

SIXTH EDITION

HEALTH
POLICY
ISSUES

AN ECONOMIC PERSPECTIVE

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THE RISE OF MEDICAL EXPENDITURES

The rapid growth of medical expenditures since 1965 is as familiar as the increasing percentage of US gross domestic product (GDP) devoted to medical care. Less known are the reasons for this continual increase. The purpose of this introductory chapter is threefold: (1) to provide a historical perspective on the medical sector; (2) to explain the rise of medical expenditures in an economic context; and (3) to set forth criteria for evaluating the Patient Protection and Affordable Care Act (ACA), which is likely to have a significant impact on the medical sector in coming years.

Before Medicare and Medicaid

Until 1965, spending in the medical sector was predominantly private—80 percent of all expenditures were paid by individuals out of pocket or by private health insurance on their behalf. The remaining expenditures (20 percent) were paid by the federal government (8 percent) and the states (12 percent) (see Exhibit 1.1). Personal medical expenditures totaled \$35 billion

EXHIBIT 1.1
Personal Health
Expenditures
by Source of
Funds, 1965
and 2012

Source of Funds	1965		2012	
	\$ (Billions)	%	\$ (Billions)	%
Total	34.7	100.0	2,360.4	100.0
Private	27.6	79.5	1,244.1	52.7
Out-of-pocket	18.2	52.4	328.2	13.9
Insurance benefits	8.7	25.1	807.0	34.2
All other	0.7	2.0	108.9	4.6
Public	7.1	20.5	1,116.4	47.3
Federal	2.8	8.1	869.0	36.8
State and local	4.3	12.4	247.4	10.5

SOURCE: Data from CMS (2014).

and accounted for approximately 6 percent of GDP—that is, six cents of every dollar spent went to medical services.

Two important trends have been the increasing role of government in financing medical services and the declining portion of expenditures paid out of pocket by the public. As shown in Exhibit 1.1, 47.3 percent of total medical expenditures in 2012 were paid by the government; the federal share was 36.8 percent and the states contributed 10.5 percent. Meanwhile, the private share dropped to 53 percent (from 80 percent in 1965); of that amount, 14 percent was paid out of pocket (from 52 percent in 1965).

The Greater Role of Government in Healthcare

Medicare and Medicaid were enacted in 1965, dramatically expanding the role of government in financing medical care. Medicare, which covers the aged, initially consisted of two of its current four parts—Part A and Part B. Part A is for hospital care and is financed by a separate (Medicare) payroll tax on the working population. Part B covers physicians' services and is financed by federal taxes (currently 75 percent) and by a premium paid by the aged (25 percent). Medicare Part C and Part D have since been added. Part C is a managed care option, and Part D is a prescription drug benefit—financed 75 percent by the federal government and 25 percent by the aged. Parts B, C, and D are all voluntary programs. Medicaid is for the categorically or medically needy, including the indigent aged and families with dependent children who receive cash assistance. Each state administers its own program, and the federal government pays, on average, more than half of the costs.

The rapid increase in total national health expenditure (NHE) is illustrated in Exhibit 1.2, which shows spending on the different components of medical services over time. Since 2000, NHE per capita has risen from \$4,884 billion to \$8,925 billion. During this time frame, hospital care and physician and clinical services—the two largest components of medical expenditures—have surged from \$416 billion to \$882 billion and \$291 billion to \$565 billion, respectively. These data indicate the enormous amount of US resources flowing into healthcare.

In the United States, \$2.793 trillion (or 17.2 percent of GDP) was spent on medical care in 2012.¹ From 2000 to 2012, these expenditures climbed by about 9 percent per year. Since peaking in the early part of the decade, the annual rate of increase in NHE has been declining, although it remains above the rate of inflation. These expenditures continue to rise as a percentage of GDP.

	1965	1970	1980	1990	2000	2012
Total national health expenditures	\$42.0	\$74.9	\$255.8	\$724.3	\$1,377.2	\$2,793.4
Health services and supplies	37.2	67.1	235.7	675.6	1,289.6	2,633.4
Personal healthcare	34.7	63.1	217.2	616.8	1,165.4	2,360.4
Hospital care	13.5	27.2	100.5	250.4	415.5	882.3
Physician and clinical services	8.6	14.3	47.7	158.9	290.9	565.0
Dental services	2.8	4.7	13.4	31.7	62.3	111.0
Other professional care	0.5	0.7	3.5	17.4	37.0	76.4
Home health care	0.1	0.2	2.4	12.6	32.4	77.8
Nursing home care	1.4	4.0	15.3	44.9	85.1	151.5
Drugs, medical nondurables	5.9	8.8	21.8	62.7	152.5	317.0
Durable medical equipment	1.1	1.7	4.1	13.8	25.2	41.3
Other personal healthcare	0.7	1.3	8.5	24.3	64.5	138.2
Program administration and net cost of private health insurance	1.8	2.6	12.0	38.8	81.2	197.9
Government public health activities	0.6	1.4	6.4	20.0	43.0	75.0
Research and construction	4.7	7.8	20.1	48.7	87.6	160.0
Research	1.5	2.0	5.4	12.7	25.5	48.1
Construction	3.2	5.8	14.7	36.0	62.1	111.9
National health expenditures per capita	\$210	\$356	\$1,112	\$2,851	\$4,884	\$8,925

