at a higher cost.

Government healthcare programs cover 28% of the population. Programs such as Medicare (for citizens over 65 and who are disabled), Medicaid for low income people, State Children's Health Insurance Program (for low-income children not covered by Medicaid, and the Veterans Administration (for veterans and their families). In

⁶⁵ California Office of the Patient Advocate. "HMOs, PPOs & Other Health Insurance." HMOs, PPOS and Other Health of Insurance. <http://www.opa.ca.gov/Pages/HMOsPPOsandOtherHealthInsurance.aspx>.

addition to these public programs, federal law ensures that individuals have access to emergency services regardless of ability to pay.⁶⁶

The Affordable Care Act (ACA) was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government. The ACA aims to extend health insurance coverage to 40 million uninsured Americans by expanding both private and public insurance. As of April 2014, more than 10 million Americans have enrolled in healthcare coverage since the ACA's launch. This figure includes more than 8 million individuals who have selected insurance through the health insurance marketplaces established by the ACA, and another 3 million who have enrolled in Medicaid during the Act's rollout.⁶⁷

Several states with legislatures controlled by Republicans have opted to reject the expanded Medicaid coverage provided. Over half of the nation's uninsured live in those states. They include Texas, Florida, Kansas, Georgia, Louisiana, Alabama, and

⁶⁶ "Emergency Medical Treatment & Labor Act (EMTALA)." Centers for Medicare & Medicaid Services. <http://www.cms.hhs.gov/EMTALA/>.

⁶⁷ "Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period." The Commonwealth Fund. <http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/health-coverage-access-aca>.

Mississippi. In states that do not expand Medicaid, some of the neediest people will not get coverage.⁶⁸

An estimated 11.5 million uninsured, non-elderly, poor adults live in states that have opted out. Without the Medicaid expansion, the ACA would reduce the number of uninsured by an estimated 15.1 million (28%) by 2022. If all states adopted the Medicaid expansion, the number of uninsured in 2022 would decline by 25.3 million (48%) – an additional 10.1 million people.⁶⁹ In the future, the U.S. Congress will have to address the Medicaid gap in order to the ACA to reach its universal coverage goals.

The United Kingdom

History/ Overview

The National Health Service was created with the National Health Act of 1946. The NHS was the first Western country to offer free medical care to its entire population.⁷⁰

Minster of Health of the Labor Government during that time, Aneurin Bevan, is said to be the architect of the NHS. The system was based on one central concept, “the health

⁶⁸ "Where Each State Stands on ACA's Medicaid Expansion." The Advisory Board Company.<http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap>.

⁶⁹ Holahan, John, and Joshua Weiner. "Federalism and Health Policy: State and Federal Roles in Health Care." Urban Institute Press.

⁷⁰ Klein, Rudolf. The new politics of the NHS: from creation to reinvention. 5th ed. Oxford: Radcliffe, 2006.

service will be available to all and financed entirely from taxation, which means that people pay into it according to their means.”⁷¹

The NHS was founded on three-core principles, “that it meet the needs of everyone, that it be free at the point of delivery, and that it be based on clinical need, not ability to pay”. These principles have guided the NHS since its inception; however, in July 2000, the NHS underwent “a full-scale modernization program” and new principles were added. These included that the NHS would provide a comprehensive range of services, work continuously to provide quality services and minimize errors, and support and value its staff. ⁷²

In England, the UK government through the Department of Health controls the NHS. The Department of Health oversees NHS policy; however, the Department of Health “does not 'run' the NHS, but it sets national policy and provides advice and guidance and oversees the performance of NHS organizations”. Locally, Strategic Health Authorities (SHAs) oversee all NHS operations, particularly Primary Care Trusts (PCTs). PCTs are responsible for “providing and commissioning services [and] controlling the majority of the budget.” ⁷³Funding for the NHS is provided mainly through taxation, but

⁷¹ "The NHS in England." The structure of the NHS in England.
<http://www.nhs.uk/NHSEngland/aboutnhs/Pages/NHSstructure.aspx>.

