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AICGS POLICY REPORT

ACCESS, QUALITY, AND
AFFORDABILITY IN HEALTH
CARE IN GERMANY AND THE
UNITED STATES

Dirk Göppfarth



American Institute
for Contemporary
German Studies

JOHNS HOPKINS UNIVERSITY

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FOREWORD

Despite dramatic differences in the history of their health care systems, the United States and Germany face similar challenges in improving the quality of care while simultaneously expanding access and making health care more affordable. Although the United States and Germany have issued a series of reforms to contain costs while supporting quality improvements, both countries persistently spend more than average on health care while lagging behind in quality.

In this Policy Report, DAAD/AICGS fellow Dr. Dirk Göppfarth analyzes the challenges confronting U.S. and German policymakers in attempting to formulate an effective regulatory framework for health care, exploring the options available to policymakers, and evaluating the successes of proposed programs. Currently, both countries use a system balancing competition and management, with Germany favoring the latter and the United States the former. According to Dr. Göppfarth, neither has found the correct balance. Dr. Göppfarth argues that, though there is no one-size-fits-all solution to the challenges of health policy, both the United States and Germany must foster a data-sharing culture in order to facilitate the effective use of data to address the challenges of access, quality, and cost.

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SUMMARY OF MAIN FINDINGS

01

SUMMARY OF MAIN FINDINGS

All health care systems are different, but all systems face the same challenges. The main health policy goals are usually seen to be access to care, quality of care, and affordability of care. The challenge of achieving these goals simultaneously is common to the health care systems in both the United States and Germany.

Access

Access can mean access to health insurance and access to medical care. Health insurance is important since it is the means to finance access to medical care. In the United States, the Affordable Care Act (ACA)¹ involves a huge effort to increase access to health insurance. Germany also had a small number of uninsured, a problem it addressed with the 2007 Health Reform Act (GKV-WSG²). Universal access to health insurance necessitates regulation of health insurance markets. The instruments of guarantee issue (an obligation to offer a policy to any eligible applicant without regard to health status), community rating, and an individual mandate are needed. Otherwise, adverse selection problems, endemic to health insurance markets, will lead to a vicious circle of rising premiums and contract cancellations, in effect destroying the market.

But access to health insurance does not guarantee access to medical care. In both countries governmental (or quasi-governmental) and private payers coexist. But if the level of payments to providers differs too starkly, providers may react by restricting access. There are reports of access problems in the Medicaid program in the United States, and of differences in waiting times for members of private and statutory insurance in Germany. These access problems will increase if cost containment efforts remain

restricted to the governmental programs. At the very least, there will have to be coordinated cost control efforts, preferentially an all-payer system of same prices for same services.

Quality

Achieving and maintaining quality of care is a challenge. In international comparison, both Germany and the United States achieve below-average quality outcomes despite expenditure levels far above average. Other countries achieve higher levels of quality with lower expenditures. In other words: both Germany and the United States do not get value for the money spent in health care. An important impediment to quality are payment systems that reward activity, not quality. The United States has pioneered payment reform, whereas Germany lags behind. The German system of collective contracting seems to be too procrastinated for innovations and experiments with payment systems.

But evaluations of the demonstrations and pilots in the United States have shown only weak results, at best. The main reasons seem to lie in the fragmented payer side, leaving most initiatives with insufficient impact on provider behavior. This points to a paradox: In Germany, collective arrangements would offer the perfect environment for a universal implementation with high impact, but probably are not flexible enough. In the United States, on the other hand, the fragmented system offers the perfect environment for innovation and experimentation, but seems unable to scale up successful pilots in order to impact outcomes.

This, too, shows the need to base competition on a basic level of cooperation. The development of quality

metrics should be a joint effort, best based on an all-payer database. The basic incentives set at the provider level should be the same for all payers.

Affordability

Affordability has an individual and a collective component. Premiums have to be within the means of the individual, but the burden on the federal budget has to remain manageable, too. Both Germany and the United States are in the process of implementing premium subsidies for low income households. With premium subsidies, however, individual affordability becomes a collective problem. Rising premiums mean rising premium subsidies and therefore a rising drain on public finances.

Germany has a better record on cost control than the United States. There is evidence that pricing mechanisms in the U.S. are the main culprit. Both the United States and Germany base their hope on competition between health plans as mechanism for controlling costs in health care. But the results in the U.S.—huge differential in prices paid by the same payer at different providers, and a huge differential in prices charged by the same provider from different payers—point to the fact that the competitive mechanism is not working and that market power is unevenly distributed.

Here again, the relationship between competition and cooperation needs to be addressed. In Germany, an all-payer system marshals the joint negotiation power of the payer side for cost control. But this system has proven to be susceptible to stakeholder capture and an impediment to innovation. That need not be the case with a carefully designed all-payer system, as the Maryland hospital rate-setting system demonstrates.

Conclusions

In health policy there are no easy solutions. No health care system has proven to be dominant to any other system. Rather, it is careful attention to detail and incentives that decides on the relative success of a system. The same holds for payment reform. Hence, a culture of innovation and experimentation is important as a mechanism for discovering possible

improvements. But innovation and experimentation by themselves are not sufficient; the results have to be evaluated and the system must be able to scale up successful models. The United States seems to be strong on innovation and experimentation, but weak on scaling-up, Germany vice versa.

Therefore a new balance of competition and cooperation is needed in both systems. Too much competition without cooperation will fail. Free competition will not work in health care. It will lead to market failure and fragmentation. Minimizing the information asymmetries between payers and providers, e.g., on the quality of care delivered, is a collective effort that cannot be achieved by an individual payer. There has to be a cooperative effort to provide this information in order for competing entities being able to contract on it. The same holds for pricing systems. It makes sense to direct health plans toward competition on care management and utilization control, instead of negotiating price discounts.

But the balance has to be kept in the other side, too. Too much cooperation impedes competition and leads to procrastination. Hence Germany will have to move in the other direction. Simply replacing collective contracts with selective contracts, as has been the dominant strategy in recent years, is the wrong approach. It replaces cooperation with competition instead of augmenting it. The result will be a fragmented system with all the defects discussed above. Instead, the collective arrangements should be reduced to providing the framework and metrics on which individual contracts can be based.

The key to change is data. Successful efforts in improving delivery are based on data—measuring and continuously improving performance. Not every organization has the data it needs to act upon, and providers only have access to the data from their patient contacts. But the perspective should be population-based, not case-based. The focus should not be on individual services, but on the whole episode of care. For quality metrics, end-points such as the two-year survival rates have to be available. For this the data has to come from payers. Payers today see their data as a proprietary asset, which hinders improvements in care. Instead, a culture of sharing data has to be developed. A possible solution would be the

creation of a fiduciary institution that collects and aggregates the data.



THE NEED FOR REGULATION

02

THE NEED FOR REGULATION

There is a long developed standard economic argument why health care and health insurance are unique, and why the market needs regulation. The argument goes back to a seminal article by Kenneth Arrow from the year 1963, who argued that the irregular and unpredictable nature of demand, information inequalities between physician and patient, licensing restrictions to supply, and pricing practices were special characteristics of medical care markets that necessitate a unique regulatory framework.³ This view is reproduced in most health economics textbooks.⁴

With the Supreme Court case on the constitutionality of the ACA⁵ this argument returned to the forefront of the discussion. Groups of economic scholars filed Amicus Briefs to the Supreme Court both in favor and against the ACA.⁶ The economics scholars supporting the ACA, including Kenneth Arrow, reiterated the standard argument:

“Indeed, health care violates almost all of the requirements for markets to yield first best outcomes (‘Pareto optimality’). One requirement for market optimality is that people know what they need, and have full information about how to obtain it. With health care, by contrast, need is unpredictable, and information—particularly about the costs of treatment—is far from complete.

Moreover, optimality requires that individuals’ actions affect only themselves. This is again not true of health care, where individuals’ actions have effects far beyond themselves—both directly (by spreading communicable diseases, for example), and indirectly (by not being insured and thus shifting costs to others, for example).

Optimality in a market also requires vigorous competition on the part of providers. Because of substantial market imperfections in medical care, however, medical care providers encounter a variety of constraints, including licensing requirements and the regulation of the provider-patient relationship. Structural factors in the markets for health care, such as the limited number of hospitals and primary care physicians, are also inconsistent with perfect competition.”⁷

The economic scholars opposing the ACA do not subscribe to this view. Instead, they argue point-by-point against uniqueness. Medical care is not uniquely unavoidable, since “all Americans will participate in the ‘transportation’ market [...and...] the ‘food’ market.”⁸ Medical care is also not uniquely unpredictable, since “routine costs of care are fairly predictable,”⁹ only catastrophic care could be called unpredictable. Furthermore, these economists see many alleged specialties of medical care not as result of properties of medical care as such, but as the result of other government regulation: “The healthcare market is not ‘unique’ merely because the government has legislated inefficiencies into the market.” With this they mean the federal regulation that “consumers receive certain emergency services irrespective of their ability to pay because providers are required to provide certain types of care.”¹⁰

Curiously absent from the list of refuted uniquenesses are asymmetric information and the resulting selection effects. But the health insurance market is full of information asymmetries—the physician knowing more about medical care than the patient, the seller of insurance knowing more about risks than the buyer, and the patient knowing more about lifestyle habits and compliance than physician or insurance.

Furthermore, the economists arguing against the ACA go on to claim that the individual mandate is not necessary, since guaranteed issue and rating regulations alone would be sufficient to provide coverage to uninsured with medical conditions. This, in effect, is tantamount to saying that there is no adverse selection problem in the health insurance market.¹¹ Without wanting to repeat the concise textbook treatment of this issue,¹² there are some aspects to be pointed out:

The market for health insurance is best understood as two separate markets: First, the market for term insurance, i.e., the coverage of medical care for a certain term, usually a year, given a certain health

status at the beginning of the term. Second, the market for long-term insurance, i.e., insurance against the risk that the health status deteriorates over time, or what is called the “reclassification risk.”¹³ This separation was suggested by Arrow as early as 1963: “If a plan guarantees to everybody a premium that corresponds to total experience but not to experience as it might be segregated by smaller subgroups, everybody is, in effect, insured against a change in his basic state of health which would lead to a reclassification. This corresponds precisely to the use of a level premium in life insurance instead of a premium varying by age, as would be the case for term insurance.”¹⁴

Box 1. Premium Calculation in the German Private Health Insurance

Private health insurance in Germany has found an ingenious way to prevent the problem of renewability. Private health insurance in Germany is a life-long contract the insurer may not cancel (except for severe breach of terms). Premiums are leveled over the life-span of the member, i.e., in younger years they pay higher premiums than actuarially necessary in term insurance. The surplus is used to build provisions in order to subsidize premiums in old age. The premiums are rated according to the age when joining the insurer—the older you are, the higher the saving rate necessary for old age. Pre-existing conditions are either excluded or tarified separately (pay-as-you-go) with an extra premium.

The German private health insurance succeeds in providing life-time insurance for about 10 percent of the German population. The forty-three private health insurers hold provisions for old age of €158 billion (\$200 billion). But it should not be forgotten that this system is the result of government regulation requiring private health insurers to operate in this manner. Furthermore, this solution comes at a price: The members of a private health insurer are effectively “locked in” with their insurer. If they want to change their insurance, they cannot take their savings with them. The new insurer will rate them for their higher entrance age and if medical conditions have occurred in the meantime risk rate or make exclusions for them. After a certain age, switching private insurer becomes financially untenable. The price for guaranteed renewability effectively is the loss of competition.

The reason the private insurers do not make the savings portable is not a question of bad will, but of adverse selection. Take a group of 100 healthy and young individuals joining a private insurance. After five years, say, 80 remain healthy and 20 develop medical conditions. The individuals with medical conditions are not rated for medical conditions developed after having joined. But if they switch the new insurer would rate them for these conditions, so basically only the remaining healthy can switch. Now the insurer will have calculated its premiums on the knowledge that in the statistical average of 100 healthy individuals 20 will develop medical conditions within five years (in this example). So if healthy individuals leave, that will change the composition of the risk pool on which the premium calculations were based. The insurer would have to raise premiums for all remaining members, in effect driving away even more healthy individuals and further deteriorating the composition of the risk pool.