EXHIBIT 1.2
National Health Expenditures, Selected Calendar Years, 1965–2012 (in Billions of Dollars)

SOURCE: Data from CMS (2014).

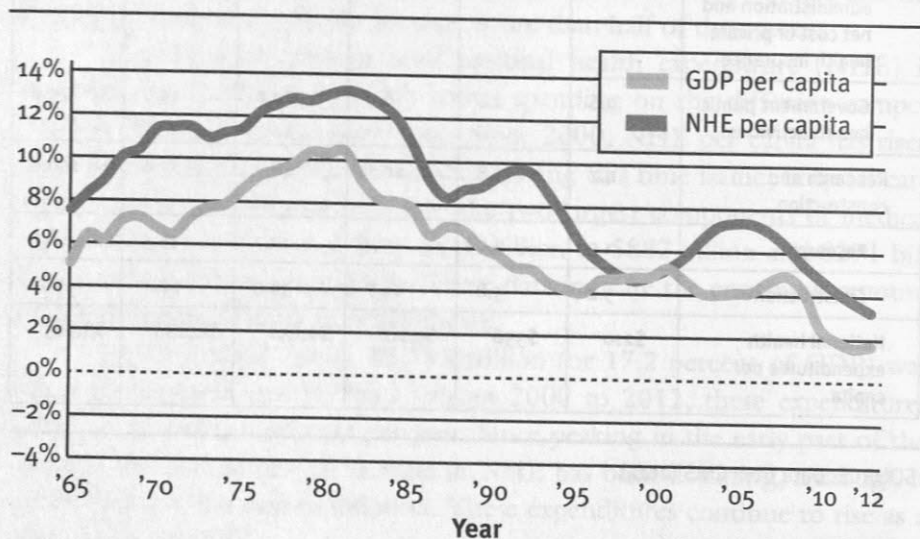
Relationship Between NHE and GDP

The growth in medical expenditures over time can be illustrated by comparing the rate of increase in NHE per capita to the rate of change in GDP per capita. (To show the relationship between the two series more clearly, a five-year moving average of the rates of change is used.) If NHE per capita is rising faster than GDP per capita, then the former is becoming a larger share of GDP. If the two series are moving together, then changes in the economy and health spending are closely related. Exhibit 1.3 shows the relationship between the two series from 1965 to 2012.

The only major divergence between NHE per capita and GDP per capita occurred starting in the mid-1990s. Medical expenditures increased at a slower rate because of the growth of managed care (which emphasized utilization management) and price competition among providers participating in managed care provider networks. By the end of the 1990s, managed care's cost-containment approaches lost support because of public dissatisfaction with managed care, lawsuits against managed care organizations (MCOs) for denial of care, government legislation, and a tight labor market that led employers to offer their employees more health plan choices. As a result, medical expenditures rose at a more rapid rate.

The decline in the annual NHE rate increase in the past ten years (Exhibit 1.3) can be attributed to the Great Recession, slow economic recovery, high unemployment levels, large number of uninsured, decrease in the number of employers paying for employee health insurance, and rapid spread of high-deductible health plans (Fuchs 2013).²

EXHIBIT 1.3
Changes in National Health Expenditures and Gross Domestic Product per Capita, 1965–2012



NOTE: Five-year moving averages
SOURCES: Data from CMS (2014); BEA (2014).

NHE is likely to rise at a slightly faster rate in the coming years as the economy continues to recover, more baby boomers become eligible for Medicare, new technology and specialty drugs that improve quality of life (but are higher in cost) are developed, and as the ACA is fully implemented (the expansion of Medicaid eligibility and subsidies for low-income enrollees on state health exchanges took effect in 2014). By 2022, federal, state, and local governments are expected to further increase their share of total NHE, which is expected to reach \$5 trillion (almost doubling from \$2.7 trillion in 2011) and to consume an even greater portion of GDP (19.9 percent) (Cuckler et al. 2013).