⁷² "About the NHS." The principles and values of the NHS in England.
<http://www.nhs.uk/NHSEngland/aboutnhs/Pages/NHSCorePrinciples.aspx>.

⁷³ Smith, Alison, Allyson Pollock, Colin Leys, and Nick McNally. The new NHS a guide. London: Routledge, 2006.

also national insurance payments. Employers and those over the age of eighteen make national insurance payments.

The NHS is divided into two sections, primary and secondary care. Primary care is generally regarded as a 'frontline' service. It is the first point of contact for most people and is delivered by a wide range of independent contractors such as General Practitioners, dentists, pharmacists and optometrists". Secondary Care, also known as acute healthcare, can be elective or emergency. PCTs are in charge of primary care "and control 80% of the NHS budget.... The PCTs oversee 29,000 GP sand 18,000 NHS dentists". If a patient requires acute care, their General Practitioner can refer them to a hospital.⁷⁴

The NHS is not the only health service available to United Kingdom residents. Individuals also have the option of purchasing private insurance. There are many reasons why an individual would purchase private insurance, "one of the most common reasons for a person selecting private healthcare as opposed to NHS care is because of the hospital or clinic setting." Because most of the population receives care through the NHS, "the private sector taking patients helps to relieve some of this stress making it easier for the hospitals to manage their individual case-load". Private insurance also has drawbacks. The NHS is able to afford the equipment needed for procedures and

⁷⁴ "About the NHS." The principles and values of the NHS in England.
<http://www.nhs.uk/NHSEngland/aboutnhs/Pages/NHSCorePrinciples.aspx>.

treatments that would be too expensive for many private sector hospitals. Also, many private hospitals are not equipped to perform emergency procedures.⁷⁵

Problems faced by the NHS

The NHS is not without problems. One problem that the NHS suffers from is funding deficits. Though the net deficit represents less than 1% of total NHS expenditure, overspends are being recorded during a period of unprecedented investment in the NHS. The British Medical Association (BMA) believes the deficit could have far-reaching implications. A survey conducted by the BMA in 2005 found “that one in three NHS trusts planned to reduce services because of deficits. Of the 171 NHS trusts that responded to the survey, a third of respondents (37.6%) reported that their trust intended to reduce patient services”.⁷⁶ The study also found that “almost half of respondents (47.3%) to the BMA survey reported that their trust was intending to freeze recruitment as a result of funding shortfalls”. The deficits many NHS trusts are facing are “causing them to suspend or delay treatment or even close services”.⁷⁷

⁷⁵ "Difference Between NHS and Private Health Services." Difference Between NHS and Private Health Services. <http://www.privatehealthadvice.co.uk/difference-between-nhs-private-health-services.html>.

⁷⁶ "BMA - Home." BMA - Home. http://www.bma.org.uk/healthcare_policy/nhs_funding/NHSdeficitsbriefing.jsp.

⁷⁷ Smith, Alison, Allyson Pollock, Colin Leys, and Nick McNally. The new NHS a guide. London: Routledge, 2006.

Another problem facing the NHS is its increasing politicization. This politicization comes from the expanding role of the private sector. Along with the modernization plan the NHS underwent in 2000, it also became increasingly reliant on the private sector. Based on the increase of individuals needing NHS services, political parties have sought to find ways to save money and would like to introduce market competition. Alison Talbot Smith and Allyson Pollock examine the increasing role the privatization the NHS, they state that the NHS is set to become a “government-funded payer, but less and less the direct provider, of health services”.

The NHS today is seeing many forms of privatization including; deregulation of state monopolies, the outsourcing of state responsibilities, and the cessation of services”.⁷⁸ The privatization of NHS is troubling because “privatised healthcare tends to cost more; accountability suffers; the fog of ‘commercial confidentiality’ makes scrutinizing public spending impossible; [and] the profit motive encourages ‘cherry-picking’ of the lucrative work, ultimately leading to NHS services being cut” (Keep Our NHS Public).⁷⁴

⁷⁸ "A Patchwork of Privatization." Keep Our NHS Public.
<http://www.keepournhspublic.com/pdf/Patchworkprivatisationexecutivesummary.pdf>.

