ON THE POLITICS OF PRESCRIPTION: AN ANALYSIS OF THE UNDERLYING PROBLEMS AND POLICY-BASED SOLUTIONS FOR THE HIGH COST OF AMERICAN HEALTH CARE

by

Alexander Cohen

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Project Approved by:

Supervising Professor: James Riddlesperger, Ph.D.

Department of Political Science

Mary Volcansek, Ph.D.

Department of Political Science

Silda Nikaj, Ph.D.

Department of Economics

ABSTRACT

American health care spending is at an all-time high. The U.S. spends more than any other developed nation on health care, yet health outcomes are far from reciprocal. Americans are not inherently less healthy nor do they utilize more care than peer nations. Rather, the crux of the problem rests in the system itself. Previous efforts to reform federal policy have either failed or fallen short. All solutions involve trade-offs, and true reform in health care policy needs to contain costs, improve quality and ensure access. With these in mind, I have established six (6) policy-based recommendations: 1) universal health coverage, 2) price transparency measures, 3) increased primary and public health investment, 4) emphasis on women's and sexual health, 5) reduction in the cost of expensive care and/or technology utilization and 6) end-of-life care reform. These prescriptive policies have potential to not only save money but also save lives.

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INTRODUCTION

The U.S. spends more money per capita on health care than any other developed nation.[1] Despite this high spending, the average life expectancy is relatively low compared to other OECD countries and has not changed much in the last 20 years. The problem of "why" has no simple solution. The basic economic relationship between producers and consumers with supply/demand and insurance to protect both parties fails to explain deficiencies in the system at hand. There exist several additional pieces to the otherwise standard economic transaction.

This paper seeks to explain what failures exist in the American health care market, why they exist, and how their interaction can explain high American health care costs. To do so, it is necessary first to demonstrate that indeed health care spending is higher in the U.S. than in other countries with no clear benefit. Next, examination looks at individual actors in each of the market arenas, and how their economic decisions help answer the question of why cost is so high. Finally, this investigation examines possible solutions. Though the market by nature could potentially settle at a fair market cost, the structure of the American system essentially nullifies free market principles. Federal policy, therefore, would be a viable solution in making health affordable.

The meat of this research project comes in the form of six (6) policy recommendations. These recommendations seek to balance the competing interests of the health care trilema, which posits that in healthcare, to assure universal access, low cost, and high quality requires major trade-offs. However, with the help of domestic and

[1] Squires, David A. "Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices and Quality." *Issues in International Health Policy*, May 2012: 1-14.

international case studies, I suggest recommendations that mitigate those trade-offs. When taken as a whole and combined, these policy recommendations are not only feasible, they have potential to save the U.S. billions of dollars. The U.S. system is currently diseased, and I seek to provide the prescription.

DEFINITIONS

A "provider" in this case is an individual or group that directly provides health care. Providers are comprised of doctors. Characteristics of the respective provider vary. For example, some doctors choose to practice privately, some in small groups of physician partnerships, some in loosely associated networks, and some in large hospitals, etc. All providers, in theory, must abide by the same set of laws and buy their products from some third party manufacturer. With this in mind, providers can then make the choice to charge a certain price they deem appropriate for the provided good/service.

A "patient" in this case is any individual that acts as a health care consumer. As with providers, patients vary vastly in their characteristics. The literature noted differences in patients' socioeconomic status, race, and culture as important factors that play a part in the puzzle. No doubt these factors make a difference, but for the sake of the present paper, the assumption is that all consumers have the simple choice to either buy or not buy a product.

A "lawmaker" in this case is an individual with the ability to create, uphold and/or destroy legislation that regulates any aspect of the health care industry. This

includes local, state, and national legislators, so long as they have some ability to change the way the industry is operated. Additionally, it could include state and federal officials that have authority over a bureaucratic organization that can regulate health markets. They can choose not to place additional regulations on the market and therefore keep the status quo. Or, lawmakers may choose to change the law and interfere with the market. This decision is greatly influenced by political pressure to not alter the status quo, keep healthcare lobby money, taut a capitalistic free-market ideology or some combination thereof. This is one of the problems behind a lack of comprehensive reform. Oberlander explains why bad things happen to good policy, and with this in mind he explains why the bigger the policy, the harder it falls.[2] When 83%-85% of the nation is insured and receiving healthcare of any degree, a proposed change that would drastically alter the system brings fear to the majority of hearts, literal hearts, and minds.

A "health care company/manufacturer" in this case is any company that makes, creates or manufactures any health related product. This includes pharmaceutical companies, medical device manufacturers and other suppliers of medical goods. It is important to note that unlike companies in other sectors, health care companies control a great deal of the market. The law protects patents on products, thus essentially creating a monopolized product.[3] Furthermore, pharmaceutical and health care

[2] Oberlander, Jonathan. "The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?" *Health Affairs*, August 2003: 391-404.
[3] Vladeck, Bruce C., And Thomas Rice. 2009. "Market Failure And The Failure Of Discourse: Facing Up To The Power Of Sellers." *Health Affairs* 28 (5) (Sep): 1305-15

companies annually spend more capital on lobbying lawmakers than any other industry.[4]

"All-payer" is a health care delivery system in which each payer essentially is charged same price for a certain service. It does not necessarily dictate a universal price schedule for hospitals, but rather the system generally allows flexibility in determining actual prices so long as the payer does not carry additional burden. All-payer comes in different shapes and sizes, but the general goal holds constant—ensure that every patient and insurance provider enters a health transaction with the full knowledge of what they are to pay. This does not necessarily curb usage of care, but it does allow for a more informed consumer and a more accountable provider. It has been successful all over the world, notably in France, Germany, Japan and the state of Maryland.

"Single-payer" is a health care delivery system in which one entity or payer covers the cost of care for all patients. In most single-payer systems, that entity is the government. Single-payer is only a form of funding, and the actual rationing of care is handled differently for each respective system. Canada and many Western European nations have implemented single-payer systems. While public opinion polls suggest an overall positive feeling towards single-payer in the U.S., the political reality suggests otherwise. In 2009, Kaiser public opinion polls found that 51% of Americans support a comprehensive classic single-payer system in the U.S., and more than 60% favor some variation that mirrors single-payer, i.e. "Medicare-for-all."[5] Despite these findings, the

[4] "Center for Responsive Politics: Lobbying Database," last modified 2012, http://www.opensecrets.org/lobby/top.php?showYear=2012&indexType=i

[5] The Henry J. Kaiser Family Foundation. 2009. *Kaiser Health Tracking Poll: Public Opinion On Health Care Issues*

PPACA supplanted any real chance at implementing a single-payer system in the U.S. in the near future.

"Moral hazard" is an underlying principle of insurance theory. Moral hazard purports that if a person goes from being uninsured to insured, their utilization of health care services will dramatically increase due to the newfound affordability of care. This concept is a main driver for cost-sharing mechanisms of insurance policies. If a payer is going to overutilize at the new insured price, then cost sharing seeks to reduce that utilization by putting more economic burden onto the patient. While moral hazard reduction is not inherently bad, I argue that it has had adverse effects on the type of utilization and therefore led to welfare loss due to underutilization.

"Cost-sharing" is a mechanism used by insurers to decrease the amount of moral hazard welfare loss due to insuring an individual. This is achieved through deductibles, co-pays, premiums, etc. The gist of cost sharing is an attempt to alter patient behavior, or at least mindset, by allowing patients to have "skin in the game." Evidence as to the effectiveness of cost sharing to reduce moral hazard is mixed. Some claim that it reduces frivolous usage while others claim that it incentivizes reactive spending on expensive care. One of the issues I discuss later is the concept of inelastic demand in health care spending and how health care decisions are not like other economic choices.

"Hospice/Palliative care" is a method of end-of-life treatment that seeks to manage a terminally ill patient's pain rather than sustain life. Palliative care is often carried out at a patient's home or in smaller facilities designed to maximize comfort in a patient's final months. The medical approach is multidisciplinary and includes a full

medical and guidance team of doctors, nurses, clergy and grief counselors. The ultimate goal of managed hospice care is to provide peace of mind and dignity for both the dying patient and his/her family.

"Terminally ill" is defined by CMS as having 6 months or less to live.

"Medicaid" is "an entitlement to medically necessary health care" for 66.7 million low- income individuals, families, and people with disabilities in the U.S.[6] CHIP, or the Children's Health Insurance Program, accounts for about 43 million child beneficiaries. Non-elderly non-disabled low-income adults account for 11 million, whereas 8.8 million disabled low-income adults are covered. Further, 4.6 million elderly low-income adults are what is known as "dual eligible," qualifying for both Medicaid and Medicare. In CY 2012, Medicaid and CHIP accounted for $433 billion of America's $2,793 billion in health care expenditures.

"Medicare" is the U.S. social insurance entitlement program for the elderly population 65 years of age and older. In 1973, the program was extended to cover several at-risk disabled populations as well. In FY 2015, 55.2 millions Americans were enrolled in Medicare. 46.1 million are those who qualify due to age, the other 9.1 are disabled persons. In CY 2012, Medicare accounted for $572.5 of America's $2,793 billion in health care expenditures.