Exhibit 1.4 shows where healthcare dollars come from and how they are distributed among different types of healthcare providers.

Changing Patient and Provider Incentives

Medical expenditures equal the prices of services provided multiplied by the quantity of services provided. The rise of expenditures can be explained by looking at the factors that prompt medical prices and quantities to change. In a market system, the prices and output of goods and services are determined by the interaction of buyers (the demand side) and sellers (the supply side). We can analyze price and output changes by examining how various interventions change the behavior of buyers and sellers. One such intervention was Medicare, which lowered the out-of-pocket price the aged had to pay for medical care. The demand for hospital and physician services by

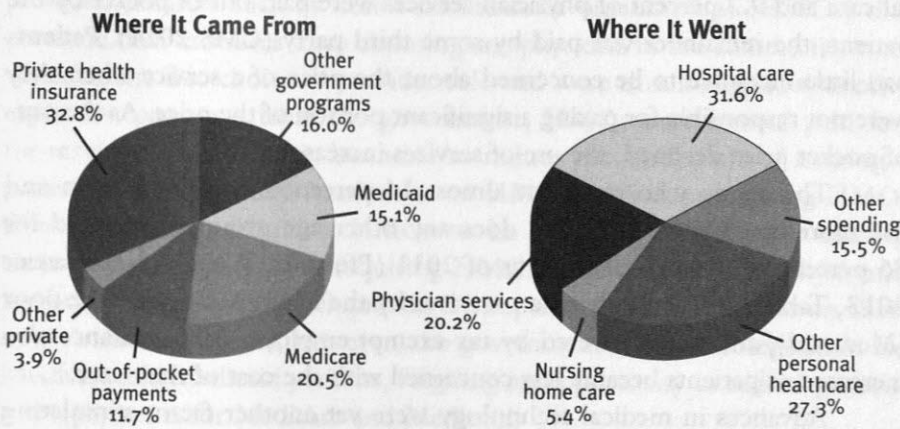


EXHIBIT 1.4
The Nation's
Healthcare
Dollar, 2012

NOTES: "Other personal healthcare" includes dental care, vision care, home health care, drugs, medical products, and other professional services. "Other spending" includes program administration, net cost of private health insurance, government public health, and research and construction.

SOURCE: Data from CMS (2014).

the aged went up dramatically after Medicare was enacted, spurring rapid price increases. Similarly, government payments on behalf of the poor under Medicaid stimulated demand for medical services among this demographic. Greater demand for services multiplied by higher prices for those services equals greater total expenditures.

Prices also go up when the costs of providing services increase. For example, to attract more nurses to care for the higher number of aged patients, hospitals raised nurses' wages and then passed this increase to payers in the form of more expensive services. Increased demand for care multiplied by higher costs of care equals greater expenditures.

While the government was subsidizing the demands of the aged and the poor, the demand for medical services by the employed population also was increasing. The growth of private health insurance during the late 1960s and 1970s was stimulated by income growth, high marginal (federal) income tax rates (up to 70 percent), and the high inflation rate in the economy. The high inflation rate threatened to push many people into higher marginal tax brackets. If an employee were pushed into a 50 percent marginal income tax bracket, half of his salary in that bracket would go to taxes. Instead of having that additional income taxed at 50 percent, employees often chose to have the employer spend those same dollars, before tax, to buy more comprehensive health insurance. Thus, employees could receive the full value of their raise, albeit in healthcare benefits. This tax subsidy for employer-paid health insurance stimulated the demand for medical services in the private sector and further boosted medical prices.

Demand increased most rapidly for medical services covered by government and private health insurance. As of 2012, only 3.4 percent of hospital care and 9.7 percent of physician services were paid out of pocket by the patient; the remainder was paid by some third party (CMS 2014). Patients had little incentive to be concerned about the price of a service when they were not responsible for paying a significant portion of the price. As the out-of-pocket price declined, the use of services increased.

The aged—who represent almost 14 percent of the population and use more medical services than does any other age group—accounted for 36 percent of all hospital stays, as of 2011 (Pfundtner, Wier, and Elixhauser 2013, Table 2). Use of physician services by the aged (Medicare), the poor (Medicaid), and those covered by tax-exempt employer-paid insurance also increased as patients became less concerned with the cost of their care.

Advances in medical technology were yet another factor stimulating the demand for medical treatment. New methods of diagnosis and treatment were developed; those with previously untreatable diseases gained access to technology that offered hope of recovery. New medical devices (such as imaging equipment) were introduced, and new treatments (such as organ

transplants) became available. New diseases (such as AIDS) also increased demand on the medical system. Reduced out-of-pocket costs and increased third-party payments (both public and private)—in addition to an aging population, new technologies, and new diseases—drove up both the prices and quantity of medical services provided.

