



C H A P T E R 5

HEALTH CARE REFORM

On March 23, 2010, President Obama signed into law landmark legislation that extends health insurance coverage to millions of uninsured Americans, ensures the security and affordability of coverage for many more, and reduces the Nation's budget deficit. The Affordable Care Act is the latest chapter in nearly a century-long history of efforts to ensure comprehensive health insurance coverage for more Americans.¹ At the same time, the new law marks an important new chapter in the quest for high value in health spending. For decades, the policy problem posed by millions of uninsured Americans has overshadowed the underlying economic challenge of how to control health care costs while preserving the high quality of the American medical care system. In addition to extending coverage to the uninsured and reforming insurance markets to ensure that Americans with pre-existing conditions have access to affordable coverage, the Affordable Care Act introduces a framework for moving the medical care system toward higher-value care.

Broadly, the Affordable Care Act controls costs and improves quality by strengthening physician and hospital incentives to improve the quality of care and provide care more efficiently. These delivery system reforms are paired with coverage reforms that create new coverage options through competitive state marketplaces for insurance, ensure access to affordable coverage through the provision of tax credits for small businesses and individuals, and put in place individual and employer responsibility requirements. Over the next decade, these reforms are expected to expand coverage to 32 million Americans, make health care more affordable, and improve the quality of care.

¹ We use the term "Affordable Care Act" to mean the Patient Protection and Affordable Care Act (P.L. 111-148, enacted March 23, 2010) and the provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152, enacted March 30, 2010) that are related to health care.

Many reforms that afford significant protection to consumers have already taken effect (Box 5-1). These reforms, in conjunction with those that will go into effect in a few years' time, provide Americans with unprecedented security, giving individuals and families freedom from worry about losing their insurance or having their coverage capped unexpectedly when they are sick. The Affordable Care Act also represents a significant tax cut for individuals and businesses purchasing health insurance; already, many small business owners who provided insurance to employees in 2010 are eligible for tax credits to offset the cost of this coverage, helping them make new hires and strengthening our economy. Beginning in 2014, additional tax credits for individuals and households will help millions of middle-class Americans afford health insurance. As a result of the Affordable Care Act, 1.2 million young adults up to age 26 now qualify for insurance under their parents' health plans. The Affordable Care Act also provides new benefits to America's seniors, improving the coverage of preventive care in Medicare and lowering the cost of prescription drugs under Medicare Part D by closing the "donut hole."

The Affordable Care Act is also fiscally responsible. The Congressional Budget Office has estimated that the law will reduce projected deficits by \$230 billion during 2012–21 and by more than \$1 trillion in the subsequent decade. The Affordable Care Act improves the financial status of the Medicare program by extending the solvency of the Hospital Insurance Trust Fund by 12 years. It provides unprecedented new authorities for fighting fraud, thus potentially returning hundreds of millions of dollars to the Medicare trust funds.

This chapter offers an economic analysis of how the Affordable Care Act will achieve the long-run goals of expanding coverage and making health care affordable once its major provisions take effect in 2014. The discussion is not meant to be exhaustive, and it necessarily excludes many parts of the law.² The focus is on the major provisions to promote value in the delivery of medical care and to expand insurance coverage. The measures aimed at controlling costs focus on promoting the provision of high-value medical care and improving the quality of care provided. Measures that expand coverage rely primarily on private markets. In both areas—controlling costs and expanding coverage—the discussion highlights the imperfections in markets for medical care and health insurance that are addressed by the Affordable Care Act. The aim is to explain how these policies work with, rather than against, the underlying economic forces that drive consumers and firms.

² Significant investments in health care workforce development and in community health centers are just a few important elements of the reform bill that this chapter does not discuss.

Box 5-1: Early Provisions of the Affordable Care Act

Although some of the Affordable Care Act's major provisions—such as the Health Insurance Exchanges and health insurance premium tax credits for individuals and families—do not go into effect until 2014, many provisions take effect much sooner, expanding coverage and making care more affordable.