Whereas insurance markets seem to be able to provide term insurance, insurance against the reclassification risk does not seem to work in practice.¹⁵

This can be seen in the private individual health insurance market in the United States. Health insurers offer term insurance, but do not guarantee renewability at the end of the term at average conditions. Some states have tried to regulate the market in order to establish guaranteed issue and guaranteed renewability, but all have experienced adverse selection.¹⁶ Since the guarantee means that everybody can seek health insurance at affordable prices when she or he needs it, healthy individuals forgo their coverage, leaving the risk pool sicker. This, in turn, leads to higher premiums, which lets even more healthy individuals leave the risk pool, etc. The German private health insurance is another example of the adverse selection problems always underlying health insurance (see Box 1).

But these problems may not only result from the problems of asymmetric information. Cutler and Zeckhauser argue that—unlike the usual presumption in economic theory—health insurers are not risk adverse.¹⁷ One reason may be that they are not sufficiently diversified, and one of the problems separating health insurance for other insurance markets is that the long-term risks may not be diversifiable: “When future medical costs increase for some people—e.g., because expensive new medical technologies become available—they will increase for others as well. Similarly, if new medical knowledge extends survival at older ages, it will yield such benefits to millions.”¹⁸

Finally, recent progress in the area of behavioral economics has shown that people have severe difficulties making decisions where small probabilities and significant stakes are involved.¹⁹

Regulation in the health insurance market should therefore not be seen as government interference in otherwise functioning markets. The aim of regulation is to facilitate the existence of functioning markets in health insurance that due to market failure would otherwise not exist or have grave deficiencies. But for this regulation has to be carefully implemented and mimic the functioning of markets.



FINDING THE RIGHT REGULATORY
FRAMEWORK

03

FINDING THE RIGHT REGULATORY FRAMEWORK

Accessibility

ACCESS TO HEALTH INSURANCE

Situation in the United States: Affordable Care Act

Access to health insurance is not guaranteed in the United States. It is the intent of the ACA to change this. Currently there are about 50 million uninsured Americans.²⁰ Medicare covers only persons over 65 years of age or severely disabled. The population under 65 years mostly depends on commercial insurance. Most people receive their insurance as group insurance through their employer (employer-sponsored insurance). But the number of employers, especially small employers, actually offering this voluntary benefit is falling.²¹ For this reason the number of uninsured has been rising and continues to rise in the current economically difficult times. Coverage by Medicaid, the co-operative federal-state program that funds care for needy individuals, is limited to certain qualifying groups—mainly children in low-income households, their parents, and disabled persons.²² All others must refer to the market for individual commercial health insurance.

The health insurers on the individual market risk select and risk rate. This means that insurers are not required to take everyone and the premium will depend on health status. Prior conditions will usually be excluded or lead to punitively high premiums. Regulations differ from state to state, but generally, renewability of contract will not be guaranteed at prior conditions. According to a recent study, 35 percent of applicants on the individual market do not receive the coverage they need.²³

Apart from uninsurance, underinsurance also causes

severe problems: those whose health insurance policies contain limitations, loopholes, and cost-sharing requirements that place them at financial jeopardy in the event of serious illness or injury. In 2006, there were 25 million underinsured adults according to this definition.²⁴

Missing or inadequate health insurance coverage is not only a moral problem,²⁵ it also has serious economic consequences. Hospitals are legally required to provide emergency services to everybody independent of their ability to pay. According to official estimates, uncompensated care delivered to the uninsured amounts to \$43 billion per year; this increases premiums for the average insured family by \$1,000 per year.²⁶ The economic costs of people avoiding switching jobs or pursuing entrepreneurial activities due to the fear of losing their employer-sponsored coverage cannot be specified.²⁷

The main thrust of the ACA is the expansion of coverage, basically to all legal residents of the United States. Illegal immigrants will remain excluded. Half of the additional coverage is achieved through an expansion of the Medicaid program, which will become the health insurance program for all low-income Americans. The program will be open for all individuals with household income at or below 138 percent of the federal poverty level. The other half of the expansion will result from a reform of the individual market.

From the year 2014 onward, health insurances will not be allowed to use discriminatory practices on the individual market. They may not decline applicants or cancel coverage due to health status (guaranteed issue). In the group market, guaranteed issue was already established in 1996 by the Health Insurance

Portability and Accountability Act (HIPAA). Furthermore, rating differentials based on health status will be prohibited, and the scope of differentials based on other factors such as age, geography, or tobacco use severely restricted (adjusted community rating). Products will be heavily regulated. There will be defined essential health benefits,²⁸ and coverage levels are pre-specified at actuarial values as the so-called “metal levels” (bronze, silver, gold, and platinum coverage). This is to make the products easily comparable for the individual purchaser, and choice should be facilitated through health exchanges, online marketplaces offering a portal and navigation function.

It is estimated that the ACA—if fully implemented—will reduce uninsurance by between 25 and 35 million, effectively cutting the rate by something between a half and two thirds.²⁹ Those remaining uncovered will be illegal immigrants, people not signing up for Medicare despite being eligible, and those unable to find affordable coverage options or choosing to pay the individual mandate penalty rather than signing up for coverage.

Situation in Germany: Universal Coverage Since 2009

The German health care system is the classic case of social insurance. The system of government-mandated health insurance with compulsory funding by employers and employees, as designed by Bismarck’s Social Health Insurance Act of 1883, has become known as the “Bismarck model,” and is often contrasted to the “Beveridge model” of a National Health Service. In the Bismarck model, the funding base is wages and salaries; the contributions drawn from these wages are the basis of entitlement. The carriers of health insurance are sickness funds (currently 136), non-profit organizations incorporated under public law with self-administration.

Today, the model is facing many challenges. Originally constructed as an entitlement associated with labor status, the model was not aimed at universal coverage. Germany gradually expanded coverage, but still left a small part of the population without coverage. Subsequently, a substitutive private health insurance system developed for those not covered by the statutory system. But private insurers traditionally

risk rate and risk select, as in the United States. Hence, not everybody was able to get affordable private coverage. The other challenge is financial. Funding based on wages up to an income threshold is too small a base to finance the expanded coverage with all the services/benefits. Concerns about competitiveness in the global economy and high rates of unemployment put a downward pressure on labor (payroll) taxes.

After long and controversial discussions, Germany settled for a major reform of health care finance in 2009. Finally, the move from near universal to universal coverage was made, as the last remaining loopholes in statutory and private insurance were closed. The revenue base was widened through new and explicit subsidies from general revenue for the sickness funds. One of the central elements of the reform was the introduction of a Central Health Fund.³⁰

As of 1 January 2009, all residents in Germany are required to obtain health insurance coverage either in the statutory or private system. Until then, coverage was only near universal, leaving about 200,000 residents without coverage. Correspondingly, both private insurance companies and sickness funds are required to make this coverage obtainable. For this reasons, sickness funds must take all non-insured that had their last prior coverage in the statutory health insurance (SHI). This is the case, for example, with insured that lost their coverage due to non-payment of contributions. The same holds for persons without any prior insurance, if not self-employed. All others are required to seek private coverage.

To ensure that those who have to obtain their mandated private coverage actually have the opportunity to do so, private insurers are obliged to offer a basic tariff. Unlike the usual private tariffs, this tariff is not risk-rated, and benefits are equivalent to those in the SHI system. The premium may not exceed the maximum contribution payable in the SHI.³¹ Holders of existing policies may switch into this tariff under certain circumstances. Private insurers complain that this tariff is not self-supporting and has to be cross-subsidized from marking-up premiums in existing contracts. They see the danger of adverse selection, i.e., the sick concentrating in this basic tariff. So far,

the Federal Constitutional Court has upheld this tariff, but obliged parliament to observe the development and react if adverse selection becomes a problem.

Achieving Universal Access to Health Insurance

Unlike in a single payer or a National Health Service system, where access derives from residency or citizenship, achieving universal access to health insurance necessitates a complex regulatory framework. Both the U.S. and Germany have introduced universal coverage in a system of competing insurers with a framework of guaranteed issue, rating restrictions, and an individual mandate, or are in the process of implementing this framework.

Guaranteed issue is necessary to ensure that everybody desiring coverage actually has the possibility to do so. But not only actual rejection through insurers can inhibit coverage, also prohibitive pricing can. Hence, rating regulations in the form of community rating or adjusted community rating is required. But guaranteed issue and community rating alone will lead to adverse selection issues. If everybody knows she or he can obtain health insurance at any time at an affordable price, why purchase when you are young and healthy? Why not wait until you actually need coverage? But if everybody acts in such manner, health insurance will not be able to pool good and bad risks—a necessary prerequisite of a functioning insurance market. Without pooling the premiums will rise and drive even more individuals out of the market. This death spiral is not hypothetical. It was experienced by those states—like Kentucky, Maine, New Hampshire, New Jersey, New York, or Vermont—that instituted guaranteed issue and rating restrictions.³² Only Massachusetts was able to avoid a death spiral by complementing the regulatory framework with an individual mandate, obliging individuals by penalty to obtain coverage.³³

Therefore, both the United States and Germany augmented the introduction of universal coverage with an individual mandate (minimum coverage requirement). But in the United States, the individual mandate has come under legal challenges,³⁴ the outcome of which remain uncertain. Critics see the individual mandate not as a means to enforcing a necessary risk pool, but as requiring healthy individ-

uals to subsidize the less healthy uninsured seeking coverage.³⁵ But this neglects the changes in the character of health insurance instituted by the reform. Health insurance will change from term insurance to life-time insurance. The healthy forced into the risk pool not only receive coverage for their current health status, but also the guarantee to keep this coverage at unchanged conditions in the case of changes in their health status—a risk every person carries.³⁶

Can adverse selection be avoided without an individual mandate? There are some suggestions of how to reduce and mitigate adverse selection.³⁷ Subsidies play a major role in this argument, “bribing” the young and healthy to remain in the risk pool. But the experience from Massachusetts shows that subsidies alone will not be sufficient,³⁸ and the fact that the subsidies under the ACA are lower than under the Massachusetts law³⁹ reinforces this. Other ideas are limiting open enrollment periods and introducing late enrollment penalties, public education and outreach campaigns, conditioning the receipt of certain government services on proof of coverage, requiring the use of health insurance status in credit ratings, etc.

There are diverging estimations on the exact effects of a rejection of the individual mandate. Eibner and Price see only limited adverse selection, with individual premiums rising only by 2.4 percent.⁴⁰ Gruber, on the other hand, sees a much higher risk with premium rises of up to 40 percent.⁴¹ Buettgens and Carroll have the intermediate view with premium rises of 10 to 25 percent.⁴² All see a significant effect on coverage, the number of uninsured remaining about 8 to 10 million higher than with the mandate, and a significant decline in employer-sponsored insurance. According to Eibner and Price, “people with modest incomes that are nevertheless too high to qualify for Medicaid or substantial subsidies will be the individuals most likely to remain uninsured if the individual mandate is eliminated.”⁴³ Paradoxically, government expenditure will decline, as fewer individuals will qualify for subsidies, while the cost per case rises.