Mayo Clinic defines "STD/STI" as follows: "Sexually transmitted diseases (STDs), or sexually transmitted infections (STIs), are generally acquired by sexual contact. The organisms that cause sexually transmitted diseases may pass from person to person in

[6] CMS Office of Financial Management. 2015. *Center for Medicare & Medicaid services program data fast facts*

blood, semen, or vaginal and other bodily fluids. Some such infections can also be transmitted nonsexually, such as from mother to infant during pregnancy or childbirth, or through blood transfusions or shared needles." The CDC estimates that 110 million Americans are currently living with an STD/STI and the number grows about 20 million per year. The most common STD is HPV followed by Chlamydia.

"Universal care" is a single-payer system. It is important to distinguish this from universal coverage. Coverage provides insurance for all, and care provides actual care for all. The U.S. is attempting to achieve universal coverage, but currently not attempting to achieve universal care.

"Universal coverage" is slightly different from universal care. Universal coverage focuses on the accessibility of reasonably priced health care for all citizens through universal availability of insurance. Insurance functions as a discount or price sharer which reduces the economic burden on the patient/payer. Universal access to coverage is a major focus of this present paper as opposed to universal care.

"Safety net provider" is a public health clinic that is generally funded through taxpayer dollars or private investors/philanthropists. They are generally 501(3)(c) nonprofit providers that provide either free or low cost care to any patient that walks through the door. A classic example is Planned Parenthood.

QUESTION: WHY ARE AMERICAN HEALTH CARE COSTS HIGH?

Establishing that American Health Care Costs Are High

Per capita, the U.S. spent $7,960 (17.4% GDP) on health care in 2009. To put that number in perspective, the next highest spending developed country was Norway at $5,352 per capita. France spent $3,978 (11.8% GDP), while Germany spent $4,218 (11.6% GDP).[7] Furthermore, even though America covers less than half the population through health care entitlement programs of Medicaid and Medicare, the U.S. spends the second highest number of taxpayer dollars per capita among developed nations. Even Canada, a single-payer system, spends less.[8] The data were adjusted for national income, so the explanation does not lie in the notion that America is wealthier than most countries.

With spending so high, one might expect health outcomes in the U.S. to be higher. This does not seem to be the case when comparing quality indicators among sampled developed nations. Generally, the U.S. does have a fairly high cancer survival rate. Despite this, the U.S. had the highest rate of death due to preventable diseases. These two factors when taken together point to mediocre overall care.

A similar study done by Banks et al. draws a comparison between the health of American adults and that of British adults. Americans, at all socioeconomic status levels, were “less healthy” in a wide array of categories.[9] Researchers found that both poor and wealthy Americans experienced worse health than their British counterparts. Some of

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[7] Squires, David A. "Explaining High Health Care Spending in the United States” 8
[8] Ibid., 9
[9] Banks, James et al."Health Disadvantage in US and Adults Aged 50 to 74 years: A Comparison of the Health of Rich and Poor Americans With That of Europeans." *American Journal Of Public Health* 99, no.3 (March 2009):540-548.

the discrepancy can be explained by the British emphasis on primary care, but the gap is too vast for a single explanation. Both articles looked at occurrence of smoking and obesity in the studied countries. Each of the studies explained that these issues had a relatively low effect on overall health of a country.

Every factor examined points to American overspending. Yet, the expenses did not increase quality of health. These articles present the data as near empirical truth. This is particularly helpful when most media, and even some research, leans towards the policies of health care. At the same time, both studies merely state that there is a problem with little explanation as to a definite why.

Socioeconomic and Political Factors Do Not Cause Americans to be Inherently Less Healthy

For Americans not employed by the government, retired or below the poverty line, health insurance is either an employment benefit or an individual purchase. Because of this, 48 million people in the U.S. are currently uninsured.[10] A disproportional number of these people belong to a racial minority group. Additionally, rates of heart disease and stroke were considerably higher among these groups.[11] Conventionally, the explanation has been that Blacks and Hispanics are more likely to be unemployed or underemployed when compared to their White counterparts. Thus, they suffer from the negative side of the employer provided health insurance system.

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[10] U.S. Census Bureau, Current Population Survey, 1988 to 2013 Annual Social and Economic Supplements—number is pre-ACA marketplace in 2013 and 2014

[11] Robinson, Dean. "US Health and Health Care: Does Political Inequality Make Us Sick?" *New Political Science* 29, no. 4 (December 2007): 529-534.

Robinson, however, states that it is the socioeconomic gaps themselves that explain America's poor health.[3] The relationship of socioeconomic status (SES) and health changes based on circumstances. For example, in Western countries, SES and blood pressure are directly related. In non-Western countries, the two are reversed.[12] Interestingly, when Hispanic immigrants became more "Anglo acculturated," the direct relationship between SES and blood pressure declined and cardiovascular health worsened. Therefore, the study found that there is a cultural gradient that moderates the relationship between SES and blood pressure.

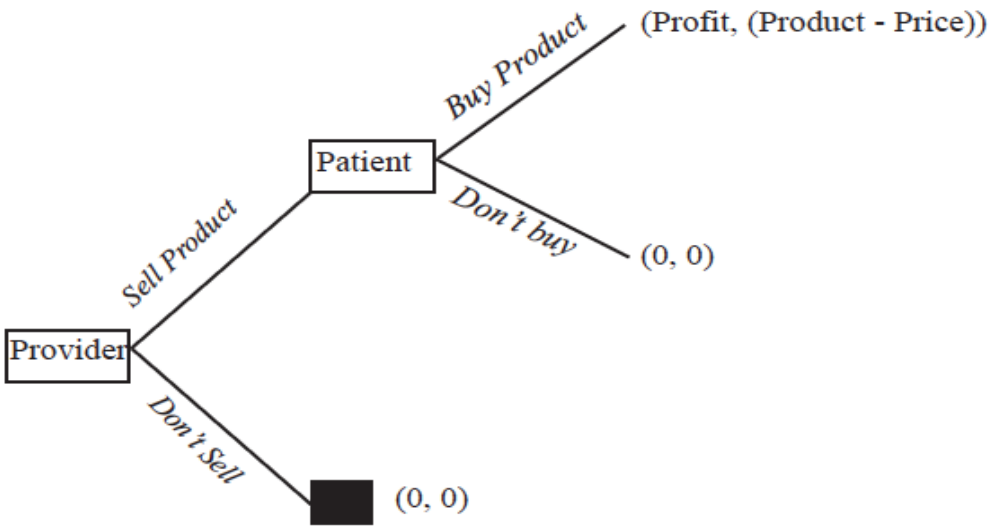
The research on effects of SES is more compelling than the common notion of an unhealthy obese America. Most of the SES data, however, only accounts for a minute piece of the astronomically complex puzzle. Even if American health is poorer than that in most advanced societies this does not justify the chasm in health care spending. Current research supports the proposition that American health care expenditures should be far lower based on relative health of the average citizen. A lack of evidence to support an inherent health difference between the average American and average world citizen indicates that the root cause for high costs more than likely rests in the differences in the American health care market and system.

[12] Steffen, Patrick. "The cultural gradient: culture moderates the relationship between socioeconomic status (SES) and ambulatory blood pressure." *Journal Of Behavioral Medicine* 29, no. 6 (December 2006): 501-510.

The Problem

Through the Lens of Rudimentary Game Theory

Intuitively, a health care market should function as any other capitalist free market. The producer has a product and/or service that the consumer needs. From there, elementary economics complete the supply and demand curves. The game tree for this relationship is shown below.



This would allow consumers to choose whether or not they would buy the good/service when it is offered. The producer's prices would be controlled by the availability of the specific good/service in the entire market, and the consumers' need for such a product. However, this is simply not the case in American health care markets. Rather, the relationship is far more complex.

Lawmakers, health care companies, and insurance providers set the regulations and base prices for the market. Their decisions determine the extent to which a provider can be a high cost or low cost provider. Additionally, the patient must make a decision

with no or little information as to which providers are high or low. So, while this game is sequential, the added complexity means the knowledge of another player's moves is limited in scope.

In actuality, the economic game functions more like this: During the transaction, the provider has an initial choice to either charge high or low. Ultimately providers are businesses and need to turn a profit, or at minimum avoid a net loss. If they charge high and the patient does not buy the product, then no profit is made. The same is true if they charge too low and run a deficit on the specific product they are providing. Although simplified, this is the fundamental decision a provider must make *in situ*. The goal of the provider, therefore, is to maximize profit while minimizing loss due to patient inability to pay.

After the provider makes the first move, the patient is given the option to either buy or not buy. If the patient buys, the product is delivered and a health outcome follows. If the patient chooses not to buy, then the provider ends the transaction with no profit and the patient ends in the same health condition as he/she began. It is important to note that a patient's decision is skewed significantly toward the "buy" option. This is because of the economic principle of inelastic demand.[13] In cases of dire need for a health care product, especially when one's life is on the line, the patient will more than likely buy the product. If the patient chooses not to buy the care, consequences can be detrimental or potentially fatal to the patient. So, that particular

[13] Vladeck and Rice, "Market Failure and The Failure of Discourse: Facing Up to the Power of Sellers," 1307

product will nearly always be bought, even if circumstances are less than optimal for the consumer.

That is not to say that all health care products are created equal. The immediate need for a kidney transplant is far more influential in a patient's decision than the need for having a skin tag removed. But, the incentive to live is usually far more powerful than the financial burden presented if the patient chooses to buy. This skewed inelastic demand essentially removes the bedrock foundational idea of rational choice in an economic equation.