Effective within 100 days of enactment

- The **Pre-Existing Condition Insurance Plan** provides coverage to individuals with pre-existing conditions who would otherwise be unable to obtain coverage.
- The **Early Retiree Reinsurance Program** helps employers with the cost of providing health insurance coverage for early retirees with unusually high medical spending.
- Rebate checks for \$250 go to eligible beneficiaries to help **close the Medicare Part D coverage gap (the “donut hole”)**. The donut hole will be eliminated entirely by 2020.
- A Web portal—www.HealthCare.gov—enables consumers to search for the best plan for their needs at the lowest cost.
- A **Small Business Health Care Tax Credit** offsets the costs of offering health insurance for small firms with low-wage workers (applies to tax years beginning on or after January 1, 2010).

Effective for insurance plan years beginning six months after enactment

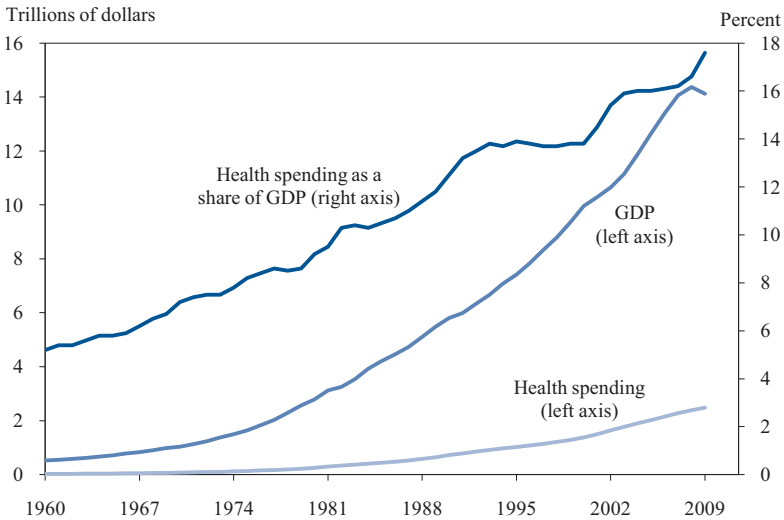
- **Consumer protections** prohibit insurance industry practices such as rescinding coverage, imposing lifetime caps on benefits, imposing unreasonable annual dollar limits on essential health benefits, and denying coverage for children based on pre-existing conditions.
- Private insurance plans covering dependent children must provide **coverage for adult children up to age 26 on a parent's plan**.
- New private insurance plans must provide **100 percent coverage with no additional out-of-pocket costs for preventive care and medical screening**, such as smoking cessation programs and blood pressure screening in adults, given an A or B rating by the U.S. Preventive Services Task Force.

ADDRESSING THE RISING COST OF MEDICAL CARE

Trends in Aggregate Health Spending

Health care spending has increased dramatically over the past half-century, both in absolute terms and as a share of gross domestic product (GDP) (Figure 5-1), placing increasing pressure on household finances, government budgets, and businesses' bottom line. Total spending in the U.S. health care sector was \$2.5 trillion in 2009, representing 17.6 percent of GDP—almost twice its share in 1980.

Figure 5-1
GDP and Health Spending



Sources: Centers for Medicare and Medicaid Services, National Health Expenditure Accounts; Bureau of Economic Analysis, National Income and Product Accounts.

These trends have given rise to concern that the Nation cannot sustain such high spending growth and must “bend the curve” of health spending. The challenge is to do so by transforming the Nation’s health care system so that it rewards providers for delivering high-quality, high-value care and discourages the provision of low-quality, low-value care. Meeting that challenge is a much more complex task than simply slowing the growth of spending, but the benefits of a system that delivers high-value care are much greater than the benefits of one that simply delivers low-cost care.