Providers (hospitals and physicians) responded to the increased demand for care, but the way they responded unnecessarily increased the cost of providing medical services. After Medicare was enacted, hospitals had few incentives to be efficient because the program reimbursed hospitals their costs plus 2 percent for serving Medicare patients. Hospitals, predominantly not-for-profit, consequently expanded their capacity, invested in the latest technology, and duplicated facilities and services offered in nearby hospitals. Hospital prices rose faster than the prices of any other medical service. Similarly, physicians had little cause for concern over hospital costs. Physicians, who were paid fee-for-service, wanted their hospitals to have the latest equipment so that they would not have to refer their patients elsewhere (and possibly lose them). They would hospitalize patients for diagnostic workups and keep them in the hospital longer because it was less costly for patients covered by hospital insurance and physicians would be sure to receive reimbursement; outpatient services, which were less costly than hospital care, initially were not covered by third-party payers.

In addition to the lack of incentives for patients to be concerned with the cost of their care and the similar lack of incentives for providers to supply that care efficiently, the government imposed restrictions on the delivery of services that increased enrollees' medical costs. Under Medicare and Medicaid, the government ruled that insurers must give enrollees free choice of provider. Insurers such as health maintenance organizations (HMOs) that preclude their enrollees from choosing any physician in the community were violating the free choice of provider rule and were thus ineligible to receive capitation payments from the government; HMOs were instead paid fee-for-service, reducing their incentive to reduce the total costs of treating a patient. Numerous state restrictions on HMOs, such as prohibiting HMOs from advertising, requiring HMOs to be not-for-profit (thereby limiting their access to capital), and requiring HMOs to be controlled by physicians, further inhibited their development. By imposing these restrictions on alternative delivery systems, however, the government reduced competition for Medicare and Medicaid patients, forgoing an opportunity to reduce government payments for Medicare and Medicaid.

The effects of higher demand, limited patient and provider incentives to search for lower-cost approaches, and restrictions on the delivery of medical services were escalating prices, increased use of services, and greater medical expenditures.

Government Response to Rising Costs

As expenditures under Medicare and Medicaid increased, the federal government faced limited options: (1) raise the Medicare payroll tax and income taxes on the non-aged to continue funding these programs; (2) require the aged to pay higher premiums for Medicare, and increase their deductibles and copayments; or (3) reduce payments to hospitals and physicians. Each of these approaches would cost the administration and Congress political support from some constituents, such as employees, the aged, and healthcare providers. The least politically costly options appeared to be number 1 (increase taxes on the non-aged) and number 3 (pay hospitals and physicians less).

Federal and state governments used additional regulatory approaches to control these rapidly rising expenditures. Medicare utilization review programs were instituted, and controls were placed on hospital investment in new facilities and equipment. These government controls proved ineffective as hospital expenditures continued to escalate through the 1970s. The government then limited physician fee increases under Medicare and Medicaid; as a consequence, many physicians refused to participate in these programs, reducing access to care for the aged and the poor. As a result of their refusal to participate in Medicare, many Medicare patients had to pay higher out-of-pocket fees to be seen by physicians.

In 1979, President Carter's highest domestic priority was to enact expenditure limits on Medicare hospital cost increases; a Congress controlled by his own political party defeated him.

The 1980s

By the beginning of the 1980s, political consensus on what should be done to control Medicare hospital and physician expenditures was lacking, and private health expenditures continued to go up. By the mid-1980s, however, legislative changes and other events imposed heavy cost-containment pressures on Medicare, Medicaid, and the private sector.

Legislative and Government Changes

Several events in the early 1980s brought major changes to the medical sector. The HMO legislation enacted in 1973 began to have an effect in this decade. In 1974, President Nixon wanted a health program that would not increase federal expenditures. The result was the HMO Act of 1973, which legitimized HMOs and removed restrictive state laws impeding the development of federally approved HMOs. However, many HMOs decided not to seek federal qualification because imposed restrictions, such as having to offer more costly benefits, would have caused their premiums to be too high to be

price competitive with traditional health insurers' premiums. These restrictions were removed by the late 1970s, and the growth of HMOs began in the early 1980s.