Health care companies can choose to keep prices and economic relationships the same. This would keep the status quo. Conversely, companies may choose to raise their prices and increase profit margins. Similarly to providers, health care companies must make a profit to survive and thrive in the market. A similar balance to that of providers also applies in this situation. To complicate matters, the American insurance system shifts balance of power even further. Insurance markets explain a large portion of how and why American health expenditures have reached exorbitant levels.

American Insurance Policies Cause High Prices

In many economic and political situations, structure trumps preferences. Since sound health is crucial in living a longer and higher quality life, the health care market is high stakes. Consumers tolerate a degree of uncertainty in seeking the optimal health care because the alternative is possibly fatal. Because of this, consumers do not act like

"'rational' economic actors.[14] According to Vladeck, this pushes consumers to pay for goods even if the price is too high. Consumers might not know prices are high because providers control the market with little to no intervention. Providers have little incentive to post prices pre-purchase. There has been some headway in price posting. Centers for Medicare and Medicaid, for example, have begun to publish price schedules of metro hospitals.[15] However, this represents only a small fraction of medical procedures, providers, and even consumers for that matter. The majority of Americans enter into health care transactions blind to cost and/or outcomes.

To curb some of the lack of consumer knowledge, insurance companies have increasingly relied on the idea of cost sharing. Traditionally, it was thought that copayments and premiums cut overspending from the moral hazard[16] of having health insurance by increasing the burden on the consumer. American obsession on reducing moral hazard has caused a monopoly of pricing. In the last 50 years, health insurance coverage has increased to over 85% of the population with even more in the time since the passage of the Affordable Care Act.[17] When insurance coverage increases, overall spending on health care rises in causal proportions.

The dramatic increase in health care expenditures during the last 50 years was thought by economists to represent moral-hazard welfare loss. Moral-hazard welfare loss purports that Americans bought otherwise medically unnecessary care because

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[14] Vladeck and Rice, "Market Failure And The Failure Of Discourse," 1307

[15] U.S. Department of Health & Human Services. The Centers for Medicare & Medicaid Services. *Draft Methodology for Estimating National Average Retail Prices (NARP) for Medicaid Covered Outpatient Drugs*, June 2012, p. 1-21

[16] "When people become insured, insurance pays for their care. In economists' view, insurance is reducing the price of care to zero. When the price is reduced in this way, consumers purchase more health care than they would have purchased at the normal market prices—this is the moral hazard." John Nyman

[17] Nyman,John A. "Is 'Moral Hazard' Inefficient? The Policy Implications Of A New Theory."*Health Affairs* 23, no.5 (2004)194-199.

they were newly insured. Policy solutions, both public policy and internal insurance policies, sought to reduce moral hazard through cost sharing mechanisms. The theory is seemingly sound: insurance companies negotiate rates for the 85% of insured Americans while seeking to stabilize profits for providers, ensure a large enough insurance pool to prevent instability when utilization exceeds expectations, and prevent overutilization/moral hazard by passing off price hikes to policy holders.

The goal of lawmakers was to ensure that the other 15% of the population would have access to similar insurance coverage. Otherwise, the 15% of individuals who did not have an insurance policy would pay the price of care plus that which insurance covers. With a lack of price transparency or regulatory measures in place, providers could charge a high rate with the assumption that the large majority of their patients would only pay a fraction of the charged rate.

The consequence of this mentality is one of the chief causes for high costs in the American health care system. The price-setting monopoly of this magnitude actually causes people, insured and otherwise, to reduce usage drastically.[18] People end up buying what they deem necessary services whether they are covered by insurance or not, and the price monopoly caused by attempting to avoid moral hazard has caused prices to increase dramatically. Or, a person will wait until the last possible minute to seek treatment. If he/she believes there is a chance an ailment will take care of itself, they will avoid an office visit. This can be an effective means of steering patients away from overusing their respective physicians. But, when a person's uninformed prognosis

[18] Nyman, ""Is 'Moral Hazard' Inefficient?," 196

is wrong, the result is often a more severe medical condition. When he/she finally does seek medical help, the only option might be the most expensive form of specialty care. Welfare, thus, is reduced. An overuse of cost sharing now negates the insurance shield that is supposed to protect policyholders from a loss of income when health problems arise.

Most other developed countries, Western European nations and Canada specifically, have universal access to health care. Solidarity, as it is called, is not necessarily single payer. It allows all people to have access to care, despite income level.[19] Many, like France and Britain, have requirements that "instruments used to promote efficiency must be consistent with universal access."[20] This puts the power of choice into hands of the consumers. Consumers have an increased ability to pick which service to purchase and where to purchase it. In this system, competition between providers within the system regulates prices.[21] This form of European competition is on a national scale in an attempt to reduce excess demand for care.

The U.S. has tried on several occasions to pass legislation that would enact similar universal access measures. Almost all bills changing the health care industry have failed. Not surprisingly, the bigger they are, the harder they fall[22]. Oberlander points to the political power of organized medicine and its resistance to change. The 15% of Americans without insurance cannot organize for any real power, especially when most of the other 85% are worried what a change in the system will do to them.

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[19] Jost, TS, D Dawson, and A den Exter. "The role of competition in health care: a Western European perspective." *Journal Of Health Politics, Policy & Law* 31, no. 3 (June 2006): 687-703.
[20] Jost et al., "The role of competition in health care: a Western European perspective," 690
[21] These methods will be further discussed in later sections
[22] Oberlander, "The Politics Of Health Reform," 395-400

Individually, the research is strong and offers multiple reasons for institutional problems. Insurance, lawmakers, consumer knowledge and providers all play a part in explaining a possible answer to the posed question. What the research seems to lack is connective tissue between all proposed rationales. This paper will attempt to blend all possible explanations then twist them towards new light. The goal is not to reinvent the wheel but rather put spokes on the hub.

QUESTION: HOW CAN U.S. POLICY CONTAIN COSTS OF HEALTH CARE WHILE PRESERVING QUALITY AND IMPROVING ACCESS?

The complexity of the American system makes testing a model of comprehensive reform challenging. However, the U.S. allows individual states a large degree of discretion in regulating their respective healthcare markets. It has been said that the states are the laboratory for democracy, and healthcare is a classic example that speaks to the power of this federal system. Several states, Maryland and Massachusetts specifically, have made changes to their healthcare markets and delivery systems. Both states have seen changes in their respective markets, and both states represent potential policy reforms at the federal level. In fact, President Barack Obama and congressional Democrats modeled much of the Patient Protection and Affordable Care Act (PPACA) after the functional Massachusetts model discussed below.

Because state and federal policy often differ in goals, needs and costs, it is also helpful to examine case studies of nations that have successful healthcare reform models. In the present paper, analysis focuses primarily on the success of Japan. Many of the provisions in their model overlap with those of Maryland and Massachusetts.

When taken together, the models provide viable policy options for cost control that have worked both in and outside of America's healthcare markets. Each case provides real-world implications of the later proposed policy.

It is important to remember that in the complex realm of health care and health policy, the wheel has already been invented. Granted, there is more innovation to be done, but the vast majority of developed nations have a relatively stable system with which they are satisfied.

The policy recommendations were chosen due in part to their synergetic capabilities. In health care policy making, as with most policy making, there are tradeoffs. For the sake of the present paper, the tradeoffs in health care policy are referred to as "the trilema of health care policy making."[23] Three themes, access, quality, and cost, act as somewhat of a three-legged stool. If you improve access, costs inevitably increase. If you decrease cost, there is a risk for lower quality of care. And, if you increase quality, costs increase and access for lower income individuals decreases. Therefore, policy making is a challenging balancing act. To mitigate the risk of sacrificing one or more of the important legs, the policies given below are designed to work in tandem. Though not completely comprehensive, six recommendations focus on beginning of life via women's health care, middle of life with "classic" care and the end of life with hospice or palliative care.

[23] Chandra, Amitabh. 2011. "The Healthcare Trilemma: Insurance, Quality And Costs." India Habitat Center, New Delhi, India

The Solution

Taking case studies and other relevant research into account, I have established six (6) policy recommendations to contain costs in the American system. Many of these are less controversial than previous failed policies and could become reality in spite of the current political atmosphere. That is not to say the policy changes in each of these areas could be implemented without a hitch. However, taken in conjunction with eventual universal compulsory insurance coverage of the PPACA, these methods will contain costs and ultimately lower expenditures while improving quality of care. In no particular order they are: 1) universal health coverage, 2) nationwide all-payer system and price transparency, 3) primary and public health investment, 4) women's and sexual health, 5) reduction in the cost of expensive care and/or technology utilization and 6) end-of-life care reform.

1) Universal Health Coverage

Universal coverage is essential in an insurance-based health care market. If 85% of the population is paying a discounted rate, price-sharing mechanisms control overall non-discounted prices for care. When someone with insurance buys care, the insurance company sets how much of that care they will pay. This, in turn, determines how much a provider will charge. Their goal, as economic beings, is to maximize margins by gleaning a profit from both the insurance company and patient. Patients with insurance have somewhat manageable prices because of the discount. Those without, however, cover

the full cost of care including what insurance would cover otherwise. This back and forth drives prices up.