In Germany, there is an individual mandate that has been upheld by the Federal Constitutional Court:

“To justify the goal expressed in the GKV-WSG [the

Health Reform Act of 2007] of ensuring that all the inhabitants of the Federal Republic of Germany have affordable health cover in the statutory or private health insurance system, the legislature may invoke the principle of the social welfare state contained in the Basic Law [Grundgesetz – GG]. The combination of compulsory insurance and obligation to enter into contracts in the basic category is appropriate to achieve the legislature's goal of guaranteeing adequate and affordable health insurance cover for the category of persons allocated to private health insurance."⁴⁴

But here, too, there is a risk of adverse selection. Private insurance has to offer a Basic Tariff without risk rating, cross-subsidized from the risk-rated regular tariffs. Obviously, there are legitimate concerns that these tariffs will disproportionately attract bad risks. But, in the words of the Constitutional Court:

"The possibility of many insured moving to the basic category is out of the question, at all events at present. For the basic category entails a high premium of approximately 570 euros per month. At the same time, the main benefits of the basic category are narrower in scope than the customary benefits of the normal categories of private health insurance. Contrary to the fears of the companies, the legislature was therefore able to assume that there would be no disproportionate increases of premium in the normal categories of private health insurance as a result of the need to finance the basic category, whose premiums might not be sufficient to cover costs, and that this would not in future lead to a substantial move to the basic category, which in the long term would destroy the complete business model of private health insurance. If it should transpire in future that this reasonable prognosis is mistaken, the legislature would if necessary have a duty to correct it."⁴⁵

So far, the prognosis of the Constitutional Court holds. But another facet of the German reform turned out to be problematic. Unlike as is stipulated in the United States, there is no enforcement of the individual mandate. Lacking the credible threat of terminating contracts, sickness funds and private health insurers find it difficult to enforce payment morale. Coverage can be restricted to emergency services

until arrears are cleared. When a person finally seeks coverage, the insurance will be backdated to that date when the person should have obtained insurance. For this time contributions and an interest on arrears of up to 5 percent per month are due. However, burden of proof of missing coverage lies with sickness funds and certain rules for deferral and abatement apply, so penalties are usually less harsh in reality.

These problems only apply to a limited number of persons—at least in statutory health insurance. For most individuals, registration and deduction of contributions are made automatically by employer or social insurance agency. But still, according the recent press reports,⁴⁶ arrears in the statutory system have risen by 50 percent last year to €1.5 billion, and to €500 million in the private system.

ACCESS TO MEDICAL CARE

Restricted Access Due to Payment Levels

Due to the nature of medical care—a highly irregular and unpredictable risk of needing care with potentially devastating financial consequences—health insurance is the necessary means of paying for it.⁴⁷ Evidence from the Oregon Health Insurance Experiment, a randomized controlled study of Oregon's Medicaid program shows how important health insurance is in order to provide access to medical care.⁴⁸ Furthermore, health insurance facilitates access to a regular provider, including preventive and screening services. This can help reduce future costs through reductions in unnecessary hospital use.⁴⁹

Medical care is an experience good, i.e., it is difficult to know the quality until you experienced it. With experience goods suboptimal consumer decisions and quality problems are rife.⁵⁰ Asymmetric information between physicians and patients exacerbate these problems. Especially when sick, patients are not really in the position to “shop” for the best medical care. All this gives health insurance a function above holding financial risk—functioning as an agent on their members' behalf in securing access to high quality medical care. As Ruger states: “If health policy is to promote human flourishing, its goal should be to

enable individuals to function best, given their circumstances, and thus reduce the vulnerability and insecurity associated with ill health. It is not enough simply to provide resources to individuals (for example, cash payouts or direct medical services). Justice requires that individuals and households be protected against

the vulnerabilities resulting from ill health, and insurance offers this protection."⁵¹

But even health insurance coverage does not guarantee access to medical care. One problem is the level of provider payments. Government programs,

Figure 1a: Relative Payment Levels in Medicare and Medicaid. Illustrative comparison of relative Medicare, Medicaid, and private health insurance prices for inpatient hospital services under current law

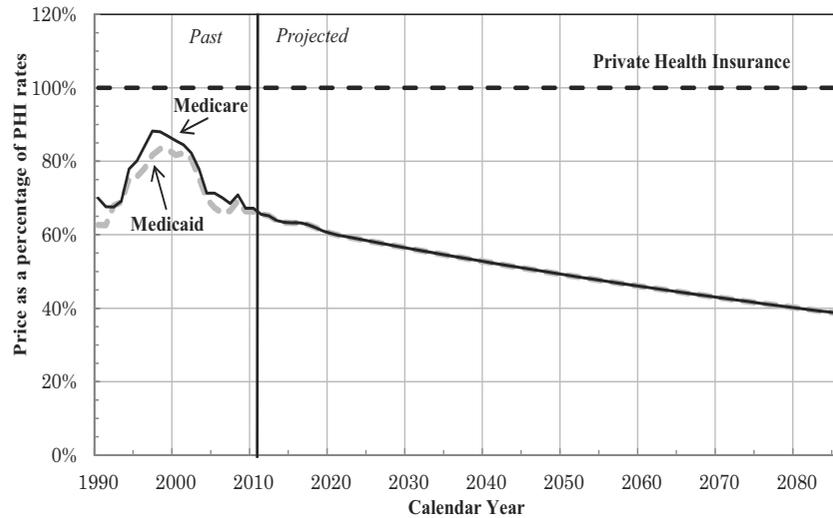
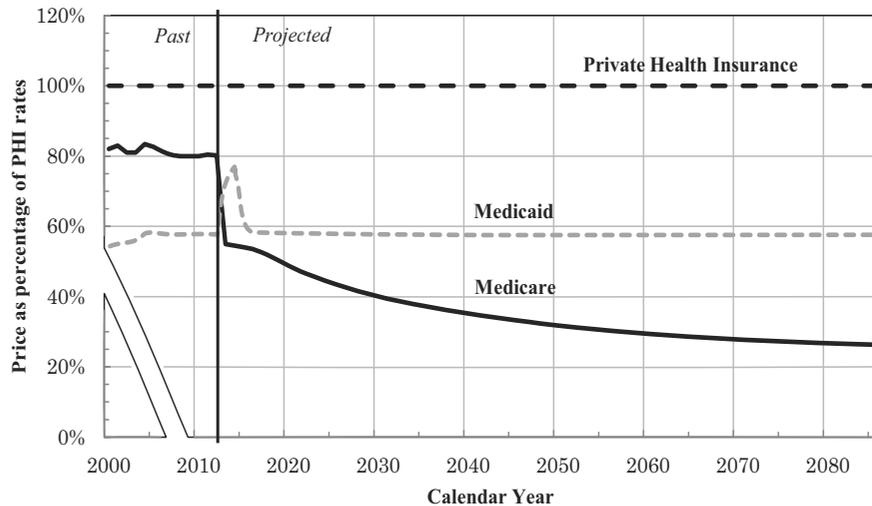


Figure 1b: Relative Payment Levels in Medicare and Medicaid. Illustrative comparison of relative Medicare, Medicaid, and private health insurance prices for physician services under current law

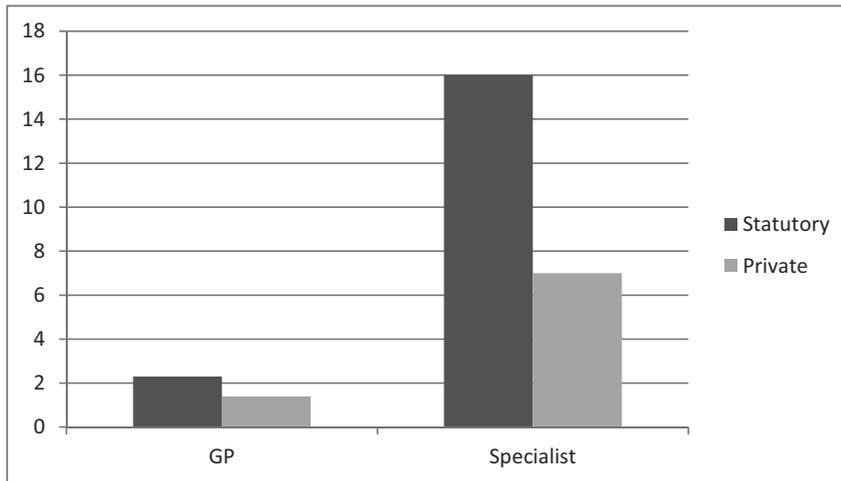


Source: The Board of Trustees 2012

such as Medicare and Medicaid, pay a lower level of payment than commercial insurers. Medicaid fees are at about 72 percent of Medicare levels,⁵² which again are way below commercial levels. Between 2000 and 2010, Medicare payments relative to hospital costs declined from 99.1 to 92.4 percent, while private payers have seen their payments rise from 115.7 to 133.5 percent.⁵³ Some studies show that these lower payment levels lead to access problems.⁵⁴ According to the projections of the Medicare Trustees Report, the long-term outlook for the payment levels is bleak (Figure 1). High levels of co-payments are another problem. According to Collins et. al., even among adults who had coverage for the full year, 31 percent reported a cost-related problem getting needed care, and a quarter of adults with a chronic condition who took prescriptions regularly said they had skipped doses or not filled a prescription for their health condition because of costs.⁵⁵

The need for cost-control in the government programs is beyond dispute. But if Medicare and Medicaid cuts are not embedded in a wider cost-control strategy they will lead to access problems: “In short, it is hard to imagine that reductions in the rate of Medicare spending growth will not be made at some point. [...] But it is equally hard to imagine cutting only Medicare spending while spending by the commercially insured under age sixty-five continues to grow at historic rates, which would lead to a marked divergence between what providers are paid for treating the commercially insured relative to what they are paid for Medicare beneficiaries. This gap could jeopardize Medicare beneficiaries’ access to mainstream medical care.”⁵⁶ Cost-control in the commercial market will therefore become an increasing issue on the government’s agenda.

Figure 2: Waiting Time for an Appointment in Days by Coverage



Source: Kathrin Roll, Tom Stargardt, Jonas Schreyögg, “Effect of Type of Insurance and Income on Waiting Time for Outpatient Care,” *Research Paper*, 2011/03 (Hamburg: Hamburg Center for Health Economics, 2011).

In Germany, an all-payer system guarantees that all statutory health insurers pay the same price for the same service to all providers in the region.⁵⁷ But the private insurers use a different payment scale; the level of payment usually is more than twice the level of statutory payers.⁵⁸ This results in reports on differences in access for privately and statutorily insured. A recent study finds that patients with private coverage receive appointments at their general prac-

titioner a day earlier and at a specialist nine days earlier.⁵⁹ Another study reports waiting times for statutory insured being three times as long.⁶⁰ Newspapers frequently report on even larger differences. In hospitals, private and statutory insurers use the same prospective payment (diagnosis-related groups – DRG) system. But private insurers cover additional services and pay the consultant directly and on top. Here, too, a study found differences in

Box 2. Maryland Hospital All-Payer System

In all-payer systems all payers in a region pay the same price to a provider for the same service. Sometimes, adjustments for differences in input prices (e.g., rents or wages) are made. All-payer systems are not unknown in the United States. Many states introduced all-payer systems for hospital payment in the 1970s—most prominently Maryland, Massachusetts, New Jersey, and New York. West Virginia followed in the 1980s. Most were abolished in the 1990s. Expiring Medicare waivers, increasing burdens on the system through uninsured, and a changing political climate in the states were reasons.⁶³ But in Maryland, the all-payer system for hospitals is up and running—for over forty years now. Its score on cost containment is impressive.⁶⁴ There have been suggestions of a universal adoption of all-payer regulation in the United States,⁶⁵ including by a majority of health care opinion leaders.⁶⁶

Under the enabling legislation in Maryland, a Health Service Cost Review Commission (HSCRC), a politically and legally independent government agency with broad powers of hospital rate setting, data collection, and public disclosure, was set up. The seven commissioners are part-time volunteers, appointed to four-year terms by the governor, and assisted by full-time staff. The commission's decisions are not reviewable by the legislative or executive branches. The HSCRC collects a broad set of hospital and patient-level data. It has auditing and compliance rights. The commission is financed by user fees. Since 1977, a Medicare and Medicaid waiver gives the HSCRC full rate-setting power for all payers and all general hospitals in Maryland.⁶⁷

The legislature did not prescribe detailed guidelines for the HSCRC, giving the commission flexibility in setting the details. Instead, the legislature gave five overarching aims: cost containment, access for all, equity among payers, accountability and transparency—including the commission—and solvency for all efficient and effective hospitals. The guiding principles for rate-setting are: a data-driven approach with sound methodologies, prospective prices reflecting market-based principle (long-term marginal costs), and sharing the burden of uncompensated care. The regulatory approach reflects individual market and hospital situations, but aims at a long-term convergence of costs. Above all, the HSCRC is required to operate in an accountable and cooperative manner, involving stakeholders.

