

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 has been the most significant healthcare legislation since Medicare and Medicaid.

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

Source of Funds	1965		2016	
	\$ (Billions)	%	\$ (Billions)	%
Total	34.7	100.0	2,834.0	100.0
Private	27.6	79.5	1,479.5	52.2
Out-of-pocket	18.2	52.4	352.5	12.4
Insurance benefits	8.7	25.1	993.8	35.1
All other	0.7	2.0	133.2	4.7
Public	7.1	20.5	1,354.5	47.8
Federal	2.8	8.1	1,093.8	38.6
State and local	4.3	12.4	260.7	9.2

EXHIBIT 1.1
Personal Health Expenditures, by Source of Funds, 1965 and 2016

Source: Data from Centers for Medicare & Medicaid Services (2017b).

Two important trends are 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, the government paid 47.8 percent of total medical expenditures in 2016; the federal share was 38.6 percent and the states contributed 9.2 percent. Meanwhile, the private share dropped to 52 percent (from 80 percent in 1965); of that amount, 12 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 ACA, enacted in 2010 and implemented in 2014, expanded Medicaid eligibility from 100 to 138 percent of the federal poverty level (FPL). The federal government reimburses states that choose to expand Medicaid for up to 90 percent of their costs for the newly eligible enrollees.

The rapid increase in total national health expenditures (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 to \$10,365. During this time frame, hospital care and physician and clinical services—the two largest components of medical expenditures—surged from \$416 billion to \$1.083 trillion and from \$291 billion to \$665 billion, respectively. These data indicate the enormous amount of US resources flowing into healthcare.

In 2016, \$3.338 trillion (or 17.9 percent of GDP) was spent on medical care in the United States.¹ From 2000 to 2016, 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.

EXHIBIT 1.2
National Health Expenditures, Selected Calendar Years, 1965–2016 (in Billions of Dollars)

	1965	1970	1980	1990	2000	2010	2016
Total national health expenditures	\$42.0	\$74.9	\$255.8	\$724.3	\$1,377.2	\$2,598.8	\$3,337.5
Health services and supplies	37.2	67.1	235.7	675.6	1,289.6	2,456.1	3179.8
Personal healthcare	34.7	63.1	217.2	616.8	1,165.4	2,196.0	2834.0
Hospital care	13.5	27.2	100.5	250.4	415.5	822.3	1082.5
Physician and clinical services	8.6	14.3	47.7	158.9	290.9	512.6	664.9
Dental services	2.8	4.7	13.4	31.7	62.3	105.9	124.4
Other professional care	0.5	0.7	3.5	17.4	37.0	69.9	92.0
Home health care	0.1	0.2	2.4	12.6	32.4	71.6	92.4
Nursing home care	1.4	4.0	15.3	44.9	85.1	140.5	162.7
Drugs, medical nondurables	5.9	8.8	21.8	62.7	152.5	304.3	390.8
Durable medical equipment	1.1	1.7	4.1	13.8	25.2	39.9	51.0
Other personal healthcare	0.7	1.3	8.5	24.3	64.5	129.1	173.3
Program administration and net cost of private health insurance	1.8	2.6	12.0	38.8	81.2	184.4	263.7
Government public health activities	0.6	1.4	6.4	20.0	43.0	75.6	82.2
Research and construction	4.7	7.8	20.1	48.7	87.6	142.7	157.5
Research	1.5	2.0	5.4	12.7	25.5	49.2	47.7
Construction	3.2	5.8	14.7	36.0	62.1	93.5	109.8
National health expenditures per capita	\$210	\$356	\$1,112	\$2,851	\$4,884	\$8,410	\$10,365

Source: Data from Centers for Medicare & Medicaid Services (2017b).

^aExcept where otherwise noted.