Germany

History/Overview

The German health care system is the Bismarck model. The system was created in 1883.⁷⁹ All individuals are required by law to have health insurance, but it is not provided directly by the government. Approximately 85 percent of residents purchase heavily regulated, non-profit insurance referred to as *Gesetzliche Krankenversicherung* (Statutory Health Insurance, GKV), 10 percent buy private insurance, and the remaining 5 percent fall into other insurance categories. Sickness Funds, or *Krankenkassen*, are regulated, non-profit insurers who are legally required to accept all applicants and are permitted to sell health insurance. Sickness funds collect premiums from employees and employers. The average insurance contributions to German sickness funds are based on the individual's gross income. Employers and employees each pay half of the premium. Generally, an employee's contribution is 8.2 percent and the employer pays the remaining 7.3 percent.⁸⁰

According to the Department for Professional Employees, AFL-CIO the "average per-capita health care costs for the [German] system are less than half of the cost in the

⁷⁹ Knox, Richard. "History Of Tinkering Helps German System Endure." NPR. <http://www.npr.org/templates/story/story.php?storyId=92189596>.

⁸⁰ American Institute for Contemporary German Studies. "Issues in the German and U.S. Health Care Systems." AICGS Issues in the German and US Health Care Systems Comments. <http://www.aicgs.org/issue/issues-in-the-german-and-u-s-health-care-systems/>.

U.S. The details of the system are instructive, as Germany does not rely on a centralized, Medicare-like health insurance plan, but rather relies on private, non-profit, or for-profit insurers that are tightly regulated to work toward socially desired ends—an option that might have more traction in the U.S. political environment.”⁸¹ Healthcare prices for procedures are lower and uniform because doctors’ associations negotiate their fees directly with the sickness funds. For comparison, an appendectomy costs \$3,093 in Germany, but \$13,000 in the U.S. Germany has a “uniform fee schedule for all physicians that work under the social code...there’s a huge catalogue where they determine meticulously how much is billed for each procedure.”⁸²

While sickness funds and physician associations have administrative autonomy, there is also government intervention. Expenditures for the sickness funds grew rapidly in the 1960’s and early 1970’s. As a result, Germany passed the “Cost Containment Act of 1977” which introduced a fixed budget for payments by the sickness funds to the physician associations. The Health Care Reform Act of 1989 and the 1993 Health Care

81 Department for Professional Employees, AFL-CIO. "The U.S. Health Care System: An International Perspective." DPEAFLCIO. <http://dpeaflcio.org/the-u-s-health-care-system-an-international-perspective/>.

82 Khazan, Olga. "What American Healthcare Can Learn From Germany." The Atlantic. <http://www.theatlantic.com/health/archive/2014/04/what-american-healthcare-can-learn-from-germany/360133/>.

Reform Act introduced more major changes. The laws attempted to further reduce the growth of health expenditures and increase competition.⁸³

Germany's cost containment measures have resulted in a decrease in primary care physicians salaries, compared to U.S standards. German hospitals also have less “high technology diagnostic, therapeutic, and surgical equipment than is available in the typical urban hospital in the United States.” Germany has 22.6 % fewer MRI units per million compared to the United States. The one area where Germany has more technology is CT scanners, where “they have 17.1 per million population compared to 13.7 per million in the United States.”⁷⁹

Like the U.K., Germany has also achieved a favorable rating in healthcare rankings. It has achieved universal coverage, but avoided queues and extensive government intrusion. Germany’s achieved cost control “by establishing an explicit tradeoff between volume and price. When utilization is higher than anticipated, fees are lowered proportionally. In addition, temporary spending caps instituted in the mid-1980s have become permanent. New laws adopted in 1993 and 1997 designed to increase competition among sickness funds, lowered pharmaceutical prices and physicians’ fees, increased required co-payments, and placed more regulations on hospital billing practices, all to reach desired spending targets.”⁷⁹

83 Ridic, Goran, Suzanne Gleason, and Ognjen Ridic. "Comparisons of Health Care Systems in the United States, Germany and Canada." *Materia socio-medica* 24, no. 2 (2012): 112.