Technological Change and Increases in Health Spending

Most health economists agree that increases in health spending are driven largely by the breathtaking pace of technological innovation in health care. The question is whether the benefits of these new technologies are worth their high cost. Economists have thought about that question in two different ways and have generally concluded that these technological breakthroughs are absolutely worth the cost.

The first approach is to estimate directly the costs and benefits associated with increases in health spending. Recent economic analyses of this kind confirm that the advance of technology in medicine is indeed “worth it” in terms of health benefits provided (Cutler and McClellan 2001; Cutler, Rosen, and Vijan 2006). Murphy and Topel (2006) estimate that discovering a cure for cancer, for example, would be worth about \$50 trillion; a breakthrough that lowers cancer mortality permanently by even 1 percent would be worth almost \$500 billion.

A second approach involves opportunity costs: what are we giving up to be able to spend so much on medical care? In this context, it is important to keep in mind that spending on health has risen during a period of overall economic growth. Health may be a “superior good” in the economic sense that as GDP rises, more and more resources go to health because other material needs are largely satisfied. Hall and Jones (2007) use a personal analogy: “[A]s we get older and richer, which is more valuable: a third car, yet another television, more clothing—or an extra year of life?” In fact GDP has grown so much over the past 50 years that increases in health spending, as large as they have been, have generally not reduced spending on nonhealth items. Rather than falling, real per capita spending on all nonhealth items more than doubled between 1960 and 1999 (Chernew, Hirth, and Cutler 2003).

Market Imperfections and Increases in Health Care Spending

Although increased spending on health delivers tremendous benefits on average, some medical spending is almost certainly of low value. Economists often attribute some of this low-value spending to a phenomenon known as moral hazard: at the point of service, most insured consumers pay only a fraction of the cost of their care, which gives them reason to opt for more, and sometimes less effective, care than they would choose if they were paying the full cost themselves. Unavoidably, the protection that insurance affords households against the risk of catastrophically high medical spending carries with it the “side effect” of some unnecessary spending (Pauly 1968).

The market for medical care also suffers from multiple information problems that contribute to rising costs. The first is incomplete information: simply put, there is considerable uncertainty for all—patients and providers alike—about the effectiveness of different medical treatments. And information in the medical care market is not only incomplete but also asymmetric. Patients know much less than providers (doctors and hospitals) do about what treatment is appropriate for a particular condition. Third-party payers such as insurance companies and state or Federal Government programs are also at an informational disadvantage relative to providers. These information asymmetries give rise to a principal-agent problem in which the less-informed party or “principal”—in this case, either the patient or the third-party payer—would like to hire the better-informed party or “agent”—in this case, the provider—to provide treatment but cannot be sure what to ask the provider to do or how much the provider should be paid. The result is that some health spending yields low value.

According to economic theory, one way to mitigate the principal-agent problem is to structure incentives so that it is in the interest of the agent to do what is best for the principal. Commissions, for example, give sales associates an incentive to work hard in situations where a supervisor might not be able to monitor their effort directly. In medical care, the challenge is to design payment mechanisms that reward providers for delivering high-quality, high-value care and discourage them from providing low-quality, low-value care while continuing to ensure that patients have control over their care and are never denied the care they need, expect, and deserve. As noted, the task is much more complex than simply reducing spending, but the potential benefits of having a system that delivers high-value care are tremendous.

How the Affordable Care Act Promotes High-Value Medical Care

Designing reimbursement systems that reward high-value care, discourage low-value care, and put patients in control represents a key challenge for reform. In addition, what may be high-value care for one individual may not be for another, because the efficacy of treatments may vary with an individual’s characteristics. Rather than imposing a single solution to promoting high-value care—one that might get it wrong—the Affordable Care Act approaches the task from three different directions to create the conditions under which the right answers will emerge. It invests in better information about what treatments work best, while ensuring that all treatment options remain available to patients. It experiments with new approaches to delivering and paying for care. And it empowers patients to make informed decisions about their providers and their care.