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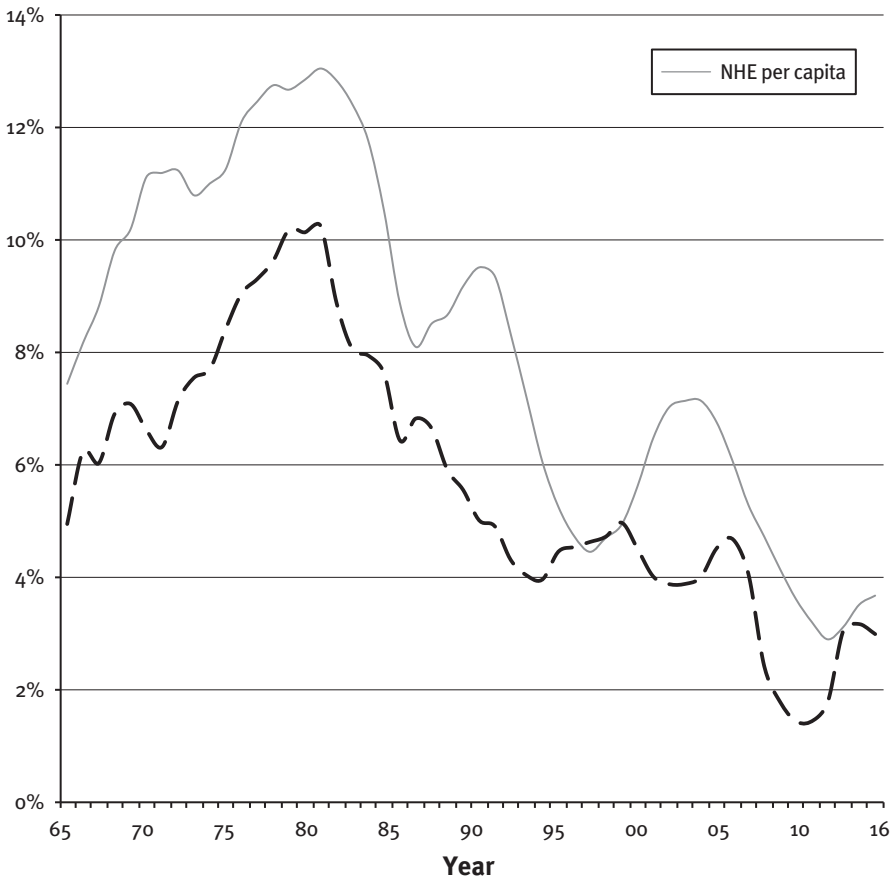
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The Relationship Between NHE and GDP

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, 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 2016.

The only major divergence between NHE per capita and GDP per capita began 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

EXHIBIT 1.3
Changes in
National Health
Expenditures
and Gross
Domestic
Product
per Capita,
1965–2016



Note: Five-year moving averages.

Source: Data from the Centers for Medicare & Medicaid Services (2017b).

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approaches lost support because of public dissatisfaction with managed care's restrictions on access to specialists, 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 from about 2008 to 2013 (exhibit 1.3) can be attributed to the Great Recession, slow economic recovery, high unemployment levels, a large number of uninsured, a decrease in the number of employers paying for employee health insurance, and the rapid spread of high-deductible health plans (Fuchs 2013).

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 the quality of life (but are higher in cost) are developed; and increased demand occurs as a result of the ACA's Medicaid eligibility expansion and subsidies for low-income enrollees on health insurance exchanges.

By 2025, federal, state, and local governments are expected to increase their share of total NHE, which is expected to reach \$2.6 trillion (almost doubling from \$1.5 trillion in 2016) and to consume an even greater portion of GDP (19.9 percent) (Centers for Medicare & Medicaid Services [CMS] 2017c, table 16). Exhibit 1.4 shows where healthcare dollars come from and how they are distributed among different types of healthcare providers.