Though simplified, this demonstration shows a fundamental reason for the necessity of universal access to care. Before proceeding, it needs to be established that the discussion below focuses on coverage and access rather than universal care. The former is an insurance market scheme. The latter is a single-payer system. Single-payer will more than likely never become political reality in the U.S. because of the capitalistic political culture that resists such change. The slight difference in coverage and care seems nuanced, but it is vitally important when discussing health care policy. The U.S. has tried and is currently trying to improve access, and lawmakers have started to make headway after decades of attempts.

One solution that has passed the proper checks and balances of American governmental institutions is the Patient Protection and Affordable Care Act (PPACA). The bill has some promising elements like reducing consumer costs for preventative care and setting up price transparency through exchanges. Notably, the PPACA creates a Cadillac tax on excessive plans to curb over spending.[24] There is potential for success, but skepticism of the PPACA's effectiveness has arisen. Oberlander says individual parts are solid, but as a whole, the PPACA is like "throwing darts." The law is full of technical fixes and increased to insurance coverage in an attempt to allow cost sharing. Aggregate system-wide cost-control options, however, were left out.

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

Based on conventional insurance theory, there is one piece of the PPACA that reduces moral hazard—the individual mandate. All individuals are now required to have insurance coverage with the hope that health coverage will ultimately become universal. Further, increasing the size of the insurance pool, especially with young healthy people previously uninsured, reduces risk. A similar policy in Massachusetts has been successful in achieving the goals of the PPACA. If states are the laboratory of democracy, then Massachusetts has conducted a seemingly successful experiment.

In addition to the mandate, the PPACA includes a provision that requires insurance companies to cover those with pre-existing conditions. The potential danger associated with the increase in high-risk individuals in a risk pool is mitigated by an increase in newly insured young individuals. While the policy is still fresh, the PPACA has taken care of a small part of controlling high costs of coverage. Insurance coverage does not necessarily reduce or control costs, but it does shift the burden slightly off of the consumer.

In an attempt to control the costs of the care itself, states like Maryland have shifted their health-care system towards a more European approach.[25] Maryland has contained costs and improved access. These changes could potentially demonstrate to the rest of the nation that moderate solutions to regulate the market can work. The approach does not go as far as a single payer system, but it also gives a sense of regulation to a market that historically has none.

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[25] Murray, Robert. "Setting Hospital Rates To Control Costs And Boost Quality: The Maryland Experience." *Health Affairs* 28, no. 5 (2009): 1395-1405.

Methods in the ACA and the Maryland plan have contributed to the current knowledge of costs. Positive data from Maryland indicates that one major problem could in fact be the method of payment. Oberlander's observations regarding the ACA explain why it is the route currently being taken.

One of the issues with using research regarding the effects of the ACA is that the law is far too fresh. The new census data has not even been compiled yet, so any estimate at the number of newly insured individuals in the nation are merely that—estimates. The most conservative counts have the increase at 9.7 million newly insured whereas the administration, thus the most political estimate, has the number around 16.4 million.[26] The takeaway, however, is that insurance numbers are up. And, model policies that mirror the PPACA show promise in both Massachusetts and Japan.

In 2006, Massachusetts passed "An Act Providing Access to Affordable, Quality, Accountable Health Care" in an attempt to lower high spending on health care. The central premise of the bill's structure revolves around affordable insurance for all individuals.[27] Insurance coverage in Massachusetts is not just encouraged but rather is mandated . To help accomplish this, the law sets up "exchanges" for individuals to buy health insurance, and requires employers to provide health insurance coverage or pay a steep fine.

In terms of increasing insurance coverage (IC), the market changes have been successful. Between 2006 and 2010, nonelderly adults with adequate insurance

[26] Alonso-Zaldivar, Ricardo. 2015. "On 5th Anniversary Of Health Care Law, No End To Debate." *New York Times*
[27] Long, Sharon, Karen Stockley, Kate Willrich Nordhal, "Findings from Massachusetts Health Reform: Lessons for Other States," *Inquiry,* Vol. 49, 303-315.

coverage increased from 86.6% to 94.2%.[28] Gains were also made in the realm of employer-sponsored coverage as the rate of those insured climbed from 64.4% to 68.0%. When IC is broken down by SES, it appears that lower income insured adults went from 75.9% to 90.1%. Compared to others in New England, Massachusetts increased insurance coverage 4.5% more than any other state.[29]

Access to medical care saw considerable gains as well. Rates of individuals who reported issues meeting health needs due to high costs experienced a large drop. And, utilization of care has moved away from emergency departments (ED) towards primary preventative care.[30] This shift in type of care has been significant in reducing overall spending. And, this movement to primary/preventative care lessens concerns of moral hazard welfare loss associated with quickly insuring a large group of people. Overutilization may still occur, but it has not hampered an overall decrease in individuals' health care expenditures.

Massachusetts has seen a significant decrease of the cost burden for patients. Since a large majority of patients have IC, the non-negotiated cost of care has a far lower effect on whether or not patients decide to buy the care.

Because of this, fewer adults report having major financial difficulties affording care for their families.[31] As noted, a major concern with increasing an insurance pool is increasing moral hazard of overspending.[32] So, not surprisingly, when insurance

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[28] Long et al., "Findings from Massachusetts Health Reform," 309
[29] Dhingra, Satvinder S., Matthew M. Zack, Tara W. Strine, Benjamin G. Druss, and Eduardo Simoes. 2013. "Change in Health Insurance Coverage in Massachusetts and Other New England States by Perceived Health Status: Potential Impact of Health Reform." *American Journal Of Public Health* 103, no. 6: e9
[30] Long et al., "Findings from Massachusetts Health Reform," 308
[31] Ibid., 313-315.
[32] Nyman, "Is 'Moral Hazard' Inefficient? The Policy Implications Of A New Theory." 194.

coverage was expanded, use of health services increased throughout the state. What the moral hazard argument fails to account for is the type of care utilized. Uninsured adults in Massachusetts were 10 times more likely to use an ED for non-emergency illnesses than those with IC.[33] Since Massachusetts's reform, utilization of services has been moved from the ED to the primary care office. These services are less expensive for taxpayers and providers. Preventative care also reduces the risk of newly insured adults from having to go to the hospital later on. This reduces patient cost (C) and improves ΔH. With these changes, overall self-reported health of adults improved.[34]

While the Massachusetts plan mainly addressed insurance markets, the state has noticeably improved payoffs for patients. The better payoffs leads to more informed health decisions and overall better health. Moving forward, the state of Massachusetts is planning to borrow Maryland's price transparency concept and apply it to major providers in the state.[35] At this time, there is not sufficient data to make predications on the effects of these developments. However, observation of changes in Japan may offer a degree of insight on what is to come.

In Japan, universality is achieved through somewhat of an aggressive manner. More than 3,500 insurance providers make up the universal public health insurance system (PHIS). Each employer offers plans based on available insurers in the PHIS. Employed citizens achieve coverage via employers' plans or through the Japan Health Insurance. Those who do not receive insurance through employers do so via state-run

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[33] Miller, Sarah, "Findings from Massachusetts Health Reform: Lessons from other States" *Inquiry,* Vol. 49: 17.
[34] Dhingra et al., "Change in Health Insurance Coverage in Massachusetts and Other New England States by Perceived Health Status: Potential Impact of Health Reform" e9.
[35] Long et al., "Findings from Massachusetts Health Reform:," 311.

Citizen Health Insurance or Health Insurance for the Old-Old. The former is for the "unemployed, self-employed, retired or others" in the health insurance gap and the latter is for those over the age of 75.[36] To a large extent, they are akin to our Medicaid and Medicare respectively. These coverage methods combined cover nearly every aspect of healthcare from prescription drugs to mental health care. The PPACA mirrors the Japanese coverage scheme, almost to a tee. If the PPACA reaches a similar level of universal coverage as Japan, there is cause for optimism in the arena of overall quality and universality of care. However, coverage alone does not necessitate cost control.

In the present paper, we assume, arguendo, that the PPACA is effective in its attempts to mitigate the market failure in the insurance market. The insured pool will, ideally, shift from 85% to 100%. This will satisfy the "universality" piece of the trilema that exists in the health care system. Every American will pay *some* negotiated price for care. The ambiguity in the word "some" will undoubtedly be a challenge in actual cost control policy. However, both American domestic (Massachusetts) and international (Japan) health care markets have seen success with similar policy. When analyzed together, each model offers insight as to the potential impacts of the PPACA. This recommendation and supporting research demonstrates that universal access to coverage does not have to exacerbate cost burden nor cut quality necessarily. In fact, in Massachusetts, Japan, and even post-PPACA America, it does the exact opposite.

[36] Thompson, Sarah, Robin Osborn, David Squires, and Miraya Jun. 2013. *International Profiles Of Health Care Systems, 2013: Australia, Canada, Denmark, England, France, Germany, Italy, Japan, The Netherlands, New Zealand, Norway, Sweden, Switzerland, And The United States.* Washington, DC: The Commonwealth Fund, 1-138

2) Price Transparency Measures, Including a Nationwide All-Payer System

The concept of "all-payer" is one that has thrived both domestically and internationally. Essentially, the all-payer system shifts the burden of price setting away from individual providers and puts it in the hands of a third-party regulator. To accomplish this, all-payer functions through the use of artificially set price ceilings for public and private payers alike. To avoid tainting by those with vested interests, much of the market controls are determined by a third party. Maryland, for example, uses a regulatory board that functions based on limited government intervention. Japan has a similar approach, however their regulatory process takes place within a government agency. Both are explained below.