Better Information about What Works: The Patient-Centered Outcomes Research Institute. The Affordable Care Act supports research through a private, not-for-profit Patient-Centered Outcomes Research Institute, governed by a multistakeholder group and expert advisory panels, whose task is to identify priorities for research. The Institute will continue the work of the Federal Coordinating Council for Comparative Effectiveness Research created by the American Recovery and Reinvestment Act in February of 2009. The Institute’s research findings cannot be used to mandate coverage or reimbursement policy. The information the findings provide will enable patients, providers, employers, and insurers to choose high-value care.

New Approaches to Delivering and Paying for Care. The Affordable Care Act includes a host of new programs and demonstration projects designed to identify effective ways to encourage the provision of high-value care. Two illustrative examples are “bundled payments” and a delivery system reform that reduces hospital-acquired conditions.

Bundled payments are one-time reimbursements to providers for the costs of treating a patient’s condition across multiple settings. For example, the hospital, the cardiologist, the primary care physician, and any other caregiver for a patient undergoing coronary artery bypass graft surgery would receive one payment. Bundled payments create incentives for providers to coordinate care and keep to a minimum any treatments that are of little or no value. Providers who keep patients healthy, and thus spend less, make a profit, and those who spend more lose money. The approach builds on the success of Medicare’s inpatient prospective payment system, introduced during the 1980s, which has been adopted by many private insurance companies.

Hospital-acquired conditions (HACs) are generally avoidable health problems caused by medical treatment; they are considered indicators of poor-quality care. Examples include surgical site infections and urinary tract infections associated with catheters. Since 2008, Medicare has not reimbursed most hospitals for costs associated with treating these conditions in hospitalized patients. The Affordable Care Act increases the incentive to prevent these conditions by reducing Medicare reimbursement for *all* conditions in hospitals that have high rates of HACs and by extending the nonpayment policy to the Federal share of the Medicaid program. These changes will reduce Federal health spending through Medicare and Medicaid and will provide a roadmap to reduced spending for private insurers and employers. They also create a high-powered incentive for hospitals to prevent these conditions in the first place. The result—lowering spending *and* improving patient outcomes—is a classic win-win solution.

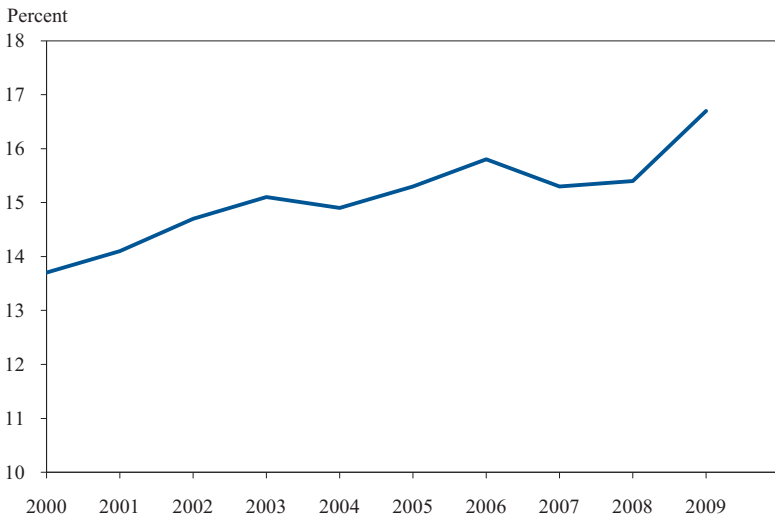
Bundled payments and nonpayment for HACs are just two examples of Affordable Care Act delivery system reforms that will result in higher value for patients; other promising reforms include Accountable Care Organizations and a program that reduces Medicare payments to hospitals with relatively high rates of preventable readmissions. In this same area, the Affordable Care Act also establishes the Center for Medicare and Medicaid Innovation (also known as the Innovation Center), which will identify, test, disseminate, and evaluate new models of delivering and paying for care. The Innovation Center will ensure that Medicare and Medicaid have the flexibility to test new incentive and delivery systems to keep pace with technological innovation in medical care. It will also seek to enlist the participation of private third-party payers to align provider incentives and accelerate the adoption of successful delivery system models.