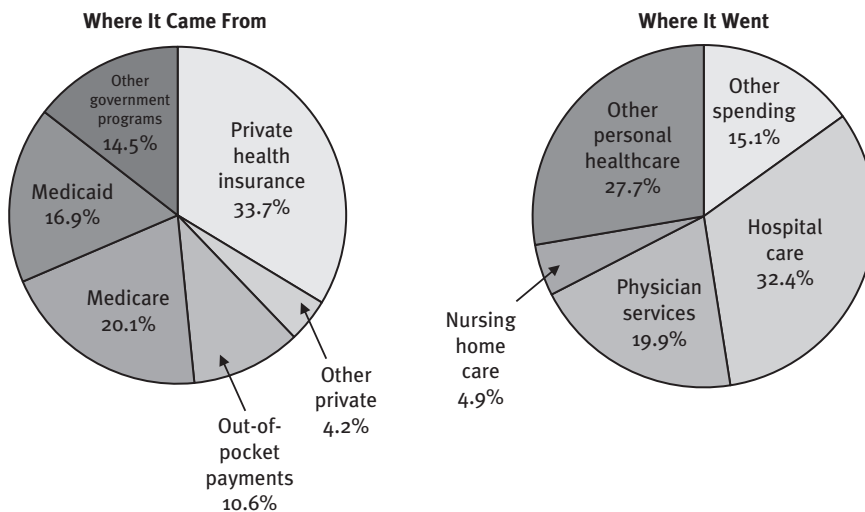


EXHIBIT 1.4
The Nation's
Healthcare
Dollar, 2016

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 the Centers for Medicare & Medicaid Services (2017b).

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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 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 population. 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 on 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, on 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 2016, only 3 percent of hospital care and 8.9 percent of physician services were paid out of pocket by the patient; the remainder was paid by a third party (CMS 2017b). 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 16 percent of the population and use more medical services than any other age group—accounted for 35.4 percent of

all hospital stays as of 2015 (Agency for Healthcare Research and Quality 2017). 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 about the cost of their care. Historically, advances in medical technology have been 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 the hope of recovery. New medical devices (e.g., imaging equipment) were introduced, and new treatments (e.g., organ transplantations) became available. New diseases (e.g., 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 prices and the 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 Medicare 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 by 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 on a fee-for-service basis, wanted their hospitals to have the latest equipment so they would not have to refer patients elsewhere (and possibly lose them). They would hospitalize patients for diagnostic workups and keep them in the hospital longer than necessary 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 federal 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 precluded enrollees from choosing any physician in the community were violating the free choice of provider rule and, thus, were ineligible to receive capitation payments from the government. Instead, HMOs were paid fee-for-service, reducing their incentive to reduce the total costs of treating a patient. Numerous state restrictions on HMOs, such as prohibiting them 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 services.

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, increasing use of services, and resulting in 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 working population 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 successive administrations 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 employees) and number 3 (reduce payments to hospitals and physicians). The aged have the highest voting participation rate of any age group, as well as the political support of their children, who are relieved of the financial responsibility to pay their parents' medical expenses.

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 investments in new facilities and equipment. These government controls proved ineffective as hospital expenditures continued to escalate through the 1970s. The federal 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 providers' 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 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 was lacking on what should be done to control Medicare hospital and physician expenditures, and private health expenditures also continued to rise. 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

President Nixon wanted a health program that would not increase federal expenditures. The result was the Health Maintenance Organization 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 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, the Reagan Administration removed the free-choice-of-provider rule in 1981, 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 Medicaid patients. The free choice rule continued for the aged; however, in the mid-1980s, Medicare patients 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 2016, 34 percent of the 48 million aged were enrolled in Medicare HMOs, referred to as Medicare Advantage plans [CMS 2017a].²)

Federal subsidies were provided to medical schools in 1964 to increase the number of students they could accommodate, and the supply of physicians expanded. The number of active physicians grew from 146 per 100,000 civilian population in 1965 to 195 per 100,000 in 1980; it reached 233 per 100,000 by 1990 and 321 per 100,000 in 2013 (American Medical Association [AMA] 1991, 2015). 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. Under the new system, 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 about 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 cap the total rate of increase in physician Medicare payments. 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 or none of their Medicare patients. 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.

To contain increases in Medicare expenditures during this period, the federal government imposed price controls and expenditure limits on hospital and physician payments for services provided to Medicare 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. In 1975, the number of admissions in community hospitals was 155 per 1,000 population. By 1990, it had fallen to 125 per 1,000 and continued to decline thereafter, dropping to 104 per 1,000 in 2015. The number of inpatient days per 1,000 population declined even more dramatically—from 1,302 in 1977 to 982 in 1990 to 565 in 2015 (American Hospital Association [AHA] 2017).

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 63.5 percent in 2015 (AHA 2017).