Problems faced by the German system

Despite the success at currently controlling costs, the German system also suffers from several problems that could affect the country's long-term ability to control costs. One of the biggest problem with the system is the “reliance on third-party payment.” Because of this, “patients have no incentive to limit their demand and medical providers have no incentive to limit their supply.”⁷⁹ The only competition is among medical practitioners to attract more patients. As a result, “the ability of the system to control costs depends solely on the relative bargaining power between sickness funds and medical providers.”⁷⁹

Based OECD data, “Germans see their doctors more often, are provided more prescription drugs, have a higher hospital admission rate, and stay in the hospital longer than citizens of the major developed countries in the OECD.”⁷⁹ Germany also faces additional pressure from having a much older population than the United States. The aging German population is, causing a demographic change that will place significant pressure on health care programs.⁷⁹

Conclusion

Based on the existing similarities between the Germany's healthcare system provides the best example for the U.S. to explore for future healthcare legislation and

controlling costs. Although the U.K. system ranks higher in comparative studies and has lower costs than the German system it is a more radical system that would be difficult to implement given the current political climate in the U.S. As we have seen from the bitter fight over the Affordable Care Act and the Medicaid expansion, conservative states are reluctant to increase government intervention in healthcare. John McDonough, a professor at the Harvard School of Public Health, states, "...the notion that government may be a big part of the solution, instead of the problem, is anathema, and Republican controlled legislatures, and their governors, would find it too substantial a conflict to pursue with any vigor."⁸⁴ The current U.S. system is a patchwork of different programs for different segments of the population. As T.R. Reid asserts that, "this fragmentation is another reason that we spend more than anybody else spends and still leave millions without coverage. All the other developed countries have settled on one model for health-care delivery and finance; we have blended them all into a costly, confusing bureaucratic mess."⁸⁵

⁸⁴ Khazan, Olga. "What American Healthcare Can Learn From Germany." The Atlantic. <http://www.theatlantic.com/health/archive/2014/04/what-american-healthcare-can-learn-from-germany/360133/>.

⁸⁵ Reid, T.R.. "5 Myths About Health Care Around the World." Washington Post. http://www.washingtonpost.com/wp-dyn/content/article/2009/08/21/AR2009082101778_pf.html.

Conclusion

This paper examined solutions to the problem of rising healthcare costs by examining cost-controls in the Affordable Care Act, reforms tested at the state level, and the U.K. and Germany's healthcare system. The analysis showed some cost-saving benefits for these methods, but also shortcomings.

In the first chapter, the three potential cost-savings solutions examined ACOs, healthcare exchanges, and government negotiation of healthcare prices all show evidence for potentially lowering costs, to varying degrees. Although several ACO systems examined in the paper have experienced improvement in quality and lower costs, other systems, including the Medicare pilot have not produced significant savings. The evidence for the success of accountable care organizations lowering healthcare costs is mixed, but since they have only been implanted for a few years, more time is needed to see a more accurate view for success.

Similarly, the healthcare exchanges have only been open to the public to purchase insurance for a few months; data on their effect on lowering costs is limited. However, based on preliminary studies, there is evidence that the exchanges will result in lower costs for insurance; especially in states with a large number of insurance options in the healthcare marketplace

The government negotiation of prices for healthcare has much stronger evidence that it will reduce costs. Many other countries utilize price setting as an effective method to keep healthcare prices considerably lower than in America. As evidenced by Germany and the U.K.'s healthcare system, government negotiation of prices is an integral part of controlling costs.

