Health Care Cost Control and the Affordable Care Act

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Chapter 1: Introduction

Every American will at some point will seek health care treatment for a condition that chicken soup alone cannot fix. Without their health, people are unable to work, spend time with their family, or be productive members of society. As a society we want everyone to have access to health care so that illness does not devastate people's lives. However, the cost of the American health care system has become unsustainable. Many Americans have to choose between purchasing health insurance and paying their bills. In 2008 the average cost of a trip to emergency room was $1,265.[1] An insurance provider's denial to cover a treatment or a drug can saddle a patient with thousands of dollars in costs. Health care, which is essential to every American, has become financially devastating.

In fact, health care costs are so high that they have become too much for even the American government to afford. The government struggles to afford the cost of Medicare and Medicaid without adding to the debt. Making matters worse, this financial commitment grows every single year. Finally, American businesses, which are the main source of health care for non-elderly Americans, struggle to afford health insurance premiums. Business costs skyrocket when employers have to provide for their patient's health. Overall, the U.S. spends approximately one-sixth of GDP or over $2 trillion on health care every single year. The enormously high cost of health care has made the financial future of the United States untenable.

The financial consequences of America's health care system were certain to get even worse without reform of the health care system. The growth of health care costs had been unbroken through the 20th century, though not from a lack of cost control efforts.

Since the creation of Medicare and Medicaid, the government has worked to control its' spending on the program. Today, a lot of political discussion on the costs of health care have wrongly centered on America's aging population, the number of medical malpractice lawsuits, and the price of prescription drugs. However, these explanations ignore the fact that health care industry functions exactly the participants are incentivized to behave.

The current structure of the health care system allows some of the participants in the health care market to expand their revenue. Under the fee-for-service systems, patients are charged a fee for each health treatment they receive. For participants such as physicians and hospitals providing more treatments only provides more revenue. Other participants in the health care market such insurers. However, the benefits that some participants are able to extract from the market leave consumers, the government, and employers to bear the burdens of high costs.

The high cost of health care is one of the many reasons that health care has long been a contentious political issue. This has been especially true recently. President Obama made health care reform one of the central focuses of his campaign in 2008. Once President Obama made health care reform a priority for Congress in 2009 the entire nation was engulfed in heated debate for nearly an entire year. Health care has also been a heated issue because of America's concern about the size of its' debt. After the Republican Party won control of the House of Representatives after the 2010 elections they frequently pushed for cuts in government spending on health care in order to reduce budget deficits.

The untenable nature of the health care system spurned action. The passage of the Affordable Care Act in 2010 created a multitude of new programs and agencies designed to control health care costs. The passage of health care was a historic moment for America. Congress had not attempted comprehensive health care reform since the Clinton administration. The ACA created an enormous expansion in the number of insured Americans, numerous regulations of participants in the health care market, and a multitude of programs to try control the costs of health care. The programs created to control the costs of the health care system are critical to overall success of the ACA. If health care costs continue on their current trajectory no one will be able to afford treatment. The government is frightened of the consequences of even more debt. Americans have already been saddled with extra health care costs.

This thesis examines the ACA to determine how effective it will be at controlling the costs of health care. In order to do so analysis will focus on the incentives of players in the health care system. Like any other market, players make decisions based on what is in their rational self-interest. The most important incentives to consider are those of health care providers. Under the current fee-for-service system health care providers financially benefit from providing expensive treatment. Many of the other participants in the health care market are able to insulate themselves from harms of high health care costs. Analyzing whether participants in the health care markets are incentivized to constrain costs will be a critical aspect of determining whether the Affordable Care Act will live up to its name.

Analyzing the incentives in the health care market will require a comprehensive look at health care costs. Chapter two will frame the history of health care cost growth

and the problems that this has created. Chapter three will explain how incentives in the health care market reinforce high health care costs. Next, chapter four will delve into why health care reform was able to pass despite the entrenched incentives of the health care system and the political process the ACA went through to become law. Finally, chapter five will use the conclusions in the previous chapters to analyze the how effective the ACA will be at controlling health care costs.