To achieve savings in Medicaid, in 1981 the Reagan Administration removed the free choice of provider rule, enabling states to enroll their Medicaid populations in closed provider panels. As a result, states were permitted to negotiate capitation payments with HMOs for care of their Medicaid patients. The free choice rule continued for the aged; however, in the mid-1980s they were permitted to voluntarily join HMOs. The federal government agreed to pay HMOs a capitated amount for enrolling Medicare patients, but less than 10 percent of the aged voluntarily participated. (As of 2012, 28 percent of the 42 million aged were enrolled in Medicare HMOs, referred to as Medicare Advantage plans [CMS 2013, Table 2.1].³)

Federal subsidies were provided to medical schools in 1964 to increase the number of students they could accommodate, and the supply of physicians went up. The number of active physicians grew from 146 per 100,000 civilian population in 1965 to 195 per 100,000 in 1980; it reached 229 per 100,000 by 1990 and 283 per 100,000 in 2011 (AMA 1991, 2013). The greater supply created excess capacity among physicians, dampened their fee hikes, and made attracting physicians—and therefore expanding—easier for HMOs.

A new Medicare hospital payment system was phased in during 1983. Hospitals were no longer to be paid according to their costs. Fixed prices were established for each diagnostic admission (referred to as diagnosis-related groups [DRGs]), and each year Congress set an annual limit on the amount by which these fixed prices per admission could increase. DRG prices changed hospitals' incentives. Because hospitals could keep the difference if the costs they incurred from an admission were less than the fixed DRG payment they received for that admission, they were motivated to reduce the cost of caring for Medicare patients and to discharge them earlier. Length of stay per admission fell, and occupancy rates declined. Hospitals also became concerned with inefficient physician practice behaviors that increased the hospitals' costs of care.

In addition, in 1992 the federal government changed its method of paying physicians under Medicare. A national fee schedule (referred to as resource-based relative value system [RBRVS]) was implemented, and volume expenditure limits were established to limit the total rate of increase in physician Medicare payments. Today, the imposition of price controls and expenditure limits on payments to hospitals and physicians for services provided to Medicare patients continues to be the approach used by the federal government to contain Medicare expenditures. The RBRVS also prohibited physicians from charging their higher-income patients a higher fee and

accepting the Medicare fee only for lower-income patients; they had to accept the fee for all their Medicare patients or none. Medicare patients represent such a significant portion of a physician's practice that few physicians decided not to participate; consequently, they accepted Medicare fees for all patients.

Private Sector Changes

In addition to the government policy changes of the early 1980s, important events were occurring in the private sector. The new decade started with a recession. To survive the recession and remain competitive internationally, the business sector looked to reduce labor costs. Because employer-paid health insurance was the fastest-growing labor expense, businesses pressured health insurers to better control the use and cost of medical services. Competitive pressures forced insurers to increase the efficiency of their benefit packages by including lower-cost substitutes for inpatient care, such as outpatient surgery. They raised deductibles and copayments, intensifying patients' price sensitivity. Further, patients had to receive prior authorization from their insurer before being admitted to a hospital, and insurers reviewed patients' length of stay while patients were in the hospital. These actions greatly reduced hospital admission rates and lengths of stay. The number of admissions in community hospitals in 1975 was 155 per 1,000 population. By 1990 it had fallen to 125 per 1,000 and continued to decline thereafter, dropping to 110 in 2012. The number of inpatient days per 1,000 population fell even more dramatically—from 1,302 in 1977 to 982 in 1990 to 591 in 2012 (AHA 2014).

Because of the implementation of the DRG payment system, the changes to private programs, and a shift to the outpatient sector facilitated by technological change (both anesthetic and surgical techniques), hospital occupancy rates decreased from 76 percent in 1980 to 63.3 percent in 2012 (AHA 2014).

Antitrust Laws

The preconditions for price competition were in place: Hospitals and physicians had excess capacity, and employers wanted to pay less for employee health insurance. The last necessary condition for price competition was set in 1982, when the US Supreme Court upheld the applicability of the antitrust laws to the medical sector. Successful antitrust cases were brought against the American Medical Association for its restrictions on advertising, against a medical society that threatened to boycott an insurer over physician fee increases, against a dental organization that boycotted an insurer's cost-containment program, against medical staffs that denied hospital privileges to physicians because they belonged to an HMO, and against hospitals whose mergers threatened to reduce price competition in their communities.

The applicability of the antitrust laws, excess capacity among providers, and employer and insurer interest in lowering medical costs brought about profound changes in the medical marketplace. Traditional insurance plans lost market share as managed care plans—which controlled utilization and limited access to hospitals and physicians—grew. Preferred provider organizations (PPOs) were formed and included only physicians and hospitals that were willing to discount their prices. Employees and their families were offered price incentives in the form of lower out-of-pocket payments to use these less expensive providers. Large employers and health insurers began to select PPOs on the basis of their prices, use of services, and outcomes of their treatment.