Better Information on Provider Quality. One more way to drive the system to high-value care is to empower patients with better information on provider quality. The Affordable Care Act creates a quality-reporting program for physicians that will collect performance data on physicians who participate in Medicare and publish it on a Web site similar to the existing Hospital Compare and Nursing Home Compare Web sites. Research has shown that quality report cards influence consumer choice in health care and lead to higher-quality care (Bundorf et al. 2009; Mukamel et al. 2008; Werner, Stuart, and Polsky 2010). Reimbursement mechanisms that explicitly reward quality will be reinforced by patients “voting with their feet” in response to information on the quality of their providers.

IMPROVING THE HEALTH INSURANCE MARKET

The ranks of the uninsured have grown steadily in the United States over the past decade, as shown in Figure 5-2. Almost 51 million Americans—16.7 percent of the population—lacked health insurance coverage in 2009 (DeNavas-Walt, Proctor, and Smith 2010). An increasing body of credible evidence has documented that being uninsured has negative consequences for health, access to medical care, and financial security (Asplin et al. 2005; Card, Dobkin, and Maestas 2009; Cooke, Dranove, and Sfekas 2010; McWilliams et al. 2004). The failure of the United States—unlike other industrialized nations—to ensure access to basic care for all its citizens, together with our Nation’s continuing mediocre record on measures such as life expectancy and infant mortality, compared with other industrialized nations, has made the need for reform increasingly urgent.

Figure 5-2
Percent of Americans Uninsured



Source: DeNavas-Walt, Proctor, and Smith (2010).

Problems in the Market for Health Insurance

Complicating the policy problem posed by the many uninsured Americans are long-standing market failures in the individual and small group health insurance markets. The most important such market failure is adverse selection. In the context of health insurance, adverse selection means that individuals or families with poorer health and thus high expected medical spending are more likely than their healthier counterparts to buy coverage at a given price. The selection of more high-cost people into coverage triggers a vicious cycle. To cover the health needs of this costly group, the insurer raises the premium, generating still more adverse selection into coverage. In the extreme case, the market simply does not function. In practical terms, some people are uninsured because the only policies available to them do not seem to be a good deal (although they might be a good deal for someone in worse health). Many more people pay higher prices than they should in order to get coverage at all.

A second failure contributing to dysfunction in health insurance markets is the problem of missing markets; in particular, there is no market for multiyear health insurance contracts that would protect individuals throughout their lives from the risk of becoming sick and having to pay much higher insurance premiums or lose their coverage altogether. The missing market problem contributes to multiple inefficiencies. Individuals

with high medical spending may be “locked in” to a policy for fear that their premiums will increase if they change their coverage, particularly in the individual market. The decision not to seek new coverage may reduce competition in health insurance markets. Labor markets too suffer negative consequences when workers who want to change jobs—especially entrepreneurs who want to start new businesses—stay in their old jobs for fear of losing insurance.

Health insurance markets are also characterized by the high search costs they impose on consumers. Largely unaided, consumers must gather and evaluate comparative information about the prices and quality of an array of complex health insurance plans. The high cost of conducting that search reduces competition and may result in prices that are higher than the competitive level. One effective way to reduce search costs is through information systems that assist consumers in comparison shopping. In the market for life insurance, for example, greater use of price comparison Web sites has led to substantial reductions in premiums and gains in consumer surplus (Brown and Goolsbee 2002). For reasons that are not entirely clear—but may be related to the multiple other market failures—health insurance markets have been slow to adopt these innovations.

Health insurance markets are also highly concentrated; in all but four states, the three largest insurers control half of the market or more (Robinson 2004). Such concentration raises the possibility that insurers may have market power to set prices above the competitive level, and recent evidence suggests that increased concentration leads to higher premiums, consistent with that possibility (Dafny, Duggan, and Ramanarayanan 2010).