The HSCRC gives a high regard to the careful design of incentives. For example, whereas the costs of uncompensated care are shared equally, this is done in a prospective manner, leaving the hospitals enough incentives to collect payments. In New Jersey, this proved to be a major fault line.⁶⁸ All hospitals must bill, and all payers pay, based on a list of approved payment rates for service-specific and departmental units. Aggregate payments are capped at an average per case rate based on DRGs for urban hospitals. Rural hospitals are regulated on total budgets.⁶⁹ To constrain volume increases, volume that exceeds the baseline year is reimbursed at 85 percent of the approved case rate.⁷⁰

Rating setting in Maryland has been successful in cost containment. In 1974, the average price per hospital case was 25 percent above national average; in 2009, it was 3 percent below. The regulatory system has also been able to stop cost shifting. Hospitals earn profits by managing cost and utilization, not through the application of artificially high mark-ups and cost shifting. On national average, hospitals mark-up their prices up to 200 percent of costs for commercial insurers. Health plans try to negotiate discounts, but only those with market leverage are able to do so. In Maryland, the mark-up is uniform for all payers at about 20 percent, including the mark-up needed for uncompensated care. Compared to other areas, the erosion of hospitals serving poor neighborhoods was mitigated.⁷¹ The all-payer system also enhances hospitals' financial stability by supplying a constant and secure revenue stream.

Maryland also has a history of innovation in hospital payment. In 1976, it was the first state to introduce DRGs for reimbursement purposes—preceding Medicare's Prospective Payment System by seven years. Maryland was also an early adopter of Pay-for-Performance, introducing a mandatory Quality-Based Reimbursement (QBR) system in 2008 and the Maryland Hospital Acquired Conditions (MHAC) program in 2009. Experiments with new payment methods can be either proposed by the HSCRC with voluntary participation, or by providers and/or payers seeking approval for an innovative arrangement. In the latter case, lower payment rates will be accepted if the changes will decrease utilization.⁷²

The most obvious disadvantage of an all-payer system is that it gives incentives to providers to expand volume. Rate regulation has to be complemented by volume control. In those years in which Maryland abandoned these controls, volume expanded significantly.⁷³

The comparison of the successful regulation in Maryland with the other states shows that a careful design of the regulatory framework is necessary. The successful factors in Maryland seem to be the independence of the HSCRC both from regulatory capture and political interference, the high level of flexibility in regulations, and a culture of promoting innovations and experimentation.

waiting times.⁶¹ Albeit, so far there is no evidence that these differences in access have led to differences in health outcomes.

These differences in reimbursement levels lead to a misallocation of resources. The time and attention of the most experienced physicians should go to the patients with the highest need for care. Economists assume that need is reflected in willingness-to-pay. But with health insurance this is not the case. The current system withdraws scarce resources from their most productive use, leading to an underperforming health care system. Porter and Guth therefore conclude: “Under value-based principles, reimbursement levels should be dependent on the resources required in care and the value achieved, not the insurance status of a patient. Identical services to patients with similar medical circumstances should carry the same reimbursement levels.”⁶² An all-payer-system, as it exists in Maryland for hospital payments, is an obvious solution to this problem (see Box 2).

Restricted Access Due to Networks and Gatekeeping

Health insurers also restrict access to medical care through limited networks. But these restrictions proved to be very unpopular and led to the “managed care backlash.”⁷⁴ Restricted networks have been mostly concerned with locking patients in with providers in order to give their insurance negotiation

leverage.⁷⁵ This proved difficult, since—as in Germany—patients seem to show a greater loyalty to their physician than to their health plan.⁷⁶ Furthermore, in the United States there is widespread employer resistance to choice-limiting networks.⁷⁷ But provider networking can also have other functions, like contracting on quality and care integration.

Gatekeeping is usual in some health care systems such as the English NHS or in the Netherlands. Germany traditionally has a free choice of provider, including specialist and hospital. But recent reforms in Germany have started to give financial incentives for voluntary enrollment in gatekeeping models, while leaving the free choice basically intact.⁷⁸ Some see this form of “soft gatekeeping” as evidence for a convergence of the Bismarck and Beveridge systems, since the latter at the same time have tried to increase provider choice.⁷⁹

While restricting access, there is no compelling evidence that gatekeeping models actually reduce costs.⁸⁰ But the evidence on the effect on access is contradictory. While the restriction of access is a key element of gatekeeping models, certain groups may actually profit from gatekeeping. At least in Germany, there is evidence that direct access to specialists is mostly used by patients with higher educational attainments.⁸¹ Some argue that from a social equity perspective this makes gatekeeping models attractive.

As with networking, the most recent development in the United States has been away from restrictions on provider choice. Latest endeavors under the Accountable Care Organization model have been to replace choice restriction with models of attribution and accountability.⁸² In these models, patients retain the right to choose their provider, but are attributed according to their utilization patterns to a provider who is made accountable (i.e., financially responsible) for the care delivered. It has to be seen if this provides an adequate alternative to enrollment models.

CONCLUSIONS

Access to health insurance necessitates a regulatory framework consisting of guaranteed issue, some form of community rating, and an individual mandate. Guaranteed issue and community rating without a mandate will lead to adverse selection. Some strategies are suggested to mitigate adverse selection without an individual mandate, but are so far unproven. If the U.S. Supreme Court strikes down the individual mandate but upholds the other provisions of the ACA, the United States may come into the position to try this mitigation strategy. It is hard to predict if this could be successful, but it certainly would increase the price of the coverage expansion, an expansion many already see as too pricey.

But access to health insurance is not equal to access to medical care. With diverging developments of payment rates by private and government/statutory payers in Germany and the United States, calls for the adoption of an all-payer systems will become louder. The main argument for a single-payer system is that it increases efficiency by allowing providers to devote most of their scarce resources to those patients needing the most time and energy. But a single payer system would also contribute to equal access by ensuring that all patients were treated similarly because providers would be paid the same amount for delivering the same service. This would ensure access to care for patients with public insurance. This is true for the United States with its fragmented payer system with many commercial and different public payers. But it is also true for Germany, where the split between statutory and private insurance is leading to increasing problems.

Restriction of access through provider networks and gatekeeping has proven to be unpopular with patients. The ACA tries an ingenious solution by replacing the binding enrollment of patients with a data-driven allocation. If this is enough of a binding character to make providers accountable for the care they deliver to populations remains to be seen.

QUALITY

The Need for Improvement

The need to improve the quality of health care has been recognized as a major challenge on both sides of the Atlantic, largely as a result of the Institute of Medicine's landmark reports "To Err is Human" in 1999 and "Crossing the Quality Chasm" in 2001 in the United States⁸³ and the German Advisory Council for the Concerted Action in Health Care's 2000/2001 Annual Report on "Overuse, Underuse and Misuse."⁸⁴

Despite high costs, quality both in the German as in the U.S. health care system is variable and not notably superior to the far less expensive systems in other countries. Both countries have areas where they excel—for example, the United States is noteworthy for its cancer survival rates—but areas where both countries fare poorly are preventable mortality⁸⁵ or complications from chronic diseases. For example, the rate of lower-extremity amputations due to diabetes is three times above OECD average in both countries.⁸⁶ This suggests a failure to effectively manage these chronic conditions that make up an increasing share of the disease burden.

REPORTING ON QUALITY

Both countries have started serious efforts in quality reporting. The first step usually is provider reporting, i.e., giving each provider a feedback on where it stands on relevant quality measures compared to other providers. The next step is public reporting, making quality measures open to the general public. This allows the patient to make informed decisions on which provider to choose or give the referring physician information at hand. Public reporting has been shown to be effective in improving quality, at least initially, but there does seem to be a ceiling effect

beyond which public reporting does not lead to further improvements.⁸⁷ In some cases extra payments for quality reporting are made (pay-for-reporting).

Germany has a wide range of quality assurance measures including quality reporting mandates. Most importantly, hospitals have to publish biannual structured hospital reports, covering 182 quality indicators. The reports have to be published in a search engine compatible form, allowing sickness funds and other initiatives to design search portals—such as <http://www.weisse-liste.de/> set up by the Bertelsmann Foundation together with patient groups and consumer protection associations—allowing the public to easily compare hospitals. Some sickness funds have started to enrich these search engines with further indicators drawn from their claims data or from patient satisfaction surveys. Some providers have also gone a step further and developed sophisticated outcome indicators and report them voluntarily, e.g., the German-Inpatient Quality Indicators (G-IQI) by Helios, a large commercial hospital chain.⁸⁸ Together with sickness funds these measures have been expanded to the outpatient setting based on administrative data.⁸⁹

Most recent endeavors go toward cross-sectoral quality assurance. For this, an institute was set up—the AQUA-Institut—charged with drawing up indicators, instruments, and reporting systems. Hospitals and physicians are required to report data.

A similar reporting system for hospitals exists in the United States. Since 2005 the Center for Medicare and Medicaid Services (CMS) has published information on hospitals' performance and rankings based on these measures online—<http://www.hospitalcompare.hhs.gov/>.⁹⁰ Further requirements will be developed under the Affordable Care Act. All health plans will have to report on their efforts to improve health outcomes, prevent hospital readmissions, ensure patient safety and reduce medical errors, and implement wellness and health promotion activities.⁹¹

PAY FOR PERFORMANCE (P4P)

Payment systems often are a serious impediment for the business case for quality.⁹² Attention has there-

fore quickly focused not only on measuring and reporting quality, but on basing provider payments at least partially on the results of these measures. Typically, pay-for-performance (P4P) leaves the underlying payment system—usually fee-for-service—intact, but devotes a fraction of payments to performance-based bonuses. The bonus can be made to reward a high achievement and/or improvements.

The Medicare Payment Advisory Commission gives the following criteria for the development of indicators to base pay-for-performance programs on:

- Measures must be evidence based, and broadly understood and accepted.
- Most providers and plans must be able to improve upon the measures; otherwise, care may be improved for only a few beneficiaries.
- Chosen measures should not discourage providers from taking riskier or more complex patients.
- Information to measure the quality of a plan or provider must be reasonably obtained and not pose an excessive burden on any of the parties involved.⁹³

In the United States, there have been widespread demonstrations and pilots with pay-for-performance. Commercial payers have been experimenting with these instruments for some time. In Germany, in contrast, a recent survey by the OECD found no examples of pay-for-performance programs implemented (see Table 1). To be fair, this result is not quite accurate. Payment systems in Germany are mostly based on collective contracting (see section 3.3.4). But there is some limited scope for selective contracting for integrated care and general practitioner-centered care. Some sickness funds have also implemented pay-for-performance elements in these selective contracts.⁹⁴ But these contracts are very limited in scope, and hence only have very limited impact. According to Porter and Guth, the average selective contract in Germany only includes 624 patients and a reimbursement volume of €203.⁹⁵ As the negotiated payment models are trade secrets of the contractual partners, there is only limited knowledge over the models, and hardly any learning effects and up-scaling from successful models.

Table 1: Pay-for-Performance Programs and Measures in OECD Countries

Country	Bonus for primary care physicians	If so, targets related to:		Bonus for specialists	If so, targets related to:		Bonus for hospitals	If so, targets related to:			Financial incentives
		Preventive care	Chronic disease		Preventive care	Chronic disease		Clinical outcome	Process	Patient satisfaction	
Australia	X	X	X								X
Austria											
Belgium	X		X	X		X	X				
Canada											
Czech Republic	X	X		X							
Denmark											X
Finland											
France	X	X	X								X
Germany											
Greece											
Hungary	X										
Iceland											
Ireland											
Italy	X	X	X								
Japan	X	X	X	X	X	X	X	X			
Korea							X	X	X		X
Luxembourg							X				
Mexico											
Netherlands											
New Zealand	X	X	X								
Norway											
Poland	X	X	X	X	X	X					
Portugal	X	X	X								
Slovak Republic				X			X	X	X	X	
Spain	X	X	X	X							
Sweden	n.a.			n.a.			n.a.				
Switzerland											
Turkey	X	X		X	X		X		X		
United Kingdom	X	X	X	X	X	X	X	X	X	X	X
United states	X	X	X	X	X	X	X	X	X	X	X

P4P: pay for performance.

n.a.: not available.