Consequences of the 1980s Changes

The 1980s disrupted the traditional physician–patient relationship. Insurers and HMOs used utilization review to control patient demand, emphasize outcomes and appropriateness of care, and limit patients' access to higher-priced physicians and hospitals by not including them in their provider networks. They also used case management for catastrophic illnesses, substituted less expensive settings for more costly inpatient care, and affected patients' choice of drugs through the use of formularies.

The use of cost-containment programs and the shift to outpatient care lowered hospital occupancy rates. The increasing supply of physicians—particularly specialists—created excess capacity. Hospitals in financial trouble closed, and others merged. Hospital consolidation increased. Hospitals' excess capacity was not reduced until years later, when the demand for care began to exceed the available supply of hospitals and physicians. Until then, hospitals and physicians continued to be subject to intense competitive pressures.

Employees' incentive to reduce their insurance premiums also stimulated competition among HMOs and insurers. Employers required employees to pay the additional cost of more expensive health plans, so many employees chose the lowest-priced plan. Health insurance companies competed for enrollees primarily by offering lower premiums and provider networks with better reputations.

The 1990s

As managed care spread throughout the United States during the 1990s, the rate of increase of medical expenditures declined (see Exhibit 1.3). Hospital use decreased dramatically, and hospitals and physicians agreed to large price discounts to be included in an insurer's provider panel. These cost-containment approaches contributed to the lower annual rate of increase. However, although price competition reduced medical costs,

patients were dissatisfied. The public wanted greater access to care—particularly, less restriction on referrals to specialists. Public backlash against HMOs emerged. HMOs lost several lawsuits for denying access to experimental treatments, and Congress and the states imposed restrictions on MCOs, such as mandating minimum lengths of stay in the hospital for normal deliveries. Cost-containment restrictions weakened as a result of these events, and increases in prices, use of services, and medical expenditures reaccelerated.

The 2000s

The excess capacity that weakened hospitals in their negotiations with insurers dried up during this decade. Financially weak hospitals closed. Because consolidation reduces the number of competitors in an area, the number of hospital mergers—which enhance bargaining power—increased. As hospital prices went up, so did insurance premiums. Past approaches—decreased hospital use and price discounts—could no longer achieve large cost reductions. Instead, insurers tried to develop more innovative, less costly ways of managing patient care.

Newer approaches to cost containment included high-deductible health plans, evidence-based medicine, and disease management. Insurers' method of shifting a larger share of medical costs to consumers is referred to as consumer-driven healthcare (CDHC). In return for lower health insurance premiums, consumers pay higher deductibles and copayments. Consumers are then presumed to evaluate the costs and benefits of spending their own funds on healthcare. Instead of relying on consumer incentives to reduce medical costs, some health insurers use evidence-based medicine, which relies on the analysis of large data sets to determine the effect of different physician practice patterns on costs and medical outcomes. Other insurers employ disease management to provide chronically ill patients, who incur the most medical expenditures, with preventive and continuous care, which not only improves the quality of care but also reduces costly hospitalizations.

Another development was pay-for-performance (P4P) programs. Insurers pay physicians and other healthcare practitioners more if they provide high-quality care, which is usually defined on the basis of process measures developed by medical experts. Insurers also make report cards available to their enrollees. Report cards evaluate hospitals and medical groups in the insurer's provider network according to medical outcomes, preventive services, and patient satisfaction scores to enable enrollees to make informed choices about the providers they use.

In the latter half of the decade, rising premiums and increased unemployment (as a result of the Great Recession) prompted people to drop their insurance or switch to new types of insurance that charge lower premiums,

such as high-deductible plans. Many Americans became concerned that premiums would continue increasing, making insurance even less affordable. The recession, a decrease in the number of insured, and the switch to high-deductible health plans slowed the rising health expenditures (see Exhibit 1.3).

The Affordable Care Act

The most significant health policy event of the 2010s was the enactment and implementation of the ACA. Although the 2014 implementation was fraught with website and enrollment problems, the legislation will lead to major changes in the financing and delivery of medical services. As such, it should be judged according to three criteria.

The first criterion is whether it reduced the number of uninsured, presumably the major goal of the legislation. Before it was passed, about 50 million Americans were uninsured. The ACA expanded Medicaid eligibility from 100 to 133 percent of the federal poverty level (FPL), estimating that doing so would decrease the number of uninsured by 16 million. An additional 16 million (from 133 to 400 percent of the FPL) would become eligible for government subsidies when they bought insurance on state and federal health exchanges. (The legislation included an individual mandate that requires everyone to either buy insurance or pay a penalty.) Thus, 32 million were expected to gain insurance, leaving nearly 20 million uninsured.⁴ It is still uncertain how many states will increase their Medicaid eligibility levels to 133 percent of the FPL and whether the individual mandate and the subsidies, premiums, and benefits offered on the exchanges will induce many of the uninsured to seek coverage. Thus, by the end of this decade, the first criterion for judging the success of the ACA is, how many of the uninsured will have received coverage, and what will have been the cost per newly insured enrollee? Will the decrease in the number of uninsured be worth the more than trillion dollars spent to achieve it? Could another approach have achieved the same goal at a lower cost?