In 1971, Maryland hospitals were suffering from significant financial losses due to uncompensated care. So, the Maryland Hospital Association (MHA) and other healthcare officials worked toward a measure that would allow system-wide price setting. This method of negotiating with providers for an agreed upon rate is know as an "all-payer" system.[37] To limit government interference in the price setting process, Maryland set up the Health Services Cost Review Commission (HSCRC). The HSCRC is a state agency run by seven volunteer commissioners, only three of whom may have possible conflicting interests with a healthcare provider.[38] Additionally, the commission releases price reports to the public to keep the process as transparent as possible.

By regulating prices and improving transparency, Maryland has drastically swayed decision making for providers. Because an individual provider does not have

[37] Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," 1395-1405
[38] Ibid.

much power in price setting or profit leveraging, they will charge lower more times than not. Maryland is effectively seeking to solve a collective action problem. Providers previously had little incentive to post payment schedules, but now they are all required to do so. This form of market intervention encourages free market rational decision-making on the part of the consumer. This allows the patient to have a choice in which provider they choose to use—or at least some choice at all.

Moreover, since all payers pay the same price for care, Maryland hospitals have a greater incentive to treat all patients.[39] There are fewer disincentives to see those patients who could not or would not pay. Providers' fear of low reimbursement rates do not factor in to the quality of care delivered or the cost-benefit analysis of treating an unhealthy individual.

The increase in regulated competition means that Maryland hospitals cannot charge above a certain point, or patients will choose to go elsewhere. Thus, hospitals receive far lower profits than they would if they kept prices quiet until the time of payment. Between 1976 and 2008, this method of price negotiation saved the state around $43 billon in Maryland health care expenditure. Patients also felt a release in pressure per case medical care cost 2% less than the national average.[40]

During development and early implementation, a major concern with the policy was that an all-payer system cuts profit margins and increases debt of providers whose

[39] Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," 1395-1405
[40] Wagner, K. 2011. "Maryland's all-payer system: a delicate balancing act." *Healthcare Financial Management* 65, no. 11: 112-116.

costs exceed their revenue.[41] This is one of the leading causes for similar plans failing in states other than Maryland. Concerns like these evolved into fears that hospitals would cut quality of care to compensate for the loss in profits (P). As a means of preventing lower quality of care to reduce hospital costs, the Maryland plan also established "pay-for-performance (P4P)" quality standards.[42] These standards provide a financial motivation for hospitals to provide a higher quality of care while accepting the lower margins. Those hospitals that do not perform to Maryland's standards eventually operate at a net loss and either improve or foreclose.

Additionally, compensation from P4P is used for capital campaigns and expansion efforts.[43] By doing this, hospitals have become more keen as to how they manage their assets, and generally avoid unnecessary administrative costs. P4P capital provisions allow some spending on improvement and growth while controlling overspending on what could be thought of as "moral hazardous" infrastructure. Instead of charging high prices to grow a hospital, the providers will make an effort to provide a better quality product.

By paying for performance, the HSCRC has increased the value of profit (P) for hospitals that have to charge low if they provide good care. This maximizes P for providers and benefits the patient by maximizing change in health outcomes (ΔH) for a low-charging provider. Not only are providers and patients receiving favorable payoffs but lawmakers are also reaping benefit. The HSCRC operates outside of the legislature's

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[41] Pauly, Mark, and Robert Town. 2012. "Maryland Exceptionalism? All-Payers Regulation and Health Care System Efficiency." *Journal Of Health Politics, Policy & Law* 37, no. 4: 698.
[42] Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," 1395-1405
[43] Wagner, "Maryland's all-payer system: a delicate balancing act."114.

control. Therefore, if current prices are unfavorable, public opinion does not turn on lawmakers. But rather, the HSCRC handles problems.[44] This makes the favorable outcome for lawmakers to keep things status quo with the reformed all-payer system.

Along with the all-payer methods, Maryland changed their method of management for Medicaid. In 1977, the state received a waiver to handle their respective program with little help from the federal government.[45] Since that time, the poorest populations in Maryland have seen a drastic increase in quality of health and utilization. Much of the improvement happened after 1997, when Maryland changed its Medicaid program to focus more on primary and preventative care. Between 1997 and 2000, child enrollment in Maryland Medicaid increased from 57,586 to 282,402.[46] Perhaps more critical than the number of enrollees is the type of care that was being utilized. Before the new regulations, a significant amount of asthma treatment took place in hospital emergency departments. This cost was the same for the patients, but reduced profits for the hospital that did not receive proper compensation for care provided. However, the new Medicaid provisions placed an incentive to utilize cost efficient preventative asthma treatment, like the use of an inhaled corticosteroid.[47] This shift in the delivery of care drops prices for the patients and mitigates the need for additional emergency treatment that might alter ΔH. This method of treatment, furthermore, does not harm P for providers.

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[44] Murray, "Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience," 1395-1405.
[45] Ibid., 1395-1405
[46] Bollinger, Mary Elizabeth, Sheila Weiss Smith, Robert LoCasale, and Carol Blaisdell. 2007. "Transition to Managed Care Impacts Health Care Service Utilization by Children Insured by Medicaid." *Journal Of Asthma* 44, no. 9: 717.
[47] Ibid., 720

In terms of health access, delivery and care, Japan and the U.S. function in a similar manner. Both have a "fee-for-service system" with a degree of cost sharing falling on the consumer.[48] This is starkly different from many of the other high-ranking health systems that function on a single-payer method of delivery.

Furthermore, Japan shares the American affinity for high-cost advanced medical technology. Japan has the most CT and MRI machines among OECD nations, surpassing even the U.S. in terms of availability of expensive and high-quality care.[49] Despite the use of high cost care options, Japan has only seen a 2% bump in health care spending over the past 30 years, whereas the U.S. has seen an 8% increase in the same time.

This discrepancy in increases in Japanese health care is largely thanks to a combination of the universal public health insurance system (PHIS) and an all-payer system similar to the one being operated in Maryland.[50] Universality is discussed above while the all-payer mechanism is discussed in this section.

Japan has developed a method of systematic cost containment with the Shinryo-Houshu-Seido (SHS).[51] SHS is a comprehensive pay schedule that all health providers follow in determining their charges. Medical fees are regulated and implemented biennially by the Ministry of Health, Labor and Welfare (MHLW). [52] Perhaps not surprisingly, studies have found that providers still seek to maximize profits in spite of the schedule. This is not all that different from the American model explained earlier.

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[48] Squires, David A. "Explaining High Health Care Spending in the United States," 11.
[49] Ibid.
[50] Thompson et al., "International Profiles of Health Care Systems, 2013." *The Commonwelath Fund*, 75
[51] Kakinaka, Makoto and Ryuta Ray Kato. 2013. "Regulated Medical Fee Schedule Of The Japanese Health Care System." *International Journal Of Health Care Finance And Economics* 13 (3-4) (12): 301-17
[52] Ibid., 302

The difference, however, is that the economic decision to maximize margins while maximizing level of care do not rest in the hands of manufacturers and providers. Rather, the MHLW can use predictions of provider economic behavior in setting the SHS. If procedure A provides better profit margins than procedure B, but the inverse is true in terms of patient health outcomes, the MHLW can adjust the price schedule to mirror what is optimal for both parties. The cost burden is shared between the government, the provider and the patient's copayment. While it is difficult to quantify physician benevolence regarding a patient's quality of care, the regulators can influence economic behavior based on generally beneficial health outcomes.

With the SHS price schedule set by the MHLW, providers are capped in terms of margins per treatment. However, the Japanese system does not necessarily preclude competition and further free market price regulation. In fact, it does the opposite. Providers still attempt to maximize overall profit, and oftentimes they will charge below the SHS price thereby creating a market price for the drug or service.[53] Actual market prices are, therefore, around 2% lower than SHS suggested prices.

The Japanese method has been objectively effective, or at least not ineffective, in terms of ensuring overall positive health outcomes. Japan has the world's longest life expectancy at 86 years old in 2012.[54] In contrast, the U.S. average life expectancy was 81 years old in 2012. The net increase in life expectancy from 1980 to 2012 was 8 years in Japan and 4 in the U.S. This suggests that the Japanese system and its recent reforms have at minimum correlated with a significant rise in the health outcomes its citizens.

[53] Ikegami, Naoki, And Gerard Anderson F. 2012. "In Japan, All-Payer Rate Setting Under Tight Government Control Has Proved To Be An Effective Approach To Containing Costs." *Health Affairs* 31 (5) (05): 1049-56
[54] World Health Organization. 2009. *World Health Statistics*

As seen in the case of Maryland, an all-payer system can function well within the current American system. Japan has been even more successful in using oversight as a mechanism to set a cap for costs. By setting a price ceiling, but not a price floor, competition is actually encouraged. This is one of the most fundamental pieces precluding American health care from functioning on free market principles. Currently, providers face a collective action problem—there is no incentive to be transparent about prices. Hospitals do not tell a patient how much a procedure will cost until the bill comes in the mail. This eliminates the idea of rational choice and allows providers the ability to determine profits as they go.