A final market failure is the “Samaritan’s dilemma”; because hospitals and other health care providers offer charity care, some people do not purchase insurance (Coate 1995). Indeed, multiple studies document that the availability of charity care reduces the rate of private insurance coverage, suggesting that there is some “free riding” on the system (Herring 2005; Rask and Rask 2000).

How the Affordable Care Act Addresses the Insurance Market Failures

Exchanges. The Affordable Care Act extends insurance coverage to the uninsured and makes insurance markets work more effectively for those who already have coverage. To achieve these goals, it establishes Health Insurance Exchanges, organized marketplaces in every state that enable individual consumers without access to affordable employer-sponsored coverage to shop easily for coverage and receive any tax credits or reduced cost-sharing for which they are eligible. The Affordable Care Act also establishes Small Business Health Options Program (SHOP) Exchanges, similar

marketplaces in each state for small group coverage. Private insurance companies will offer plans for sale through the Exchanges beginning in 2014. Beginning in 2017, states can choose to expand their Exchanges to larger employers as well.

Minimum Benefits and Coverage Tiers. Every plan available in these marketplaces must include a specified set of minimum essential benefits and will be categorized as platinum, gold, silver, or bronze depending on the extent of consumer cost-sharing. For platinum coverage—the most comprehensive—on average, consumers will pay only 10 percent of the cost of covered services as cost-sharing at the point of service. Consumers who choose this option can expect to pay a higher premium up front for the increased cost-sharing protections. The next three types of coverage—gold, silver, and bronze—feature progressively higher point-of-service cost-sharing corresponding to 20 percent, 30 percent, and 40 percent of the total cost of covered services. Consumers can expect to pay lower premiums up front for these categories of coverage, with bronze plans being the least expensive.

Online Choice Tools. Online tools will enable consumers to choose coverage based on the characteristics that are most important to them: premium costs, cost-sharing, or plan quality ratings, for example. The HealthCare.gov Web portal, which launched on July 1, 2010, is one such tool. Beginning in 2014, Exchanges will leverage these technologies to allow consumers to make informed choices among multiple plans. The Affordable Care Act has already provided states \$49 million in funding to plan and develop their Health Insurance Exchanges, including information technology systems that will enable consumers to search for plans that best suit their needs and preferences.

Tax Credits for Premiums. Beginning in 2014, individuals and families without access to adequate, affordable coverage will receive tax credits for premiums purchased in the Exchange. These tax credits, which are available to households with incomes between 100 and 400 percent of the federal poverty level, limit the amount that an individual or family must pay for health insurance coverage as a share of household income.³ The income share ranges from 2 percent for families at the low end of the eligibility threshold to 9.5 percent for those at the upper end. Some families eligible for a premium tax credit also receive cost-sharing assistance that limits their out-of-pocket spending at the point of service.

³ The Federal poverty level in 2011 is \$22,350 for a family of four living in the contiguous 48 states or the District of Columbia; 400 percent of the poverty level for such a family would be \$89,400.

Coverage Responsibility. Creating Health Insurance Exchanges and developing online choice tools are significant steps toward making individual and small group health insurance markets more competitive, transparent, sensible, and affordable. By themselves, however, these steps do not address the critical problem of adverse selection. Correcting that market failure requires changing the current practices of both insurers and consumers. To that end, the Affordable Care Act provides a new protection for consumers called “guaranteed issue,” which prohibits insurers from denying coverage to anyone who wants to buy it. The law also prohibits insurers from charging higher premiums for individuals in poor health. For their part, consumers who can afford coverage are required to have coverage or pay a penalty, except for specified exemptions such as individuals with religious objections. Any remaining incentives that insurers may have to try to attract healthier consumers will be offset through risk adjustment that transfers payments from insurers with relatively healthy enrollees to those with sicker enrollees. This framework largely solves the adverse selection problem.