Source: OECD, *Value for Money in Health Spending* (Paris: OECD, 2010).

EMPIRICAL RESULTS

Despite all theoretical and conceptual appeal, there is little empirical evidence to support the effectiveness of these programs.⁹⁶ Pilots in Medicare⁹⁷ and Massachusetts⁹⁸ have also not been shown to be effective. In some studies pay-for-performance had moderately better results than pure public reporting.⁹⁹ The evaluation of the Quality and Outcomes Framework (QOF), the extensive pay-for-performance program in the English NHS, has also not been positive.¹⁰⁰ After a broad overview of the literature, a recent OECD report comes to the conclusion that pay-for-performance is “very expensive [...]

without large increases in the quality of care.”¹⁰¹ The case for pay-for-performance is firmly based in economic theory, however. The information asymmetries between provider and purchaser lead to severe agency problems. These lead in due course to suboptimal quality performance. The task of pay-for-performance is to reduce these information asymmetries by providing quality metrics providers and purchasers can contract on. But in practice, this depends on the reliability of the quality metrics. McClellan reminds us of the dangers: “The principal-agent literature emphasizes that measurement and incentives are compliments: that is, when measure-

ment can capture the desired outcomes fully, the incentives can be strong. Conversely, if measurement captures the desired outcomes only weakly, the incentives should be weaker. Too-weak incentives mean inefficient and (in a third-party payment system) likely very costly care. But if high-powered incentives are linked to measures that do not fully capture the desired quantity and quality of health care for each patient, the incentives can lead to both inefficient overprovision and underprovision of certain kinds of care.¹⁰²

The Achilles' heel of pay-for-performance therefore is measurement.¹⁰³ Are the quality indicators really measuring what they are supposed to measure? Too broad measures may irritate providers, too narrow indicators may lead to a false focus, often described as “learning to the test.” Pay-for-performance clearly carries the risk of unintended consequences.

But another problem is impact. Pay-for-performance programs often are only very limited in scope. Often they involve only one payer. This not only reduces the impact of the financial incentives with regard to total provider payments, it also means that the incentives are offset by diverging incentives set by all other payers.¹⁰⁴ Furthermore, not all providers are incentivized. If a patient has contacts with many providers along a continuum of care, the effects of changing the behavior of one of these providers on overall utilization and costs may be negligible.¹⁰⁵

CONCLUSIONS

Quality measurement in Germany is highly fragmented and focused on structural measures and certification processes. There are hardly any experiments with payment reform to improve incentives for quality or at least reduce impediments to quality.

In the United States many payers experiment with financial incentives such as pay-for-performance. But the overall impact so far has been limited. The most important reason lies in the multiplicity of providers. The volume of incentives set by an individual payer to a provider may be too small, and counteracted by different incentives set by different providers.

Hence, in order to implement a successful pay-for-

performance system, it is important to develop a meaningful quality metric. To develop this metric a central database is needed. The data should enable the tracking of patients along the care continuum. Therefore, the data should not come from the providers, but from the payers, allowing a population base. Furthermore, to achieve scale and consistent incentives, the metrics should be on an all-payer basis. Again, in the words of McClellan:

“Just as all healthcare payers today rely on standard codes for thousands of procedures and diagnoses in their fee-for-service payments, consistent methods of measuring quality and cost performance would enable more accurate measurement and thus a greater ability for providers and payers to compete on quality and cost. Such consistent measures are also a necessary feature of reforms that seek to increase consumer pressure for greater efficiency.”¹⁰⁶

Porter and Guth even go a step further: “Outcome measurement should be consistent nationally, and over time internationally.”¹⁰⁷

Furthermore, there has to be a system of institutionalized learning. This includes the encouragement of experiments, pilots, and demonstrations, but also making the results of these available to a wider set of payers. Successful models should be able to be scaled up at short notice. The Center for Medicare and Medicaid Innovation set up by the ACA may come to serve this purpose (see Box 3).

Affordability

INDIVIDUAL AFFORDABILITY

Risk Adjustment

The main mechanisms to insure affordable health insurance premiums are risk adjustment and some form of rating restrictions such as community rating.¹⁰⁹ This guarantees that risk rating due to health status—i.e., higher premiums for pre-existing conditions—does not make the premium unaffordable. Risk adjustment is extensively used in the German SHI system¹¹⁰ and in the United States for Medicare Advantage¹¹¹ and many Medicaid programs.¹¹² Under the ACA, health plans both

Box 3. The Center for Medicare and Medicaid Innovation

The ACA established the Innovation Center at the Center for Medicare and Medicaid Services (CMS) with the task to research, develop, test, and expand innovative payment and delivery arrangements.¹⁰⁸ These new payment and delivery models are to reduce expenditure for the government health insurance programs Medicare and Medicaid while improving or maintaining the quality of care provided to patients. The Innovation Center is funded with \$10 billion every ten years—about 0.1 percent of Medicare and Medicaid spending.

Demonstrations and pilots are not new to Medicare and Medicaid, but the Innovation Center will now provide a reliable stream of financing, without the need to go through the usual budgeting process. The Secretary of the Department of Health and Human Services has the authority over the demonstration approval process. The Secretary also has the authority to scale up successful demonstrations without obtaining prior approval through Congress. The Innovation Center can also produce midway evaluations, in order to inform about successful demonstration before the formal evaluation has been completed. On the other hand, unsuccessful demonstrations have to be terminated immediately.

The Innovation Center will both develop and enforce existing ideas as well as developing new ideas. Among the existing ideas—actually mandated by the ACA—are the Accountable Care Organization (ACO) programs, the Bundled Payment for Improved Care Initiative and the Comprehensive Primary Care Initiative (medical homes). It is noteworthy that the last mentioned programs will be implemented in a multi-payer setting. To create new ideas, the Health Care Innovation Awards are funding up to \$1 billion in grants to applicants who will implement the most compelling new ideas to deliver better health, improved care, and lower costs. The Innovation Center's web page gives a good overview over all activities (<http://innovations.cms.gov/>).

within and outside the health exchanges will be subject to risk adjustment.¹¹³

Premium Subsidies

But for low income households, even a community-rated premium may be unaffordable. Affordability involves the cost of premiums along with cost sharing in the form of co-payments, deductibles, and co-insurance. Therefore, premium subsidies and cost-sharing limits are usually made available. Under the ACA, premium and co-payment subsidies will be available for individuals seeking coverage through the health exchanges. Depending on household income, the individual's premium share is restricted at initially 3 to 9.5 percent. But, beginning in 2020, the rise of premium subsidies will be restricted to the rise in the consumer price index. Since this index usually rises at a lower rate than medical inflation, the individual shares will rise, exacerbating affordability problems.

In Germany, individual affordability was traditionally guaranteed through premiums in the form of wage-

related contributions. But as of 2009, the individual contribution rates of sickness funds were replaced by a uniform contribution rate set by the government. The revenue from this uniform rate does not flow directly to the sickness funds, but to the Central Health Fund. There this revenue is complemented by a federal subsidy drawn from general revenue. Sickness funds receive risk adjusted payments from the Central Health Fund. If these payments are insufficient to cover expenditure, the sickness fund has to charge an additional flat-rate premium. In the case of overpayment, however, the sickness fund can make a refund to members. As soon as an additional premium is charged on average, means tested subsidies for low-waged members become available.

SHI members are eligible for subsidies if the predicted average premium rate exceeds 2 percent of wages. The subsidy then restricts the burden of the premium to exactly 2 percent of wages. The predicted average premium rate is officially set every year by the Federal Ministries of Health and Finance. The means test is performed by the employer or social insurance

agency. The premium subsidies are then paid out by the employer or agency by reducing the deduction for SHI contributions. This leads to an increase in net wages by that amount that 2 percent of wages fall short of the predicted average premium rate.

But the federal budget and SHI budgets have not only become interconnected through the federal subsidy. In the long term, the means-tested subsidies will have a more severe impact on public finances. In the current arrangement, all future health expenditure increases that exceed the gain in the revenue base will have to be financed through additional premiums. Future health care expenditure increases will then lead to rising additional premiums, a rise not reflected in wages. But this means that the tax-financed means-tested premium subsidies will have to rise more than proportionally, too. Hence, future health care expenditure increases will for the first time have direct impact on public finances.

As so far no premium subsidies have been paid, this is a problem for the future. But the mechanics are already well understood by the Federal Ministry of Finance. In the summer of 2011, parliament discussed an act with the aim to provide financial incentives for physicians to set up practice in rural areas with an under-provision of physicians (*Versorgungsstrukturgesetz*). The Federal Minister of Finance intervened, since he saw future risks for the federal budget in the incurred expenditure. The compromise found is that the expenditure incurred under this law is to be disregarded when calculating the premium subsidies. This gives a preview of future debates to come.

The same mechanism will come into effect in the United States. Until 2020, the maximum burden of income through premiums is fixed. If premiums rise faster than incomes, the premium subsidies increase. Rising health care costs in the commercial market will bear a direct financial risk for the federal budget. After 2020 the indexation of premium subsidies with the consumer price index shields the federal budget from this effect. But the upshot will be a rise in problems of unaffordable premiums, as the effective level of premium subsidies falls over time. This situation may soon become politically untenable.

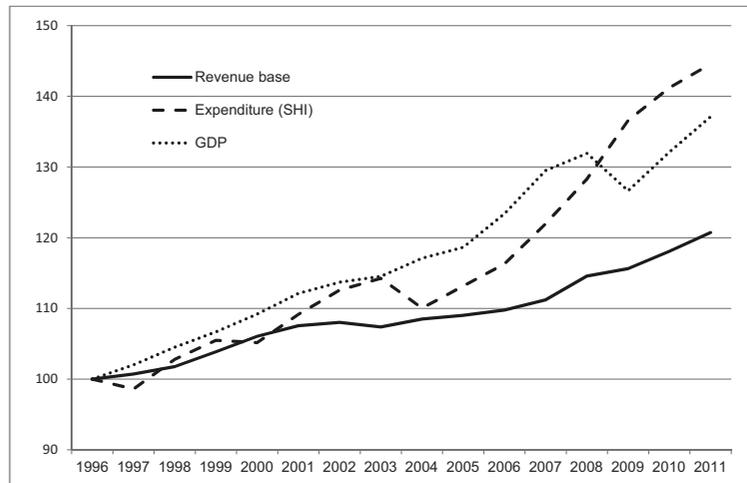
COLLECTIVE AFFORDABILITY

Health Care Expenditures in Germany and the United States

The United States spends far more on health care than any other country. This holds both as percentage of gross domestic product (GDP) as at the per capita level. On a per capita level, Germany spend just over half as much for health care. In relation to national income, the United States spends more than 17 percent of GDP on health care, compared to less than 12 percent in Germany and OECD average. Not only is the level of spending higher in the United States, but also the rate of growth continues to exceed the level of Germany and many other countries. A recent analysis of the Commonwealth Fund finds “that the U.S. spends more than all other countries on health care, but this higher spending cannot be attributed to higher income, an aging population, or greater supply or utilization of hospitals and doctors. Instead, it is more likely that higher spending is largely due to higher prices and perhaps more readily accessible technology and greater obesity.”¹¹⁴ The former director of the White House’s Office of Management and Budget, Peter Orszag, warns that “the United States’ standing in the world depends on its success in constraining this health-care cost explosion; unless it does, the country will eventually face a severe fiscal crisis or a crippling inability to invest in other areas.”¹¹⁵

Whereas health expenditure growth has almost consistently outpaced GDP growth in the United States, the same does not hold for Germany. Germany has seen a rise in contribution rates over the years, but the problem has mainly been the revenue base (wages and salaries up to a threshold). Whereas the annual rise in the revenue base between 1996 and 2008 amounted to 1.1 percent, the corresponding annual rise in expenditure was 2.1 percent (see Figure 3). Interestingly, GDP growth held up to the expenditure rise: Over the period 1996 to 2008 the average GDP growth rate was 2.3 percent (all figures nominal). Obviously, the problem is not expenditures running out of control. Rather, the revenue base of SHI seems to comprise an ever smaller part of GDP.