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 occurred in 1982, when the US Supreme Court upheld the applicability of antitrust laws to the

medical sector. Successful antitrust cases were brought against the AMA 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 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 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 treatment outcomes.

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 costlier inpatient care, and influenced 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 in 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 hospital stays for normal deliveries. Consequently, cost-containment restrictions weakened, 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 the 2000s. Financially weak hospitals had closed. Because consolidation reduces the number of competitors in an area, the number of hospital mergers—which enhance bargaining power—increased. As hospital prices rose, so did insurance premiums. Previous approaches, such as 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, reliance on evidence-based medicine, and chronic 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 then presumably evaluate the costs and benefits of spending their own funds on healthcare. Another approach to lowering medical costs is to use evidence-based medicine, which relies on scientific evidence and analysis of large data sets to determine the effect of different physician practice patterns on costs and medical outcomes. Other insurers emphasize disease management to provide chronically ill patients, who incur the most medical expenditures, with preventive and continuous care. This approach not only improves the quality of care but reduces costly hospitalizations.

Pay-for-performance (P4P) programs also have been developed to lower costs and improve care. Insurers pay higher amounts to physicians and other healthcare providers 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 are a means of describing 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 (resulting from the Great Recession) prompted people to drop their

health insurance or switch to plans that charged 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 rising healthcare expenditures (see exhibit 1.3).

In 2015, Congress again revised Medicare payments to physicians with passage of The Medicare Access and CHIP Reauthorization Act (MACRA). The law's provisions are being phased in and will become fully effective for all physicians by 2019. MACRA is the most substantive change in physician reimbursement since Medicare was enacted. Congress had previously been reluctant to enforce the accumulated Sustainable Growth Rate (SGR) cuts, which would have reduced Medicare payments to physicians. The SGR formula was eliminated with passage of MACRA. The new law attempts to change physician incentives by moving payments away from fee-for-service toward financial accountability for the care they provide. Another objective of MACRA is to move physicians into alternative payment systems that require them to bear financial risk. (MACRA is discussed more completely in chapter 10.)

It is too early to judge how physicians will adjust to the new Medicare payment system, which requires them to submit a great deal of data. This requirement may force many physicians to decide to become employees of hospitals and insurers.

The Affordable Care Act (ACA)

The most significant health policy event of the current decade was the 2010 enactment and 2014 implementation of the ACA. Although implementation was fraught with website and enrollment problems, the legislation, which did not receive bipartisan support and has proved to be controversial, has led to important changes in the financing and delivery of medical services. Sufficient time has elapsed to examine the extent to which the ACA has achieved its stated objectives. Consequently, 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 the ACA was enacted, about 50 million Americans did not have health insurance. Several approaches were used to decrease the number of uninsured. The ACA expanded Medicaid eligibility from 100 to 138 percent of the FPL. (However, not all states chose to expand their Medicaid eligibility levels.) Federal and state health insurance exchanges were established, primarily for those who purchase insurance in the individual market. In addition, premium tax credits and cost-sharing subsidies were provided on a declining scale to those with incomes between 138 and 400 percent of the FPL. The legislation included an individual mandate that

required everyone to buy insurance or pay a penalty. An employer mandate was imposed that required employers to offer health insurance to their employees or pay a penalty of \$2,000 per employee. Small employers (those with fewer than 50 full-time employees) were exempted from this mandate and, instead, were offered a tax credit for providing health insurance to their employees.

In 2010, when the ACA was enacted, the Congressional Budget Office (CBO) estimated that these steps to increase insurance coverage, expand Medicaid, provide health insurance exchange subsidies, include individual and employer mandates, and provide tax credits for small employers would increase the number of insured by 23 million, leaving 21 million Americans uninsured by 2016. By 2016, however, only 16 million people gained insurance, leaving 28 million uninsured (CBO 2017, 9).

