



The Simple Economics of Health Reform

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The Affordable Care Act (ACA) is the most important piece of health care legislation since the creation of Medicare and Medicaid. The ACA¹ touches every corner of the medical system, addressing issues ranging from how people get health insurance coverage, to what type of care they receive, to how that care is paid for. Its impact will be felt for decades.

The ACA was, and is, enormously controversial. It passed without any Republican votes, and with a mixture of public support and opposition. Republicans have vowed to

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repeal it and replace it with something smaller. Thus, the ACA itself may change, even as it changes the medical system.

Full disclosure: I am a proponent of the legislation. I worked to craft President Obama's health care proposal when he ran for President, and was senior health care advisor to his campaign. I continued to advise the Administration and Congress as the bill moved forward. By nature, therefore, this article will highlight more of the ACA's good features than its bad.

Two features of the ACA have particular economic salience: (1) taking steps to insure all Americans and regulating insurance companies so that can happen; and (2) reforming the financing and delivery of medical services. Here, I address each issue in turn.

INSURANCE COVERAGE AND REGULATION

An estimated 47 million people in the United States lack health insurance coverage, and without reform, that figure was projected to rise to 54 million by 2019.² The first goal of the ACA is to extend insurance coverage to as many of those individuals as possible. Out of the projected 54 million uninsured, about 10 million will be in the country illegally. The goal of the legislation, with respect to non-citizens, was to extend coverage to uninsured legal residents. Together with U.S. citizens, the total number applicable for coverage is projected to be 44 million by the end of the decade.

Substantial empirical evidence shows that the major issues influencing insurance take-up are price and accessibility. The price elasticity for insurance is high, and people find it

difficult to search for coverage on their own. To address the price issue, the ACA provides income-based subsidies to low- and middle-income individuals to purchase coverage. Families with an income below 133 percent of the federal poverty line (about \$30,000 in 2010) will pay 2 percent of their income for health insurance. Subsidies phase out when an income of 400 percent of the federal poverty line (about \$88,000 in 2010) is reached.

To make insurance accessible, the ACA creates a set of regional health insurance exchanges for individuals and small businesses, modeled after those operating in Massachusetts and Utah. The exchanges (discussed at greater length in the article in this issue by Duggan and Kocher) will certify plans, collect and process contributions, ensure that insurance products are standardized, and distribute risk-adjusted payments to plans.

In many cases, the coverage provisions in the ACA match those in Massachusetts—which uses an insurance exchange, and subsidizes insurance for low- and middle-income people. As a result of the subsidies and the establishment of the exchange, the share of the population in Massachusetts that

is uninsured fell by three-quarters. Thus, the Massachusetts experience was instrumental in convincing people that coverage could be made universal.

Insurance exchanges involve choice, but choice in insurance markets is problematic. If premiums are pooled across healthy and sick people, healthy people will find insurance less attractive and may drop out. If insurers are allowed complete pricing freedom, in contrast, they will exclude the less healthy from coverage. Selection by either individuals or insurers can thus undermine efficiency and equity goals.

To reduce selection on the part of individuals, the ACA has several features. First, it extends subsidies only to purchases made through an exchange. Effectively, this means that all non-group purchases will occur through exchanges, thus enabling transfers across individuals. Second, it allows people under age 26 to be covered on their parents' policy. Since the members of this group are the least likely to buy coverage on their own, this limits the extent of selection. Third, the ACA requires that employers with more than 200 employees automatically enroll employees into

insurance plans, with opt-out disenrollment (as opposed to opt-in enrollment).

Finally, the ACA mandates that individuals either buy insurance or face a penalty of the greater of \$695 per person or 2.5 percent of income. This last part of the ACA is particularly controversial, and a number of states are suing the federal government over its constitutionality. Analysts differ as to whether or not eliminating the individual mandate would materially affect insurance coverage, though a commitment to large subsidies is essential without a mandate.

Insurers are also constrained in their operations. They must underwrite everyone who wants coverage, and renew coverage at the individual's option. Thus, rescissions of policies to the sick are not allowed. Further, policies cannot have lifetime limits on covered services. In addition, premiums in insurance exchanges are only allowed to vary by age, smoking status, and geographic location, not by other measures of health status.

The tradeoff for the insurers is that the ACA does not have a "public option"—a government-sponsored plan competing alongside private plans. A public option was strongly

supported by many on the left as a foundation for a single-payer system, if one should be judged to be necessary down the road. For the same reason, the insurance industry vociferously opposed a public option. The compromise was strong regulation.

Two issues are central to the success of insurance reform. The first is how many people the ACA will cover. The Congressional Budget Office (CBO) estimated that 32 million uninsured persons will take up coverage, resulting in 94 percent of the eligible population having coverage. At such coverage levels, most analysts believe that residual selection is not large enough to materially affect outcomes, though others—including insurers—remain worried about an adverse-selection “death spiral.”

The second issue is whether employers will drop coverage, sending more people into the exchanges. For many people, the subsidies received through the exchange are greater than the savings from the tax exclusion of employer-based health insurance available with employer-based coverage. Partly to prevent this, the ACA requires all but the smallest employers to offer coverage or pay a fee to the exchange. Interestingly, Massachusetts has seen an increase,

not a decrease, in private coverage, even with a very generous set of subsidies and no employer mandate. Following this example, the CBO estimate of the ACA assumed very little dropping of employer-based insurance.