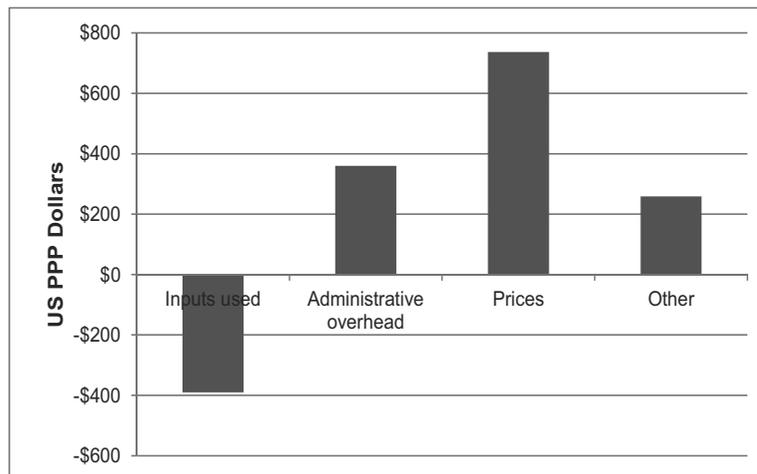
Figure 3: Development of Revenue Base, Expenditure, and GDP 1996-2008



Source: Dirk Göppfarth and Klaus-Dirk Henke,

"The German Central Health Fund. Recent Developments in Health Care Financing in Germany" (2012).

Figure 4: Decomposition of the Spending Differential between Germany and the United States



Source: Uwe E. Reinhardt, "Divide et impera: protecting the growth of health care incomes (COSTS)," *Health Economics* 21:1 (2012), p. 41–54.

Supply and utilization tend to be higher in Germany than the United States. According to OECD Health Data, Germany has 3.6 practicing physicians per 1,000 inhabitants, compared to 2.4 in the U.S. Every German visits a doctor on average 8.2 times per year, the average American 3.9 times. The number of acute hospital beds per 1,000 population are 5.7 in Germany and 2.7 in the U.S. The average length of stay is longer in Germany (7.5 days compared to 5.4

days) and Germany has almost twice as many discharges per capita (237 per 1,000 to 131).¹¹⁶

The main reason for higher expenditure in the United States seems to be the prices. Uwe Reinhardt presents a breakdown of spending differentials between the United States and Germany based on a McKinsey study (see Figure 4). The analysis confirms that actually fewer inputs are used in the U.S., but these

Table 2: Prices Paid by Commercial Insurance in Germany and the United States

	Germany*	United States**
CT Scan (Abdomen)	\$354	\$584
MRT	\$599	\$1,080
Hospital charges per stay	\$5,004	\$15,734
Appendectomy	\$3,093	\$13,003
Routine Physician Visit	\$40	\$89

* Private Health Insurance

** Average of commercial insurers

Source: International Federation of Health Plans, "2011 Comparative Price Report. Medical and Hospital Fees by Country," (International Federation of Health Plans, 2011), <http://www.ifhp.com/documents/2011iFHPPPriceReportGraphs_version3.pdf>.

savings in clinical resources were completely chewed up by additional administrative costs. Differences in prices were the main contributor to the spending differential. In a similar breakdown of spending differentials with Canada, administrative costs and provider payments were shown to be the major drivers of higher spending in the United States.¹¹⁷

As an example for differences in prices, Table 2 gives an overview as recorded by the International Federation of Health Plans. The Federation compares prices paid by commercial insurers. In Germany, these are the private health insurers that cover only 10 percent of the market. Since the prices they pay for physician services are about twice as high as for statutory insurers, the real difference in prices will be even larger. Therefore, the next sections will look at provider pricing in the United States and Germany.

RATE SETTING IN THE UNITED STATES

Pricing in the Medicare Program

Physician payment in the Medicare program is basically a fee-for-service payment consisting of two components: a resource-based relative value scale, which sets a value for each of the approximately 7,500 services provided by physicians, and a conversion factor, which translates the relative value into a dollar amount.¹¹⁸

There is meant to be an overall spending cap on physician payments through the sustainable growth rate (SGR), which sets an overall physician spending target each year. Under the SGR physicians face

across-the-board future payment cuts if the cost of their aggregate level of services to Medicare enrollees exceeds the law's targets. But, so far, the SGR reduced payments only in one year, 2002. In all other years the application of the SGR cut was overridden by Congress.¹¹⁹ One reason for this is the fear that otherwise Medicare payment would deviate too strongly from commercial rates, leading to the access problems described in the section "Access to Medical Care." Obviously, in an all-payer environment this kind of regulation would become more feasible.¹²⁰

Hospital payment is based on inpatient and outpatient prospective payment systems. Both payment systems consist of a base rate modified for differences in type of case or service.¹²¹ For inpatient services, the payment rate is the product of a base payment rate and a relative weight that reflects the expected costliness of cases in a particular clinical category compared with the average of all cases. The clinical categories are generated by the Medicare severity-diagnosis related groups (MS-DRG) classification model. The MS-DRG system consists of 749 groups, which reflect similar principal diagnoses, procedures, and severity levels. Geographical adjustments for differences in wage levels are made. For outpatient services, hospitals receive a predetermined amount per service for each of approximately 850 ambulatory payment classification (APC) groups.

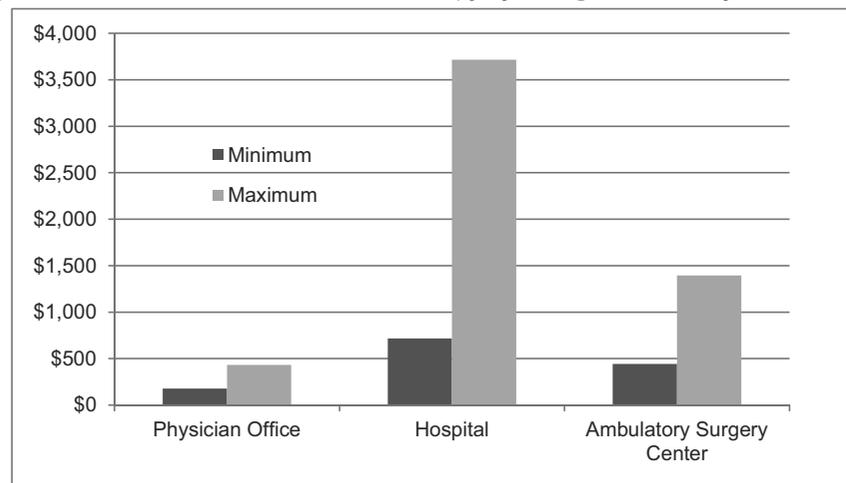
Pricing in the Commercial Market

It is difficult to give an overview of pricing in the commercial market, because basically each of the more than 2,000 commercial insurers negotiates the

payment system with providers. Often the relative values scales and relative rates of the Medicare system are used, and just different conversion factors/base payment rates negotiated.¹²² Likewise, many commercial insurers use MS-DRG relative weights with a different base rate for hospital payments. But per diems are also still common in this area. Uwe Reinhardt reportedly commented on commercial sector pricing like this: “in New Jersey... I asked an insurer a very silly question—what do you pay for a colonoscopy. And he said what do you mean? You cannot answer that. It turns out the prices they pay to different hospitals vary by a factor of three. In California I asked the same thing. Give me some prices for an appendectomy. It ranged anywhere from \$800 to \$13,000. So I'm not sure what this market actually needs. There are no prices in this. It is whatever you can grab and negotiate.”¹²³

The most striking feature of pricing in the commercial market is the divergence of prices. This refers both to the differences in prices a certain payer pays for the same service at different providers and to the differences in prices a certain provider charges for the same service from different payers. Since the negotiated prices are a proprietary trade secret between the involved parties, there is not much transparency in this area. But some studies allow peeping behind the curtain. For example, the prices a large New Jersey insurer had to pay for the same service (colonoscopy) at different providers in different settings can be seen in Figure 5.¹²⁴ New Hampshire requires disclosure of rates. A study by the Commonwealth Fund of New Hampshire rates found substantial variation in what different insurers pay for the same procedure at the same hospital: “One big health plan paid \$2,300 for a colonoscopy at a particular hospital, while another paid \$3,100; one plan paid \$1,400 for magnetic resonance imaging of the back, while another paid \$2,300.”¹²⁵

Figure 5: Actual Prices Paid for a Colonoscopy by a Large New Jersey Health Insurer



Source: New Jersey Commission on Rationalizing Health Care Resources, Final Report, http://www.nj.gov/health/rhc/finalreport/documents/entire_finalreport.pdf (16 June 2012), p. 102; Uwe E. Reinhardt, “The Many Different Prices Paid To Providers And The Flawed Theory Of Cost Shifting: Is It Time For A More Rational All-Payer System?” *Health Affairs* 30:11 (2011), p. 2125–2133.

The prices health insurers have to pay are the result of their negotiating power vis-à-vis providers. As Murray shows, hospitals mark up their prices, on average, by almost 200 percent in order to be able to offer discounts.¹²⁶ White contends that the early savings made by HMOs were due to their power to

reduce price (and not improvements in care management), and the following increases not due to the “managed care backlash,” but rather the result of negotiating leverage shifting back to a consolidating provider side.¹²⁷ Berenson et al. and Frakt also observe increased negotiation power of the provider

side.¹²⁸ Many see a further consolidation of the health insurer side as necessary to create a countervailing power to the provider side. But, as Berenson et al. note, the more concentrated the health insurer market, the less the need of insurers for hard negotiations, since they can more easily pass costs along through higher premiums.¹²⁹

Another example for provider negotiating power is the discussion about cost shifting. Some contend that providers react to cost-containment by government payers by shifting costs to commercial payers. The evidence for this is mixed,¹³⁰ and health economists are skeptical since cost-shifting means that providers left money on the table before. But no matter if the observed phenomenon is cost-shifting or “mere” price discrimination—either can only occur when providers have excess market power. And either lead to inefficient market results: “This situation has resulted in an opaque system in which payers with market power force weaker payers to cover disproportionate shares of providers’ fixed costs [...] or providers simply succeed in charging higher prices when they can.”¹³¹ It also means that competitive pressures that usually ensure that production efficiencies get passed through to consumers do not apply here. And, finally, it impedes cost containment: “If the United States, like many other countries, were able to marshal the power of purchasers, it would be in a much stronger position to control spending.”¹³²

RATE SETTING IN GERMANY

Physician Payment in Germany

The relationship between sickness funds as payers of health care and providers is mostly based on collective contracts between sickness fund associations and provider associations, mostly on the regional level. Sickness funds have the possibility for selective contracting in the area of integrated care and general practitioner-centered care (gatekeeping) models.

Outpatient and inpatient care are strictly separated in Germany. Outpatient care is provided by office-based physicians. This includes specialist outpatient services provided by office-based specialists, who are different persons than those specialists providing inpatient services in hospitals. Most physicians (two-

thirds) work in solo practice. Since 2004, it is possible to establish multi-specialty group practices (*Medizinische Versorgungszentren – MVZ*) with salaried physicians. The current government restricted the establishment of MVZ, but existing facilities may remain. Currently, there are 1,654 MVZ with a total of 8,610 physicians.¹³³

Patients have a free choice of physician (except when enrolled in a GP-centered care model). There is a consultation fee (*Praxisgebühr*) of €10 (\$13), payable once per quarter. If a patient visits a specialist without referral, an additional consultation fee of €10 incurs. This gives a weak financial incentive to seek a referral before consulting a specialist. The effects of the consultation fee on utilization have been very limited.¹³⁴

Physician payment is effected in two steps. All physicians offering services to statutory health insurance member are organized in Regional Physician Associations at *Bundesland* (state) level. Sickness funds contract with the Regional Physician Associations and not with individual physicians. Payments are capitated, reflecting the risk structure of the plans. Capitated payments cover all necessary services. So the sum of capitation payments from sickness funds constitutes the regional budget for physician payments (*Gesamtvergütung*). Annual increases are negotiated between the Regional Physician Associations and their regional sickness fund counterparts. Increases are to reflect changes in morbidity. For the years 2011 and 2012 the government restricted the increases to 1.25 percent by law as part of a cost containment package.