The second criterion relates to cost. The Obama administration and Congressional Democrats expected the ACA to increase the demand for health insurance and, consequently, the demand for medical services without raising the costs of care. In fact, the ACA was expected to “bend the cost curve down,” “decrease premiums by \$2,500 a year for a family of four,” and “not add a dime to the deficit.” These promises were made by President Obama in promoting the legislation’s benefits to the middle class. The CBO initially calculated the projected cost over a ten-year period and estimated that it would be budget neutral for this period. Budget neutrality was to be achieved by increasing ACA taxes for the entire ten-year period but delaying spending for several years (from 2010 to 2014). Whether the ACA succeeds in reducing the rate of increase in medical expenditures, reducing family premiums, and achieving budget neutrality at the end of the decade will determine if it has met this second objective.³

The third criterion is whether people who already had insurance were able to keep the coverage they had, as President Obama promised. He stated numerous times, “If you like your healthcare plan, you can keep your healthcare plan” and “if you like your doctor, you can keep your doctor.” What made these promises doubtful was that the ACA made numerous changes to the health insurance market, such as mandating “essential” (i.e., more comprehensive) health benefits, requiring a smaller difference in premiums between older and younger individuals on the health insurance exchanges, establishing gender equality in premium ratings, and initiating a new health insurance tax on premiums for those buying insurance on the exchanges. Additional regulations, as well as subsidies, were imposed on health insurers.

Did these and other changes to the health insurance market, particularly to the individual market, affect the ability of those currently insured to keep their health plans?

These criteria for evaluating the ACA are discussed in chapter 38, “The Affordable Care Act: Did It Achieve Its Goals?”

Finally, any evaluation of the ACA should be based on a comparison—not with the previous healthcare system, but with other proposed healthcare reform approaches in achieving the same objectives. Chapter 36 discusses several of these approaches, including the refundable tax credit.

Summary

The forces that increase 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 treatment methods 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, expensive new prescription drugs that extend life and alleviate pain have been brought to market. In addition, the number of people receiving organ transplants, the introduction of new equipment, and the use of imaging tests have grown dramatically. 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 has further increased demand for medical care. More people have become eligible for Medicaid, and many previously uninsured individuals buying insurance on the exchanges receive government subsidies. Everyone is required to have insurance under the legislation's individual mandate (in 2019, the penalty for this mandate ends as a result of legislation passed in December 2017), and under the employer mandate, most employers are required to provide insurance for employees or pay a fine. However, the ACA provides no additional patient or provider incentives to encourage them to be more efficient in use of medical services.

The developing shortage of physicians is a growing concern. The demand for physician services is increasing faster than the supply of physicians, and access to care, as indicated by increased waiting times for a physician appointment, has declined. As the costs of financing expansions of Medicaid eligibility and new exchange subsidies increase, the already large federal deficit is likely to grow even faster. The federal government is 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 adopted in a system that has price incentives to do so (i.e., enrollees have a financial incentive to choose less costly health plans, and health insurers compete for enrollees on the basis of premiums, access to care, and quality) 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.

The United States spends more on healthcare than any other country; nevertheless, a scarcity of funds exists to provide for all of our medical needs and population groups, such as the uninsured and those on Medicaid. 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 toward healthcare? Our 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? The third choice is to determine how rapidly medical innovation should be introduced. Should regulatory agencies evaluate each medical advance and decide whether its benefits exceed its costs, or should the evaluation of those benefits and costs be left to the separate health plans competing for enrollees? Our 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 (e.g., Medicaid), or should they receive subsidized tax credits 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 does the federal government have 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 three criteria have been proposed to evaluate 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. Medicare does not place a limit on a Medicare patient’s total out-of-pocket expenses. Consequently, the out-of-pocket medical payments for low-income aged have forced many people to rely on Medicaid. Medicare Advantage plans provide enrollees with additional benefits and a limit on out-of-pocket expenses (Medicare2017.org 2017).
3. As shown in exhibit 1.3, the slowdown in medical expenditures started before the ACA was enacted and was the result of many factors; it should not be attributed solely to the legislation. 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) reported that the decline started several years before enactment of the ACA (as shown in exhibit 1.3), and that most of the ACA’s cost-control measures did not begin until several years after its 2010 passage. In addition, Ryu and colleagues (2013) discuss the reasons for the decline in medical expenditure increases. More recently, Dranove, Garthwaite, and Ody (2016) concluded that economic conditions, not the ACA, accounted for most of the reduction in healthcare spending during the 2009–2011 period.

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