Employers and the Affordable Care Act

Most employers already offer health insurance; 95 percent of employers with 50 to 199 employees and 99 percent of employers with 200 or more employees do so (Kaiser Family Foundation and Health Research and Educational Trust 2010). The Affordable Care Act imposes financial penalties of approximately \$2,000 per full-time worker on the very few employers with 50 or more workers who do not offer coverage if their workers obtain premium tax credits for the purchase of coverage in an Exchange. The first 30 full-time employees are exempt for purposes of this calculation. Fewer than 10,000 firms, or 0.2 percent of American businesses, are likely to be affected by the penalty. Small employers (those with fewer than 50 workers) face no such penalties. On the contrary, the Affordable Care Act includes a tax credit to help businesses with fewer than 25 full-time workers and average annual wages below \$50,000 afford health insurance for their workers, as described in Chapter 7. Together with the SHOP Exchanges described above, which allow small employers to join a larger pool of buyers and purchase coverage that has the same fair prices and low administrative cost that large employers have historically enjoyed, this tax credit will level the playing field for small and large employers in the area of health benefits.

Expanding Medicaid

In addition to expanding private coverage through the Exchanges, the Affordable Care Act expands public coverage. Specifically, it extends Medicaid eligibility to all individuals in families with incomes at or below

133 percent of the Federal poverty level. Expanding Medicaid eligibility provides a critical coverage option for the most economically vulnerable citizens. The Affordable Care Act also allocates resources to states to offset their added costs for newly eligible individuals (100 percent of the costs for the first three years, phasing to 90 percent permanently). The Administration has also proposed additional resources that will help states design and implement streamlined enrollment systems to make obtaining health insurance a seamless process.

CONCLUSION

In the end, the Affordable Care Act will benefit both those who now have health coverage and those who are uninsured. The more than 30 million uninsured Americans who will gain insurance coverage will reap the benefits of longer life and better health conferred by innovations in medical technology. The newly insured will also enjoy relief from the economic insecurity of lacking coverage; no longer will American families have to worry about being one illness away from bankruptcy. Americans who are now insured will benefit from lower premiums because they will no longer pay a “hidden tax” associated with the costs of providing uncompensated care to the uninsured. They will enjoy greater security of coverage because the law prevents insurance companies from canceling their coverage unexpectedly if they are in an accident or become sick. The insured will also be free from the worry that they will exhaust the limits of their coverage, because the new law prohibits annual and lifetime coverage limits. And the law ensures that they will have 100 percent coverage for important preventive care services with no additional out-of-pocket costs.

Insurance market reforms and the new Exchanges will make it possible for all Americans who lack access to employer-based insurance to obtain coverage, and thus feel greater economic security, during periods of labor market transition or instability. The Affordable Care Act will smooth the transition from school to work for young adults, who have historically been uninsured at very high rates. The law will also mitigate the consequences of job loss because losing a job will no longer entail losing all access to affordable insurance.

Moreover, the Affordable Care Act levels the playing field for small employers, who will be able to compete for workers by offering benefits that are comparable in price and generosity to those offered by large employers. Potential entrepreneurs will be able to pursue their dreams without having to worry about where they will get health insurance at a fair price, thus tapping new reserves of creativity for the American economy. And all

employers—large, small, and in-between—will benefit from reduced uncertainty about health spending as a result of the larger and more stable private insurance pool that the Affordable Care Act will create. Reforming insurance markets will transform American business in subtle but far-reaching ways, improving the bottom line for both workers and employers.

The benefits of delivery system reform will be even more widely shared. Improvements in health care quality, such as reductions in hospital-acquired conditions, should, within just a few years, yield measurable benefits that will touch the lives of most, if not all, Americans. The transition to a uniformly high-quality, high-value system of medical care will take longer, but by improving the quality and value of health care while freeing up resources that can be used for other productive purposes, will lay the foundation for future economic growth.