The second criterion relates to cost. The ACA expects to increase the demand for health insurance and, consequently, the demand for medical services without raising the costs of care. Will the ACA be able to “bend the cost curve down,” “decrease premiums by \$2,500 for a family of four,” and “not add a dime to the deficit”? All of these were promises made by President Obama in promoting the legislation’s benefits to the middle class. The cost was initially calculated over a ten-year period and was estimated by the Congressional Budget Office to be budget neutral for the first ten years by increasing taxes for the entire ten-year period but delaying the

spending for several years. Whether the ACA is able to reduce the rate of increase in medical expenditures, reduce family premiums, and be budget neutral at the end of the decade will determine whether it was able to meet its second objective.⁵

The third criterion is whether people who already had insurance could keep the coverage they had, as President Obama promised. He stated numerous times, “if you like your health plan, you can keep it” and “if you like your doctor, you can keep your doctor.” If the first objective of the ACA was to reduce the number of uninsured, then why was it necessary to require changes in the insurance choices of those already insured by mandating greater benefits and, consequently, higher premiums? In 2013, about half of the almost 10 million people enrolled in the individual insurance market (consisting of 5 percent of those privately insured) received cancellation notices from their insurers; their coverage no longer met the ACA’s mandated benefit standards. To continue being insured, those receiving cancellation notices were forced to buy more expensive insurance on the new exchanges, which had very limited (low cost) provider networks. Many were very angry they could no longer retain their previous coverage or their physician.

The major concern regarding “keeping your coverage” relates to the remaining 170 million privately insured who receive employer-based coverage. Will employers continue to provide insurance for their employees, or will many employers pay a penalty (the employer mandate) and shift their employees to the exchanges? In a competitive labor market, employers will likely continue to offer insurance for their high-wage employees, who prefer employer coverage rather than the very limited provider networks offered by insurers on the health exchanges.⁶ However, employers with low-wage employees may have a different incentive and act differently. A major disruption in the public’s coverage would occur if 30 to 50 million employees lose their employer coverage, are shifted to the exchanges, end up with a limited choice of providers, and believe they are worse off and consequently feel dissatisfied. The ACA will then have failed in its promise to enable people to keep the coverage they had.

Finally, any evaluation of the ACA should be based on a comparison—not with the previous healthcare system but with other healthcare reform approaches in achieving the same objectives. Chapter 34 discusses several of these approaches, including the refundable tax credit.

Summary

The forces increasing demand and the costs of providing care have not changed. The population is aging (the first of the baby boomers retired in

2011), technological advances enable early diagnosis, and new methods of treatment are emerging—all of which stimulate increased demand for medical services. Of these three developments, new technology is believed to be the most important force behind rising expenditures. For example, the number of people receiving organ transplants has grown dramatically, as have the diffusion of new equipment and the use of imaging tests. The cost of providing medical services is also rising as more highly trained medical personnel are needed to handle advanced technology and as wage rates increase to attract more nurses and technicians to the medical sector.

The ACA will further increase the demand for care. More people will become eligible for Medicaid, and many previously uninsured individuals buying insurance on the exchanges will receive government subsidies. Everyone is required to have insurance under the legislation's individual mandate, and under the employer mandate, employers are required to provide insurance for their employees or pay a fine. However, the ACA makes no changes to patient or provider incentives to encourage them to be more efficient in their use of medical services.

The developing shortage of physicians is becoming a concern. The demand for physician services is increasing faster than the supply of physicians. Will access to care decline, indicated by increased waiting times for a physician appointment?

As the cost of financing these expansions of Medicaid eligibility and new exchange subsidies increase, the already large federal deficit is likely to grow even faster than it is growing today. The federal government will be under great pressure to reduce the rising deficit and the burden of increasing premiums faced by the middle class. Will the government rely more on regulatory (provider price controls) or competitive approaches to reduce medical expenditures and premium increases?

Innovative approaches to reducing healthcare costs are more likely to be taken in a system that has price incentives to do so (enrollees have a financial incentive to choose less costly health plans, and health insurers compete on premiums, access, and quality for enrollees) than in a regulated system. Any regulatory approach that arbitrarily seeks to reduce the rate of increase in medical expenditures will result in reduced access to both medical care and new technology.