Individual physicians bill their Regional Physician Association for the services provided. It is a fee-for-service (FFS) system based on a relative value scale. The FFS scale includes some bundling over time. For general practitioners (GPs), basic services are covered by a quarterly attendance fee, with only limited possibilities for billing extra services. About 70 percent of GP income derives from these capitation-style payments within the FFS schedule. For specialists it is more strictly FFS.

The challenge for the Regional Physician Associations is to keep the amount of services billed

by physicians within the overall regional budget. For this a volume control mechanism applies. Every practice is allotted an allowed volume of services, the so-called standard service volume (SSV). With this the overall budget is broken down to every individual practice. The SSV for a practice is calculated as the case value of the specialty multiplied by the number of cases, again multiplied by an adjustment factor for the age structure of patients. Physicians get full payments (reference conversion factor) for volume within the SSV and reduced payments (reduced conversion factor) for volume exceeding the SSV. To be able to apply the system, Regional Physician Associations must hold back a portion of the overall budget in order to be able to pay for volume exceeding the SSV. Some physician services such as preventive services are excluded from the overall budget. No volume limits apply to these.

Physicians bill patients covered by private insurance directly based on a separate payment schedule (*Gebührenordnung für Ärzte – GOÄ*) set by government ordinance. A limited amount of differentiation comes through the level of conversion factor accepted by different insurances. The GOÄ is set as government ordinance.

Total physician income (pre-tax) in Germany was €142,000 (\$195,000) in 2007. Of this, €100,800 derives from statutory insurance. So even if privately-insured constitute only 10 percent of patients, they contribute 30 percent to income. The range of total income was from €116,000 for general practitioners to €264,000 for radiologists.¹³⁵

Hospital Payment in Germany

There are public, private for-profit, and private not-for-profit hospitals in Germany. The number of hospitals is evenly distributed between the three types of ownership, but about half of the bed capacity is in public hospitals and only 16 percent in private for-profit hospitals. Public hospitals tend to be larger than other hospitals, but for financial reasons many municipalities are selling their hospitals to private for-profit chains, so their market share is rising. In theory, every patient is restricted to one of the two nearest suitable hospitals, but in practice there is free choice.

Hospitals are paid by a DRG system, a severity-adjusted case-based payment system similar to the Medicare Prospective Payment System (PPS) in the United States.¹³⁶ A relative cost weight is assigned to every DRG. Germany's DRG system contains a readmission clause. If a patient is readmitted with the same principal diagnosis within thirty days, no extra payment will be made. The conversion factor is set at the state level, but convergence on a national conversion factor is planned. DRG payments cover the running costs of hospitals. Capital expenditure is financed by separate grants from state governments. Certain services, mostly new and innovative activities, are excluded from the DRGs and paid separately.

The DRG system gives fixed prices to all services. But there still remains a system of volume control. Sickness funds negotiate with every hospital a prospective hospital budget, containing volume, severity, and kind of services. The hospitals then bill every case according to the DRG schedule. After the year has ended, actual services provided are compared to negotiated services. If the hospital has exceeded its budget, it will have to refund between 35 and 75 percent of the surplus revenue. If the hospital stays below its budget it receives 25 percent of savings.

CONCLUSIONS

Containing health care expenditure is an existential challenge to governments. Health expenditure has become a major liability for public finances. Not only health care expenditure has risen, so has the exposure of the federal budgets both in Germany and the United States. In the United States, the direct exposure to rising expenditure in the public programs has been supplemented by an indirect exposure to the expenditure rises in the commercial market. The mechanisms for this are twofold: First, Medicare and Medicaid cuts will lead to an increasing gap between the reimbursement rates to providers paid by government programs compared to commercial insurers. Without including commercial insurers in cost-control efforts this will lead to increasing access problems. Second, the ACA provides for premium subsidies to keep commercial insurance affordable. Rising premiums in the commercial market will therefore mean an increasing burden on the federal budget.

In Germany, SHI expenditure was traditionally dealt with by separate contribution-financed budgets. But with a federal tax subsidy and premium subsidies, this separation has ended. The federal budget is also exposed to the unfettered rise in the private insurance markets: About half of the members of private insurers are civil servants who get 50 percent of the expenditure reimbursed from the state.

Germany has performed better both on the level as on the growth rate of health expenditure. The main reason for the differences seems to lie in the level of prices. The United States has the more parsimonious level of utilization. But this is more than compensated by prices. But not only the level of prices is surprisingly high; the divergence of prices paid or charged for the same service is surprising and not explainable

as outcome of competitive processes. The fragmented payer side in the U.S. is not marshaled as countervailing power to a consolidated provider side.¹³⁷

Cost containment is not an end in itself. Its rationale is that the market left to itself is not able to control costs and put appropriate pressure on providers. It is too easy for payers to pass on higher costs as higher contribution rate (in Germany) or as higher premium to employers (in the U.S.). But providers have an entitlement to adequate payments for their services. The question is if there is enough room for improvements through better care management and a more evidence-based use of services. Otherwise, public finances can only be improved by rationing health care. But encouraging signals come from the analysis

Box 4. Geographical Variation in Health Expenditure

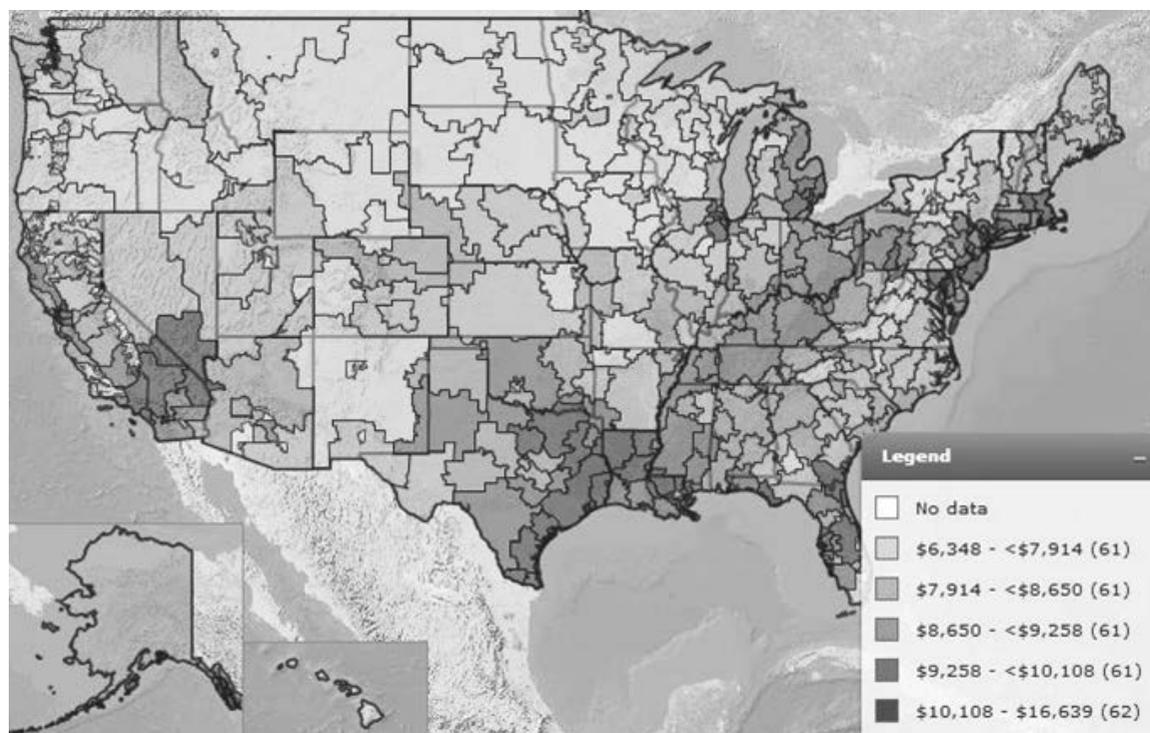
It is a well-known fact that health care expenditures show a large regional variation. In the United States these variations have been documented by the Dartmouth Atlas of Health Care for almost forty years.¹³⁹

The variations in health expenditures, procedures, etc. are enormous. Not all variation is bad, however. Variations caused by differences in the populations due to morbidity, medical evidence, and patient preferences are generally seen as desirable. According to the Congressional Budget Office (CBO), 30 percent of the variation in Medicare spending is due to differences in input prices and 20 percent due to differences in health status.¹⁴⁰ An earlier MedPAC study came to the conclusion that 40 percent of variation can be explained by prices, age, and health status. A further 35 percent is explainable through further demographics, uninsurance, and supply conditions.¹⁴¹ So, overall, health status can be seen to explain 30 to 45 percent of regional variation in Medicare spending.¹⁴² But that still leaves over half of the variation unexplained.¹⁴³ Figure 6 shows the variation of Medicare spending at the hospital referral region level after controlling for differences in age, sex, and race. Per capita expenditure ranges from \$6,348 to \$16,639.

Furthermore, higher expenditure at the regional level is not correlated with better health outcomes. In some cases there even may be negative correlations.¹⁴⁴ It has been concluded from this that health care expenditure in the United States could be reduced by 30 percent without loss of quality.¹⁴⁵ There are also critical viewpoints. Bernstein et al. argue that “[t]he best available research does not provide a solid basis for drawing conclusions about how much of the variation in Medicare spending across localities reflects inappropriate or inefficient spending.”¹⁴⁶ Anyway, achieving those reductions will not be easy. Low expenditure areas will have differences in organization care and probably differences in the culture of performing care, too. Just reducing expenditure in high cost areas without changing organization and culture will lead to inferior results.¹⁴⁷

Regional variation in health care expenditure is not only restricted to traditional Medicare. It can be observed (to a lesser extent) in Medicare Advantage,¹⁴⁸ the commercial health insurance market,¹⁴⁹ and even in the centrally-budgeted Veterans’ Administration system.¹⁵⁰ Regional variation is also a topic in Germany’s statutory health insurance system.