The models used by the CBO and others to estimate insurance coverage changes are not ideal. They are based on elasticities in employer-sponsored insurance settings or Medicaid, neither of which is a natural fit for new exchanges. Further, they do not account for the opt-out provisions of the law, which in other settings have had a large impact on take-up. Finally, they are extrapolated from small changes, when the ACA is much larger. For these reasons, the coverage estimates for the ACA are subject to uncertainty. It will thus be essential to monitor trends as they occur, and be flexible about implementation.

THE DELIVERY OF MEDICAL SERVICES

A great deal of evidence shows that the delivery of medical care is inefficient: People pay more, and get less, from the medical system than they ought to. The inefficiency is manifested in several ways: Too much care is provided in acute settings; preventive and

chronic care are not utilized to the extent they should be; and there are excess layers of administration and wasted resources. Estimates suggest that anywhere from 30 to 50 percent of medical spending is not needed to realize the outcomes we achieve—a waste of about \$1 trillion annually.

The ACA attempts to rectify this. Indeed, the lengthiest sections of the ACA are those that are designed to reform the incentives of the medical system. The philosophy behind the ACA has three parts: First, the lack of good information inhibits better care. Patient information is generally not electronic, and care is based on too little evidence. A common guess is that only 10 to 20 percent of what is done in medicine is founded on a good evidence base.

Second, the lack of good information is compounded by perverse financial incentives. Providers paid on a fee-for-service or piece-rate basis do many more tests and procedures than those paid on a global basis, without any improvement in outcomes. On the flip side, services that are reimbursed only poorly, such as patient outreach, team-based consultation, and chronic care management are underprovided, leading to too much serious disease.

Third, Medicare is the key actor in reforming payments and the use of information. Medicare accounts for 25 percent of overall medical spending, and an even larger share of acute care payments. Without Medicare reform, no payment reform can be successful. In turn, successful Medicare reform will spur changes in private insurance as well.

The first step in delivery system reform actually predates the ACA. The HITECH Act of 2009, a part of the American Recovery and Reinvestment Act, allocated \$30 billion over five years to support the adoption of electronic medical records. The ACA builds on the HITECH Act to change the way that medicine is reimbursed. Specifically, the ACA has a variety of demonstrations, pilots, and new programs designed to move away from fee-for-service Medicare payments and towards a system of more “bundled” payments. For example, the ACA proposes to take all payments related to an acute event (such as a hip fracture or stroke) and group them into a single total. Providers that receive the bundled payment would then be responsible for the hospital costs, post-hospital rehabilitation, and subsequent follow-up care for those patients. Providers that limit

unnecessary care (for example, reducing re-admission) and seek out more efficient suppliers would make money; more wasteful ones would lose money.

This type of methodology shows up in many guises: from bundled chronic disease programs, to accountable care organizations (bundling payments for patients as a whole), to pay-for-performance programs for primary care physicians. The hope is that, within a few years, fee-for-service payment will be the residual—rather than the dominant—mode of medical care payment.

The fact that many of these new programs are demonstrations or pilots has raised some concerns. Skeptics view the plethora of programs as a wasteful commitment that is unlikely to amount to much. The CBO, for example, judged that none of these programs would save significant sums. In reality, though, this focus on demonstrations and pilot programs reflects the fact that policy analysts did not have a strong sense about which reforms would be most successful, and what their precise contours should be. Thus, the idea was to unleash a period of widespread experimentation, and to build upon the successful changes.

For delivery system reform to be effective, medical care providers will need to make significant changes. Practices done on paper will need to be done electronically. Doctors who work individually will need to join teams. Hospitals that make money by doing more surgery will have to figure out how to become more efficient.

Whether this will occur, and at what speed it will happen, is the major unknown about health care reform. Again, flexibility will be key. During this period of experimentation, the federal government, as well as providers themselves, will need to evaluate continuously and change liberally. For much of American business, experimentation has become the norm – but not in medical care. It will certainly be a culture shock, but it is one other industries have absorbed.

THE BIG QUESTIONS

There is much more to the ACA than these two areas. Insurance coverage is expensive in the short run, so money is raised from higher-income people, and Medicare and Medicaid costs are reduced. Money is spent to research the quality of different medical care

providers. Payments to primary care providers are increased, and additional opportunities are created for preventive care. A Prevention and Public Health Fund is set up to fund programs in those areas.

All of these are important changes, but they are dwarfed by the coverage, insurance market, and delivery system reforms. Put simply, health care reform will succeed or fail based on two fundamental criteria: Do people get the coverage that they were promised, and that they want? And, do we change the delivery of medicine to promote high quality, lower cost care? If the answer to these questions is yes, the ACA will turn out to be the most successful piece of health care legislation ever, not just the largest one.

(CBO), see <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.



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NOTES

1. For a detailed description of the ACA's provisions, see <http://www.kff.org/healthreform/upload/8061.pdf>.
2. For details of the insurance and federal budget calculations from the Congressional Budget Office