Massachusetts has achieved nearly universal coverage and greatly improved access to care for the state's residents. Both the ACA and the Massachusetts law share similar components and the Massachusetts law is considered to be a blueprint for the ACA. Universal coverage was the primary objective of the health reform law. Based on the evidence, the methods utilized by the Massachusetts law were successful at increasing healthcare coverage. Universal coverage is one of the main goals of the ACA, and the Massachusetts law provides encouraging results. However, Massachusetts has continued to experience high health-care costs in the nation, making cost-containment the state's next priority. Future research should study whether the cost controls have been effective.

Although United Kingdom and Germany have different models of healthcare, both countries spend far less than the United States on healthcare and rank higher on studies of quality and affordability. Although both countries face their own set of problems, they are able to provide their residents with higher quality care at lower costs. Should the U.S. decide to implement further healthcare reform, Germany's

system provides the best model. Not only is it a less radical option, the U.S. already has elements of the Germany system, such as employer paid health insurance.

Enacting the Affordable Care Act was a positive step for the U.S. toward expanding access to healthcare and making healthcare more affordable. Under the ACA, many low and middle-income individuals are able to purchase health insurance. However, the full impact of the law cannot be seen because the Medicaid expansion is not available for residents in conservative states. Finding a solution to the Medicaid-gap should be a priority for the U.S. Congress.

As this paper has shown, the issue of healthcare costs is complex and there is single policy solution that will solve the problem. Continued implementation of healthcare legislation meant to expand care, while controlling costs, will allow the U.S. to expand on the success of the ACA. Since most of the provisions in the ACA have only been in effect since January 1, 2014 and some provisions will not be implemented until 2015; further research is needed to know what effect the ACA and the measures in the law will have on healthcare spending and coverage. Future research would also examine what effects potential cost-control measures could have on the availability and issues of “care-rationing.”

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Curriculum Vita

EDUCATION

Johns Hopkins University, Washington, DC

August 2014

- Master of Arts, Government

Hendrix College, Conway, AR

May 2011

- Bachelor of Arts, Psychology

PROFESSIONAL EXPERIENCE

U.S. Department of Health and Human Services, Washington DC *August 2014 – Present*
Presidential Management Fellow, Office of Budget

American Association for Justice; Washington, DC

Formerly known as the Association of Trial Lawyers of America

State Affairs/Outreach Assistant

July 2012 - June 2013

- Drafted grassroots messages and updated grassroots software with relevant content.
- Served as staff liaison to AAJ's Key Contact Committee tasked with identifying fellow members that have relationships with Members of Congress in order to promote the association's legislative agenda.
- Coordinated meeting scheduling for legislative advocacy days with Members of Congress
- Updated and maintained state profiles and state legislative tracking documents
- Developed and wrote public affairs presentation for the CEO
- Served as staff liaison to AAJ's Republican Trial Lawyer Caucus
- Coordinated and supervised the Public/State Affairs Internship program

Public Citizen; Washington, DC

Web/Administrative Assistant, Health Research Group

October 2011 - July 2012

- Used content management system (CMS) to create new pages, forms, and templates
- Created databases of adverse drug reaction for analysis
- Performed research and responded to consumer correspondence regarding drug and subscription questions
- Maintained social media accounts

Center for American Progress; Washington, DC

Campus Progress Policy and Advocacy Intern

June 2010 - August 2010

- Contributed to planning and execution of most successful Advocacy Day of National Conference for 100 participants
- Scheduled lobbying meetings with over 70 U.S. Senate offices for constituents to lobby their Senators
- Researched, tracked, and summarized relevant legislation for Policy Manager and staff
- Drafted web content, talking points, policy issue briefs, and letters to members of Congress
- Conducted research on a range of domestic policy issues using government and third-party Internet source

U.S. Equal Employment Opportunity Commission; Washington, DC
Office of Research, Information, and Planning Intern ***June 2009 - August 2009***

- Developed and organized materials for project Wiki of employment opportunities for

Black and Hispanic felons

- Conducted research on employment statistics and drafted reports of findings
- Updated and maintained research literature database using bibliographic software (Citation)
- Developed key technical assistance guide used by enforcement staff
- Performed data analysis using SAS statistical software