Figure 6: Medicare Reimbursement Adjusted for Age, Sex, and Race per Enrollee 2009



Source: <http://www.dartmouthatlas.org>

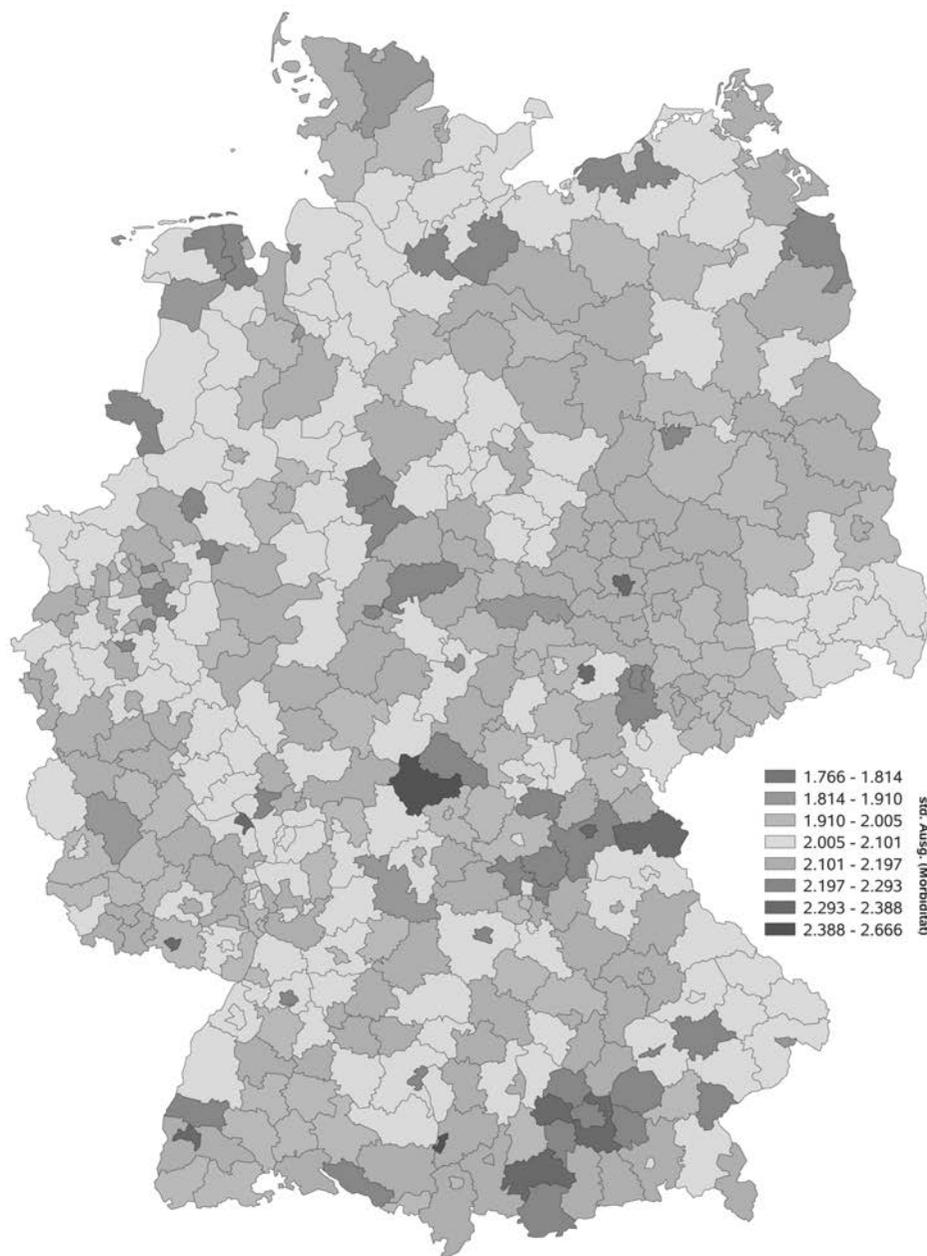
of regional variations in health expenditure. In both countries there are huge variations in expenditure levels that cannot be explained by differences in need. Higher expenditure is also not correlated with better health outcomes (see Box 4). Therefore:

“Evidence regarding regional variations in spending and growth, however, points to a more hopeful alternative [to rationing]: we should be able to reorganize and improve care to eliminate wasteful and unnecessary services.”¹³⁸

Annual per capita expenditure in the SHI at the county level ranged from €1,718 to €2,735. Expenditure level and range are significantly lower than in Medicare, but it has to be borne in mind that Medicare serves a population of over 65 year olds, whereas the German SHI serves 90 percent of the population and therefore all age groups. Age and sex alone account for about 30 percent of this variation. Controlling additionally for health status, about 44 percent of vari-

ation can be explained.¹⁵¹ Further socio-demographic variables are shown to have on a limited influence on the remaining variation. This leaves about the same level of unexplained variation in health expenditure as in the United States (see Figure 5). A certain amount of the remaining variation can be attributed to differences in medical supply.

Figure 7: German SHI Per Capita Expenditure Adjusted for Age, Sex, and Health Status



Source: Dirk Göppfarth, "Regionalmerkmale im Risikostrukturausgleich. Ein Beitrag zum funktionalen Wettbewerb und zu bedarfsgerechter Versorgung?" in *BARMER Gesundheitswesen aktuell 2011* [Beiträge and Analysen], edited by Uwe Repschläger (Wuppertal: Barmer GEK, 2011), p. 16–40.



FINAL CONCLUSIONS

04

FINAL CONCLUSIONS

“There are no silver bullets”

There is no easy solution to the health care conundrum. No health care system is clearly superior to another health care system. In an extensive review of different health care systems and their performance the OECD came to the conclusion that “it may be less the type of system that counts but rather how it is managed.”¹⁵² In all systems it is the minutiae of regulation that decide over the overall performance of the system.

There is also no perfect payment system. All payments systems have their advantages and disadvantages. Pay-for-performance seems good in theory, but weak in practice. Bundled payments may lead to better coordination and integration of care, but maybe only to more bundles. Even capitation, often seen as the optimal payment system, has its drawbacks. Capitation does not solve the difficult problems of pricing and incentives, but makes these problems someone else’s problem. Germany’s Regional Physician Associations are the most obvious example. Payment by sickness funds are capitated. Sickness funds therefore are not concerned about how individual physicians are paid. But the Regional Physician Association has the problem of payment, volume control, and incentives.

The Need to Balance Competition and Cooperation

On both sides of the Atlantic, health care systems are based on competition not only between providers for patients, but also between payers (health plans or sickness funds). The belief is that competition makes insurers managerial efficient, responsive to customer needs, and cost conscious. The payers are therefore

to be made the prudent purchasers of care, maximizing the value of services (i.e., the relation of outcome to costs) for their members. This concept is often called “managed competition.”¹⁵³

There is no empirical proof that this proposition works.¹⁵⁴ Enthoven himself tried to implement managed competition in Stanford University’s health insurance program, only to see a rapid premium increase.¹⁵⁵ In an overview of the literature, the Congressional Budget Office came to the conclusion that “there is insufficient evidence to conclude that managed competition can reduce the growth of health care costs.”¹⁵⁶

But choice of health plan has been shown to be important,¹⁵⁷ and the idea of value-based purchasing is the best hope for controlling health expenditure. Orszag distinguishes four approaches to cost control. Reducing payments to providers helps only in the short run; direct rationing would be unacceptable in the United States; consumer-directed health care disregards the fact that most expenditure is incurred by few patients who will always have massive third-party coverage; leaving the provider-value approach.¹⁵⁸

Neither the situation in the United States nor in Germany complies completely with the model of managed competition. Whereas Germany stresses too much the “managed” component, not leaving enough room for competition, the United States focuses too much on competition, disregarding the need for managing competition. The result is procrastination in Germany, and fragmentation in the United States. The result is what Michael Porter calls zero-sum competition:

“In health care, not all forms of competition are alike. In many countries, actors engage in ‘zero-sum’ competition. This is competition that shifts revenue and costs from one party to another or restricts services rather than creating value for patients. Zero-sum competition is manifested in the use of bargaining power, selective contracting, price discounting, and restricting choice instead of harnessing informed choices to improve the outcomes and efficiency of care.”¹⁵⁹

Managed competition is not a free market. It is based on a balance between cooperation and competition. Actually, in his 1993 paper, Enthoven argued for “as much standardization as possible,” on the grounds standardization actually increases competition by creating transparency and facilitating comparisons. As has been shown in this Policy Report, there are weighty arguments for standardization of price and quality metrics, and probably even for setting some reference price level. In a multi-payer environment only this can lead to an impact on provider behavior. Plan competition should be geared toward piloting new forms of care delivery and reimbursement, instead of negotiation volume discounts (on prices marked-up by the providers beforehand).

But standardization can go too far, as the German example demonstrates. Plans need the instruments to compete and influence delivery models. The system needs to retain the ability to innovate and experiment. The recent trend in Germany has been toward selective contracting as alternative to collective contracts. But this will fragment the system in a way that will lead to the defects seen in the United States. Instead, collective contracts should be limited to price and quality metrics, and possible reference levels—on the principle of “measuring jointly, contracting individually.”

Importance of Data

Data has been the most important driver of reform. Those institutions that have a reputation for high quality have used their data to analyze and continuously improve performance.¹⁶⁰ But for providers the data usually ends when the patient leaves the hospital or surgery door. To improve provider performance it would be important to be able to see the complete

continuum of care and to see survival rates after two years, or so. Therefore, the data should be population-based and come from all payers. Some U.S. states have already set up all-payer claims databases.¹⁶¹

Every organization should be able to receive the data it needs to act upon. Today the environment is too much affected by every institution trying to keep its data proprietary. Instead, a culture of sharing data should be established. An idea would be keeping the data at a fiduciary institution and enabling all institutions access to certain components with regard to their functions and under consideration of privacy concerns. To be of use in improving care, the data should be available in real time.

NOTES

- 1 The Patient Protection and Affordable Care Act (PPACA) was enacted on 24 December 2009 and 21 March 2010 by the U.S. Senate and House of Representatives, respectively, and signed by President Obama on 23 March 2010. Many provisions were subsequently changed by the Health Care and Education Reconciliation Act (HCERA), enacted on 26 March and signed on 30 March 2010. In the following, ACA refers to the PPACA as changed by HCERA.
- 2 Gesetz zur Stärkung des Wettbewerbs in der gesetzlichen Krankenversicherung of 26 March 2007.
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- 4 E.g., David M. Cutler and Richard Zeckhauser, "The Anatomy of Health Insurance," in *Handbook of Health Economics*, Volume 1A, edited by Anthony J. Culyer and Joseph P. Newhouse (Amsterdam: Elsevier/North-Holland, 2000), p. 563–643.
- 5 There were actually three cases: Department of Health and Human Services v. Florida (Docket No. 11-398), National Federation of Independent Business v. Sebelius (Docket No. 11-393), and Florida v. Department of Health and Human Services (Docket No. 11-400).
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- 8 Steven G. Bradbury, Steven A. Engel, Michael H. Park, and Elisa Wiygul, Brief for Amici Curiae Economists in Support of Respondents Regarding Individual Mandate. U.pp. Supreme Court, Department of Health and Human Services et al. v. State of Florida et al. Docket No. 11-398, http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs/11-398_respondents_amcu_economists.authcheckdam.pdf, p. 28
- 9 Ibid., p. 30
- 10 Ibid., p. 32.
- 11 Dirk Göppfarth, (2012c): "US-Gesundheitsreform vor Gericht: Ökonomische Fragen spielen zentrale Rolle," *Gesundheitsökonomie und Qualitätsmanagement* 17:3 (2012), p. 14–16.
- 12 For a novel graphical exposition of the theory, see: Liran Einav and Amy Finkelstein, "Selection in Insurance Markets: Theory and Empirics in Pictures," *Journal of Economic Perspectives* 25:1 (2011), p. 115–138.
- 13 Amy Finkelstein, Kathleen McGarry, and Amir Sufi, "Dynamic Inefficiencies in Insurance Markets: Evidence from Long-Term Care Insurance," *American Economic Review* 95:2 (2005), p. 224–228
- 14 Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* 53:5 (1963), p. 964
- 15 David M. Cutler and Richard Zeckhauser, "Extending the Theory to Meet the Practice of Insurance," in *Brookings-Wharton papers on financial services, 2001*, edited by Robert E. Litan and Richard Herring (Washington, DC: Brookings Institution Press, 2004), p. 1–53; Amy Finkelstein, Kathleen McGarry, and Amir Sufi, "Dynamic Inefficiencies in Insurance Markets: Evidence from Long-Term Care Insurance," *American Economic Review* 95:2 (2005), p. 224–228.
- 16 See John E. McDonough, *Inside national health reform* (Berkeley, New York: University of California Press; Milbank Memorial Fund, 2011), p. 41, 120; Conrad F. Meier, *Destroying Insurance Markets. How Guaranteed Issue and Community Rating Destroyed the Individual Health Insurance Market in Eight States* (Chicago: Council for Affordable Health Insurance; The Heartland Institute, 2005); Ian Millhiser, *What Happens If the Individual Mandate Is Struck Down?* (Washington, DC: Center for American Progress, 2012); and Alan C. Monheit, Joel C. Cantor, Margaret Koller, and Kimberly Fox, "Community rating and sustainable individual health insurance markets in New Jersey," *Health Affairs* 23:4 (2004), p. 167–175.
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