If U.S. policy were to eliminate the collective action problem of price setting, it would ease the burden on consumers. Maryland is the shining beacon of successful oversight, and providers not only support their plan, they proposed it. The research models from Japan point to similar outcomes. There is major potential for cost containment, or at least increased consumer knowledge. Cost sharing in the form of insurance co-payments and premiums may be successful in lowering utilization, but it encourages reactive spending. The most expensive procedures are also the most extreme measures. Americans go to the doctor less than any other OECD nation, besides Sweden, yet the U.S. spends far more.[55] Policy needs to focus on actual patient protection instead of Band-Aid fixes to insurance. Maryland has already saved more than $43 billion, and they are just one of 50 states. Savings for a nationwide adaptation of similar all-payer price transparency could bring unprecedented savings.

[55] Squires, David A. "Explaining High Health Care Spending in the United States," 3

3) Primary and Preventative Public Health Investment

Benjamin Franklin said, "An ounce of prevention is worth a pound of cure." Despite the lessons of her forefathers, the U.S. health care system is often reactive rather than proactive. Perhaps not coincidentally, the U.S. currently has the highest mortality rate due to preventable disease among OECD nations.[56] This is one area where the PPACA could yet have a large impact, and in some ways policymakers tried. One major piece of the law focuses on Medicaid expansion in states that opt-in. The PPACA also added an additional $15 billion to the Public Health Fund.[57] As with all things PPACA, the test of time will tell what the true benefit is. But, early estimates are promising that investment will achieve its desired return.

Research pre and post PPACA demonstrate just how vital preventative and early detection health care models can be in saving money and improving quality. A recent study conducted by Quest Diagnostics found that newly identified diabetes patients rose by 23% in those states that expanded Medicaid under the PPACA. In contrast, those states that did not expand Medicaid under the law saw an increase in diagnosis of 0.4%.[58] The CDC estimates that diabetes carries an annual price tag of $176 billion, with a large chunk of those expenditures going towards extreme measures like surgery or kidney replacement. Furthermore, estimates place the total loss of productivity due to diabetes is around $322 billion each year.

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[56] Ibid., 11

[57] Mays, Glen, P., And Sharla Smith A. 2011. "Evidence Links Increases In Public Health Spending To Declines In Preventable Deaths." *Health Affairs* 30 (8) (08): 1585-93

[58] Tavernise, Sabrina. 2015. "With Expansion Of Medicaid, Some States Are Identifying More New Diabetes Cases." *New York Times* 164 (56814) (03/23): A14

It is important to note that the study only takes into account the data from Quest and that the percentage hikes are measured against projected trends based on historical data and regressions. That notwithstanding, 23% versus <1% is far too large of a discrepancy to be explained by slight shifts in extraneous factors.

These data are crucial when discussing health policy because they represent real cost savings from real front-loaded investment. When lower income people, previously uninsured, gain coverage and the ability to see a physician on a regular basis, they use it. This is often misconstrued as welfare loss due to moral hazard, but that is not necessarily the case.

Newly insured individuals opt out of taking expensive care like the emergency department in exchange for the primary care physician office. And, patients pay the $4 for a diabetes screening kit instead of the several thousand dollars associated with kidney failure in later stages of diabetes.[59] Oftentimes the treatment for early-detected type II diabetes is exercise and a modified diet in conjunction with low-cost regular medication. Lifestyle changes cost the state and individual nothing, whereas surgery for the 1 in 10 Americans diagnosed with diabetes each year may bankrupt both.

Aside from federally funded entitlement programs, the majority of public health funding is funneled through the Center for Disease Control (CDC). Despite the growing U.S. population and need for public health programs in recent years, CDC funding has actually seen gradual decline since 2005. The net decrease was a little over $1 billion in

[59] Leonard, Kimberly. 2015. "Diabetes Cases Surge In States That Expanded Medicaid." *U.S. News & World Report*

10 years.[60] Local funding has filled in some of the gaps. Local funding, however, is just that—local. It varies by income level of a community and the willingness of local budget-makers to include expenditures in setting their respective budgets. It comes as no surprise that communities with a lower median income generally invest less in public health infrastructure.

In 2008, local public health funding varied from $1 to $200 per capita, with the median falling at $36.[61] Those on the higher end of investment saw substantial drops in mortality rates due to preventable diseases. For each additional 10% increase in public health expenditure, communities see the following average decreases in mortality rates: 6.9% from infant mortality, 3.2% from cardiovascular diseases, 1.4% from diabetes and 1.2% from cancer.[62] These gains are even greater when a community in question is historically lower-income.

Aside from the clear life-saving benefits, preventative health investment has considerable potential to save money as well. As with the diabetes anecdote discussed above, the ROI on front-end public health expenditures is staggering. If the U.S. were to cut chronic disease (i.e.—diabetes, hypertension, cancer, etc.) prevalence by 5% by in 15 years, U.S. public spending savings would amount to $5.5 billion per year. If the chronic disease rate decreases 25% or 50% in the same time, the savings jump to $26.2 billion and $48.9 billion respectively.[63] One estimate done by the Trust for America's Health

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[60] Centers for Disease Control and Prevention. 2015. *CDC overview*

[61] Mays, Glen, P., And Sharla Smith A. 2011. "Evidence Links Increases In Public Health Spending To Declines In Preventable Deaths." *Health Affairs* 30 (8) (08): 1585-93

[62] Mays and Smith, . "Evidence Links Increases In Public Health Spending To Declines In Preventable Deaths," 1590

[63] Waidmann, Timothy A., Barbara A. Ormond, And Randall R. Bovbjerg. 2012. "The Role Of Prevention In Bending The Cost Curve." *Medical Benefits* 29 (2) (01/30): 1-7

suggests that an additional $10 of investment per capita would result in $16 billion worth of savings within 5 years. ROI would be $5.6 for every $1 spent.[64] Numbers vary slightly based on study and purpose thereof, but the general trends are widely agreed upon.

There is legitimate room for improvements in preventative health investment, and the savings are more than significant. Policy needs to target both expenditure and public education on the benefits of preventative health. A recent *Health Affairs* survey of insured persons in the U.S. found that only 1 in 5 customers knew that a preventative health visit was exempt from their deductible and only 1 in 10 knew that a preventative screening/test was exempt.[65] A combination of further investment and education of current policy could very well shave billions off the U.S. annual expenditures. Combined with the quality standards of improved life expectancy, preventative health investment is reasonable policy with a low risk and high reward.

4) Women Healthcare, Family Planning and Sexual Health

The Massachusetts experiment revealed an unintended consequence of healthcare reform. Women are falling through the cracks. This is partially explained by socioeconomic (SES) data. Women are more likely to be either unemployed or underemployed with less access to employer-based insurance than their male

[64] *Prevention For A Healthier America: Investments In Disease Prevention Yield Significant Savings, Stronger Communities.* 2008. Washington; USA: Trust for America's Health

[65] Reed, M. E., I. Graetz, V. Fung, J. P. Newhouse, and J. Hsu. 2012. "In Consumer-Directed Health Plans, A Majority Of Patients Were Unaware Of Free Or Low-Cost Preventive Care." *Health Affairs* 31 (12): 2641-8

counterparts. However, this alone does not explain the wide discrepancy between the changes in health for men versus women.

Women, lower income women in particular, have a far different set of healthcare needs than men. Although overall coverage of Massachusetts's women increased after health reform of 2006, there are great of challenges facing at risk women populations.[66] Lower income women historically have relied on safety net providers for basic health needs. The recent shift in focus has gradually decreased emphasis on safety net providers towards a managed medical network.

Massachusetts offers "Commonwealth Care" as a low/no cost program for low-income residents who may fall through the cracks of traditional health coverage. However, the eligibility, enrollment and access to benefits are trapped in somewhat of a bureaucratic labyrinth that is difficult for many young, poor and/or immigrant women. Family planning clinics, conversely, operate on a simple community health model—walk in and get treated. There is little to no cost passed on to the patient and the clinic does not determine eligibility based on insurance. Additionally, there is an education piece involved with each clinical visit. Women are taught basic birth control methods, signs and symptoms of common diseases like breast cancer, and even how to have a healthy pregnancy.

Family planning has become a political battleground. Clinics are often touted as "abortion clinics," but abortion makes up little, sometimes none, of the services offered by a clinic. In 2012, abortion services represented just 3% of the services provided by

[66] Dennis, Amanda, Kelly Blanchard, Denisse Cordova, Britt Wahlin, Jill Clark, Karen Edlund, Jennifer Mcintosh, and Lenore Tsikitas. 2013. "What Happens To The Women Who Fall Through The Cracks Of Health Care Reform? Lessons From Massachusetts." *Journal of Health Politics, Policy & Law* 38 (2) (04): 393-419

Planned Parenthood and its affiliate clinics.[67] In comparison, sexually transmitted infections and diseases (STI/STD) testing made up 41% of the services provided. Planned Parenthood issued 4.5 million STD tests and 160,000 positive results.