Although the United States spends more on healthcare than does any other country, a scarcity of funds to provide for all of our medical needs and population groups—such as the uninsured and those on Medicaid—still exists. Therefore, choices must be made.

The first choice is to determine how much we as a society should spend on medical care. What approach should we use to make this choice? Should individuals decide how much they want to spend on healthcare, or should

the government decide the percentage of GDP that goes to healthcare? The second choice is to identify the best way to provide medical services. Would competition among health plans or government regulation and price controls bring about greater efficiency in providing medical services?

The third choice is to establish how rapidly medical innovation should be introduced. Should regulatory agencies evaluate each medical advance and determine whether its benefits exceed its costs, or should the evaluation of those costs and benefits be left to the separate health plans competing for enrollees? The fourth choice is to specify how much should be spent on those who are medically indigent and how their care should be provided. Should the medically indigent be enrolled in a separate medical system (such as Medicaid), or should they be provided with vouchers to enroll in competing health plans?

These choices can be better understood when we are more aware of the consequences of each approach (such as which groups benefit and which groups bear the costs). Economics clarifies the implications of different approaches to these decisions.

Discussion Questions

1. What are some of the reasons for the increased demand for medical services since 1965?
2. Why has employer-paid health insurance been an important stimulant of demand for health insurance?
3. How did hospital payment methods in the 1960s and 1970s affect hospitals' investment policies and incentives to improve efficiency?
4. Why were HMOs and managed care not more prevalent in the 1960s and 1970s?
5. What choices has the federal government had to reduce greater-than-projected Medicare expenditures?
6. What events during the 1980s in both the public and private sectors made the delivery of medical services price competitive?
7. What are three criteria that have been proposed for evaluating the success of the ACA?

Notes

1. GDP represents the total value of all goods and services produced in a given year. GDP is also equal to the total income received by the resources—employees, management, and capital—that produced those goods and services.

2. Proponents of the ACA claim that part of the slowdown in medical expenditure increases was a result of the legislation. However, Chandra, Holmes, and Skinner (2013) state that the decline started several years before the ACA was enacted (as shown by Exhibit 1.3) and that most of the ACA's cost-control measures did not begin until several years after it was passed in 2010. In addition, Ryu and colleagues (2013) discuss the reasons for the decline in medical expenditure increases.
3. Medicare does not have a limit on total out-of-pocket expenses incurred by a Medicare patient. Medicare Advantage plans provide its enrollees additional benefits and limit out-of-pocket expenses.
4. Among the remaining uninsured are undocumented immigrants, who are excluded from government coverage or subsidies.
5. As shown in Exhibit 1.3, the slowdown in medical expenditures started before the ACA was enacted and should not be attributed to the legislation.
6. The narrow, low-cost networks offered on the exchanges should not be confused with the limited networks an employer (such as Walmart) or an insurer constructs to provide enrollees with a choice of centers of excellence located across the United States. These centers are carefully chosen on the basis of their high quality and low costs.

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HOW MUCH SHOULD WE SPEND ON MEDICAL CARE?

The United States spends more on medical care than does any other country—17.2 percent of its gross domestic product (in 2012)—and this percentage is expected to continue to grow. Can we afford to spend that much of our resources on medical care? Why do we view the growth of expenditures in other areas (such as the automotive industry) more favorably than the growth of expenditures in healthcare? Increased medical expenditures create new healthcare jobs, do not pollute the air, save rather than destroy lives, and alleviate pain and suffering. Why should society not be pleased that more resources are flowing into a sector that cares for the aged, the poor, and the sick? Medical care would seem to be a more appropriate use of a society's resources than cars, electronics, or other consumer products, yet increased expenditures on these goods do not prompt the concern that growth in healthcare spending causes.

Are we concerned about rising medical costs because we believe we are not receiving value for our money—that more medical services and technologies are not worth their costs when compared to other potential uses of those resources? Or is there a fundamental difference of opinion regarding the rate at which medical expenditures should increase?

To answer these questions, we must define what we consider an appropriate or “right” amount of expenditure—only then can we evaluate whether we are spending too much on medical care. If we determine that we are spending too much, how does public policy have to change to achieve the right expenditure level?

Consumer Sovereignty

The appropriate amount of health expenditure is based on a set of values and on the concept of economic efficiency. Resources are limited, so they should be used for what consumers believe to deliver the most value. Consumers decide how much to purchase on the basis of their perception of the value they expect to receive and the price they have to pay, knowing that buying one good or service means forgoing other goods and services. Consumers differ greatly in what value they place on medical care and what