These tests, especially the positive tests, are a key reason why investment in women's health can be a significant tool in cost-control. The CDC estimates that there are 20 million new STI/STD infections each year and over 110 million infected persons currently living in the U.S. Sexually transmitted infections, therefore, account for nearly $16 billion in annual medical costs.[68] The vast majority of infections can be prevented or lessened through prevention and early detection. If the 160,000 newly infected individuals did not have access to STI testing at Planned Parenthood, the number of new annual infections would increase exponentially.[69]

In addition to STI/STD tests and treatment, public monies for women's health often fund state programs that subsidize the cost of birth control or preventative measures. Even though the generic birth control costs an average of $9/month with no insurance, getting a prescription and refills involves an additional charge for office visits. More than half (55%) of all U.S. women in childbearing years (18-34) report difficulty in financing prescription contraception.[70] In 2011, the state of Texas cut funding for women's health programs by $36.7 million, a 66% decrease from FY 2010. Subsequently, 146,980 women lost health coverage in the state with the highest rate of uninsured

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[67] Planned Parenthood. 2013. *Planned Parenthood Annual Report 2012-2013.* New York, NY, U.S.A.
[68] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2013. *CDC Fact Sheet: Incidence, Prevalence, And Cost Of Sexually Transmitted Infections In The United States*
[69] National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. 2013. *CDC Fact Sheet: Incidence, Prevalence, And Cost Of Sexually Transmitted Infections In The United States*
[70] The National Campaign to Prevent Teen and Unplanned Pregnancy. Policy Brief: Key Points about Contraception, September 2012.

women ages 18-34.[71] As a result, there was a net increase of 23,000 babies born in 2014-2015.[72] Medicaid pays for the majority of births in the state, financing 56% in 2009.

The average health care costs of a newborn and mother during the first year of infancy is $11,000. These estimates are only the tip of the iceberg for the additional costs that of unplanned pregnancy as they merely account for the first year of life. More than likely, the child will enroll in CHIP and Medicaid down the road. Much of these costs could be avoided with stronger access to preventative programs and contraception access.

Combined, the cuts to the Women's Health Program cost the state $33 million in additional Medicaid costs.[73] Birth control on the preventative side, conversely, would have only cost between $200-$300 per patient that utilizes safety-net family planning providers. These numbers may only be from one state, but the differences are sizable.

Nevertheless, because of the abortion issue, the Massachusetts reform and the U.S. PPACA have provided somewhat of an impetus for discussing the gradual decrease in funding for safety-net providers like family planning clinics. Women in Massachusetts had difficulty navigating the health system and often could not find providers that would accept subsidized health plans.[74] The study of women in Massachusetts provides

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[71] Ibid.
[72] Texas Health and Human Services Commission. Rider 48 Report: 2011 Annual Savings and Performance Report for the Women's Health Program, May 2012
[73] Texas Women's Healthcare Coalition. 2013. *Texas Women's Healthcare In Crisis.*
[74] Dennis et al., "What Happens To The Women Who Fall Through The Cracks Of Health Care Reform? Lessons From Massachusetts," 414

evidence for the importance of continued support of family planning providers rather than diminishing support.

These clinics and programs must remain part of federal and state policy during comprehensive reform or risk of increased cost from unintended pregnancy will continue to be a multibillion-dollar burden on the healthcare system. Texas should serve as a negative example for reform policy. When sexual and women's health are neglected, the cost to state can be dire. Further, unlike something like cancer, the $11,000 childbirth is close to 100% preventable. Basic oral contraception has, for the most part, left the moral conversation surrounding women's health. If the U.S. invested more in providing low cost treatment on the front-end, many of the moral issues on the back end could also be avoided. Therefore, this policy would both save money and improve the quality of life for women who struggle to afford their birth control.

5) Reducing the Cost and Overutilization of Expensive Medical Care and Technology

Actual costs of the treatments themselves pose one of the most complex and charged problems in containing costs of health care. Like the data on average doctor consultations, Americans do not necessarily use more care than peer OECD nations. In fact, the U.S. is below median values for number of hospital beds per capita, average length of in-patient hospital visits, and number of discharges.[75] Degree of usage is not what is driving prices, but rather the problem rests in type of usage. The mindset in

[75] Squires, "Explaining High Health Care Spending in the United States," 5

American healthcare delivery defaults to whatever is the most advanced, usually the most expensive, form of screening/treatment.

A somewhat embarrassing personification of this mindset is seen with the increase in hospitalizations due to constipation between 2006-2011.[76] The increase was in the ballpark of 42% over the 6-year study period costing the health care system about $1.6 billion compared to $700 million in 2006. In nearly every facet of care, Americans seem to equate the highest cost and most "advanced care" with a greater subsequent health outcome, even if it's only constipation. Colonoscopies serve as a more serious example of this American high-cost usage mindset.

Colorectal cancer is one of the most common forms of cancer in the U.S. It is treatable if detected early. Though colorectal cancers are the second most common cause of cancer death in the U.S., early intervention has been shown to lower mortality rates in exceptional proportions. In an attempt to improve diagnosis and early intervention, the American Cancer Society recommends a colorectal cancer screening once every 5-10 years.[77] The options for such screenings are numerous and growing.

A combination screening of fecal occult blood tests (FOBTs) and flexible sigmoidoscopy, for example, has recently shown similar detection rates as the colonoscopy screening. In fact, a recent study comparing the effectiveness between the two forms of screening found that the FOBT and sigmoidoscopy combination had a higher rate of detection success than the colonoscopy. It is also significantly more cost-

[76] Sommers, Thomas, Caroline Corban, Neil Sengupta, Michael Jones, Vivian Cheng, Andrea Bollom, Samuel Nurko, John Kelley, and Anthony Lembo. 2015. "Emergency Department Burden Of Constipation In The United States From 2006 To 2011." *The American Journal of Gastroenterology* 110 (4) (04): 572-9

[77] American Cancer Society. "American Cancer Society Recommendations For Colorectal Cancer Early Detection," 2015

efficient, as the average price of a colonoscopy in the U.S. is $1185 and the average cost of the combination is about $200.[78] This relative high cost of the colonoscopy example is exacerbated when comparing the price of an American colonoscopy to the price of the same procedure around the world. Average cost in Switzerland is $665.[79]

The above numbers indicate that the economic choices most Americans are making often seem irrational. If consumers act as rational actors, they would know that one treatment or screening is less extensive for a higher quality outcome. The rationale behind the irrational choices of consumers is complex, and the price transparency issues discussed above explain a great deal of our health "decisions." However, it is important to briefly discuss the impact of medical advertising. This falls into two primary categories—the traditional direct advertising done by medical manufacturers and the more discrete indirect endorsements.

In 2012, U.S. pharmaceutical companies spent roughly $27 billion on advertising split between marketing to physicians ($24B) and directly to consumers ($3B).[80] Indirect endorsements, however, drive up utilization of the most expensive form of care. This is known as the "Katie Couric Effect." In 2000, Couric had a live colonoscopy on camera during a block of the Today show. In the three years after her public procedure, colonoscopy usage increased by more than 3% with a strong correlation between the

[78] Zauber, Ann G., Iris Lansdorp-Vogelaar, Amy B. Knudsen, Janneke Wilschut, Marjolein van Ballegooijen, and Karen M. Kuntz. 2008. "Evaluating Test Strategies For Colorectal Cancer Screening: A Decision Analysis For The U.S. Preventive Services Task Force." *Annals Of Internal Medicine* 149 (9) (11/04): 659-69

[79] International Federation Of Health Plans. 2013. *2013 Comparative Price Report: Variation In Medical And Hospital Prices By Country*

[80] The Pew Charitable Trusts. 2013. "Persuading The Prescribers: Pharmaceutical Industry Marketing And Its Influence On Physicians And Patients."

increase and Today show viewership.[81] Though it is good that people are taking advantage of preventive screening, the procedure of choice is by far the most expensive option. By choosing a colonoscopy, Couric further reinforced the American mindset that more expensive necessitates better outcomes.

The Japanese model has found a method that eases the effect of using of high-cost medical technology. Beyond the SHS, the MHLW creates a set of directives that dissuade frivolous use of more expensive technology through peer-review committees.[82] If a committee determines that a provider ordered a more expensive test or treatment simply to inflate margins, payment may be withheld. In doing so, the Japanese can create artificially high reimbursements for otherwise inexpensive, but effective, treatments. This system of reimbursement puts the focus back on outcomes of treatment by removing some of the economic pressure on a provider. Even if a treatment is considered "low cost," like a bandage rather than surgery, the SHS MHLW committee could determine that it will reimburse at a higher rate for a bandage than market price would dictate. Further, if a screening such as an MRI is the most expensive care with marginally better results than a cheaper alternative, the committee may determine to reimburse MRIs at a lower rate to dissuade MRI use or encourage use of a less expensive, equally effective screening.

Take the colorectal screening example. If the Japanese MHLW finds that the FOBT combination screening is cheaper and more effective than the colonoscopy, they

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[81] Cram, Peter MD, MBA, MD A. Mark Fendrick, MD John Inadomi, Mark E. Cowen, MD, SM, PhD Daniel Carpenter, and MD Sandeep Vijan MS. 2003. "The Impact Of A Celebrity Promotional Campaign On The Use Of Colon Cancer Screening: The Katie Couric Effect." *Arch Intern Med.* 163 (13): 1601-5

[82] Ikegami and Anderson, "In Japan, All-Payer Rate Setting Under Tight Government Control Has Proved To Be An Effective Approach To Containing Costs." 1052

can set reimbursements for the former at $200 while the latter would only reimburse a provider $100.[83] So, even though Japan has a relatively high availability of technology like MRIs and CT machines, there are established conditions that dissuade their usage beyond what is reasonably medically necessary.

In doing so, physicians can determine what type of care to perform based on what is best for the patient rather than the reimbursement their employer will receive if the physician did the less rather than the more expensive treatment.

Any policy solution in the U.S. must be sensitive the complexities of medical device/technology. Medical technology does save lives. It is no coincidence that technology improvements and overall quality of health for Americans have increased in a direct manner. However, there is a pervasive mindset in American health care that high cost necessarily equates with high quality of care, a mindset contradicted by the case of McAllen, TX. McAllen is one of the poorest cities in the nation, a border town with an extraordinarily low median household income. Despite the poor citizenry, the city of McAllen is the second highest per capita spender on health care. Miami, a city known for high cost of living and mecca-like plastic surgery market, is the only city that spends more.[84] Yet, McAllen hospitals do not deliver an objectively higher quality of care than even neighboring El Paso.

The culprit—Medicaid & Medicare data suggests heavy overutilization of the most expensive care. Data from publically funded programs are used because they provide the most comprehensive and accurate available figures for trends in spending.

[83] Numbers are solely for the purpose of demonstration, not actual rates
[84] Gawande, Atul. 2009. "The Cost Conundrum: What A Texas Town Can Teach Us About Health Care." *The New Yorker*

In an analysis of individual state spending on Medicare beneficiaries, Baicker and Chandra found that the states with highest per Medicare beneficiary spending had the lowest beneficiary health outcomes.[85] The negative relationship between spending and quality is striking, but not unexplainable. Places like McAllen, TX have a relatively large ratio of specialists to generalists. With a higher utilization of niche care comes more technology and more specialized procedures that both bear a higher price tag. Spending is not in and of itself a negative aspect of care, but the type of spending is. The American system is placing a disproportional emphasis on what is dubbed "better care," when in reality this type of care yields less favorable results.

A similar study done by Fisher et al examined Medicare beneficiaries in high spending versus low spending regions. They found that beneficiaries living in regions in the highest spending quintile received 60% more care than those in the lowest spending quintile regions.[86] Further, those in the highest quintile scored lower on health quality measures and self-ranked a lower overall satisfaction with care received. This is yet another example of fault in the "more is better" mentality within the American healthcare system.

By dis-incentivizing the use of the most expensive care, the U.S. could save millions without negatively affecting outcomes. Maryland, Massachusetts and Japan all point to ways in which this can be done. Moreover, policy that encourages utilization of

[85] Baicker, Katherine, and Amitabh Chandra. 2004. "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care." *Health Affairs* 23, 184-197

[86] Fisher, Elliott S, David E Wennberg, Thérèse A Stukel, Daniel J Gottlieb, F L Lucas, and Etoile L Pinder. 2003. "The Implications Of Regional Variations In Medicare Spending. Part 2: Health Outcomes And Satisfaction With Care." *Annals Of Internal Medicine* 138, no. 4: 288-298

less expensive care would tie into the policy recommendations of increased primary care and reformed end-of-life care.

6) End-Of-Life Care Reform

Currently in the United States, 27% of the $327 billion annual Medicare budget is spent on patients in their last year of life, 28% of that in the last 6 months.[87] Furthermore, 78% of this $88 billion is spent on patients who are in their final month of life.[88] That is a large chunk of not only the Medicare expenditures but also overall public money spent on healthcare. It is important to note that the subsequent recommendations do not involve death panels or prematurely carried-out advanced directives. However, the American health care system needs to reform how end-of-life and elderly care is administered and paid for. The latter is of timely importance as more of the baby-boomer generation moves into the 65+ demographic.

In a way, Medicare and end-of-life care policy has been a somewhat of a political "third rail" like social security. This has resulted in a lack of large-scale coordination and regulation on a federal level. There is, nonetheless, already a framework policy in place that allows Medicare patients to chose less-expensive hospice care in the final years of their life. The Medicare Hospice Benefit (MHB) allows Medicare beneficiaries to opt-in for hospice care if they already receive Medicare Part-A benefits, are certified "terminally ill" with six or fewer months to live, and sign a waiver opting for hospice

[87] Estimated $170 billion
[88] Nakhoda, Zein. 2010. "End-Of-Life Care And The Medicare Hospice Benefit: The High Cost Of End-Of-Life Care." *Journal of Financial Service Professionals* 64 (2) (03): 24-28

instead of the default Medicare route of treatment.[89] But, this policy is vastly underutilized, mainly due to lack of knowledge. In a study conducted by the National Hospice Foundation, 80% of Americans over the age of 45 did not know what the word "hospice" meant and 90% did not know that Medicare pays for it.[90]

A systematic review of care utilized by terminally ill cancer patients found that 66% of those on life-sustaining treatment did not seek hospice or palliative care in their last month of life.[91] Hospice care has been found to have significant mean cost reductions as opposed to patients who live the final weeks of life in hospital beds. For patients who utilized hospice care to treat terminal diseases, mean cost differences were $6735 for congestive heart failure, $5163 for pancreatic cancer and $8935 for ovarian cancer.[92] In all but two categories of terminal diseases tested, the hospice option was less expensive. These results are for individuals, so the savings for the nation as a whole could be exponentially more effective in containment.

These issues are understandably difficult to talk about, but talking about end-of-life could actually save a person and his/her family thousands of dollars in the final weeks of life. "The multimillion-dollar conversation," as an end-of-life (EOL) conversation is often called, has shown considerable differences in both price and quality of care for patients suffering from terminals ailments. Patients who reporting having EOL discussions with physicians spent $1876 in the last week of life versus $2917

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[89] Nakhoda, "End-Of-Life Care And The Medicare Hospice Benefit: The High Cost Of End-Of-Life Care," 25
[90] Ibid.
[91] Langton, Julia, M., Bianca Blanch, Anna Drew K., Marion Haas, Jane Ingham M., And Sallie-Anne Pearson. 2014. "Retrospective Studies Of End-Of-Life Resource Utilization And Costs In Cancer Care Using Health Administrative Data: A Systematic Review." *Palliative Medicine* 28 (10) (12): 1167-96
[92] Pyenson, Bruce, Stephen Connor, Kathryn Fitch, and Barry Kinzbrunner. 2004. "Medicare Cost In Matched Hospice And Non-Hospice Cohorts." *Journal of Pain & Symptom Management* 28 (3) (09): 200-10

for those who did not.[93] Higher spending showed no correlation with higher survival rate. Further, those who reported EOL discussions has a higher quality of life in their final week. Patients who had the EOL conversation not only had a higher quality death but they also live longer in the last few weeks of life than their non-EOL counterparts.[94]

The 37% difference in cost becomes more profound when examining large-scale implications of increased EOL discussions. If the number of individuals who have EOL discussions with their physicians each year were to increase to 50%, these results suggest that cost savings would be $76.5 million per year.[95] By drafting policy that encourages EOL discussion and coordinated hospice care, an $88 billion price tag could see considerable cost containment.

With all of the policy recommendations, EOL care must be viewed through the lens of the aforementioned trilema of health care policy. EOL is universally covered by Medicare beneficiaries, saves significant money and increases both self-reported and objective quality measures. Self-reported quality is further supported by a recent Gallup poll finding that 9 in 10 Americans would rather die at home or in a pain management health care setting than a hospital.[96] Hospice care also mitigates the number one concern of people dying—their families. Family members of the deceased are afforded hospice grief counseling for one year after their family member's death.[97] Thus, a

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[93] Zhang, Baohui, Alexi A. Wright, Haiden A. Huskamp, Matthew E. Nilsson, Matthew L. Maciejewski, Craig C. Earle, Susan D. Block, Paul K. Maciejewski, and Holly G. Prigerson. 2009. "Health Care Costs In The Last Week Of Life: Associations With End-Of-Life Conversations." *Archives of Internal Medicine* 169 (5) (03/09): 480-8
[94] Peyson et al., "Medicare Cost In Matched Hospice And Non-Hospice Cohorts," 7
[95] Based on number of cancer deaths per year, Zhang et al. 487
[96] Gallup. 2006. *Hospice Provides What Americans Want At The End Of Life*
[97] Ibid.

change in EOL care utilization would improve quality of life for more than just the patient who is dying.

CONCLUSION

American healthcare faces problems associated with tradeoffs among universal access, high costs and high quality of health care. Years of poor policy planning and patches define the current system. The U.S. is by far the highest international spender among developed nations. High spending is not explained by cultural differences like obesity rates, smoking incidence and/or age. There is a failure in the system itself, partially due to a mismatched insurance market and partially due to actual costs of the types of care utilized.

A classic economist will argue that the only time it is appropriate for a government to intervene in a market is when said market fails. That time is here. The U.S. is facing a collective action problem, and the mindset of allowing free market controls to regulate the market is not working. The inelastic demand mechanism of health care makes it a different beast. Economic choices in health care are not whether or not to buy the new iPhone, but rather whether or not the consumer wishes to continue living.

Lawmakers, both in U.S. states and abroad, have developed means to solving this collective action problem. With the help of positive and negative case studies, this paper offers six solutions that have potential to improve access, costs, and quality. The

politics of prescription are complex and difficult. Nevertheless, the policy-based solutions offered herein not only save money but also save lives.

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