A careful examination of the ACA's ability to control health care costs is critical for understanding the future of American health care. On its current path it is only a matter of time before health care is too expensive for middle class Americans to afford. This health care system will not continue to exist if Americans are going bankrupt from routine medical procedures. Measuring the likely success of the ACA's cost control programs will provide insight into whether more changes to the health care system are likely in the future.

An examination of the health care market and the ACA is also critical to understanding future of American politics. Based on the political impacts that have already been influenced by the ACA, the ACA could enormously change the political priorities of the U.S. The process to pass health care reform sent Washington D.C. and the entire nation into an uproar. The Republican Party won the 2010 midterm election largely on the discontent created by the passage of the ACA. Currently, the scope of Medicare and Medicaid are being debated. Concerns over their cost and impact on the debt have created calls to constrain the benefits provided by these programs. The magnitude of future cuts to entitlement spending will likely be determined by the success

of the ACA. Constraining the cost of health care will be essential to the financial health of the United States and will have to occur another way if the ACA does not succeed.

This thesis is limited by the timeframe for implementation of the ACA. Though passed in 2010 many of the ACA's programs will not be implemented for several more years. Plus, once the programs are implemented their impacts will likely not be discernable for several years. The conclusions that I make will be based off of projection. However, providing analysis in 2012 can still be of great use. The financial harms of health care costs grow every year. If the ACA fails to make substantial change in order to create incentives to control health care costs years could pass where the problem of health care gets worse while waiting for the ACA's programs to be implemented. The health of Americans and financial health of the United States is dependent on controlling the impact of health care costs.

Chapter 2: History of Health Care Costs

Health care costs in the United States have risen astronomically over the past century and are reaching the point at which they are untenable for the U.S. economy. As of 2009, health care spending accounted for 17.4% of the U.S. economy. This means that one out of every six dollars spent in the U.S. is spent on health care. The government is one largest sources of funding for health care with Medicare and Medicaid accounting for nearly 40% of all health spending.

This massive amount of spending on health is unsustainable for the United States for several reasons. For the federal government, health care has created budget responsibilities that exceed tax revenue. Peter Orszag, the head of the Office of Management and Budget (OMB) for President Barack Obama, has regularly quantified the budget problem as a health care problem.[2] Next, the potential of the U.S. economy is limited by the unnecessary amount of its GDP tied up in financing the health care system. Finally, for individual Americans, high and rising health care premiums are too expensive to afford. To make the situation worse, the health care cost woes of the U.S. are exacerbated by problems of health care quality and the political reality of the U.S.

History of Cost Growth

The current state of the health care system has developed over several decades. The seeds of this health care system come from the economic hardships created during the Great Depression. In the early part of the 20th century, patients generally paid doctors directly for medical treatment. However the massive unemployment and poverty during the Great Depression made it difficult for Americans to afford medical service at all. Health care providers devised a third party payment system to protect their profits.

"Realizing that they could operate better with a steady income, hospitals began to sponsor payment plans, which came to be known as Blue Cross plans."[3] While patients could not afford the cost of treatments directly, they could afford a small monthly payment. Instead of charging patient's directly, Blue Cross covered the cost of patient's treatment for health care providers with patients in Blue Cross and later state sponsored Blue Shield plans. In the 1940s, Congress reinforced the third party-payment system. With wages frozen because of WWII, Congress allowed employers to offer health care coverage as a benefit on top of salary. By 1954, the IRS declared that health care premiums paid by employers were exempt from taxation.

Patients embraced third-party insurers because they insulated health care consumers from the immensity of health care costs. By the 1960s, the employer-based health system had become the main means for health care financing and nearly 75% of Americans had some for of private insurance.[4] Millions more Americans now had access to treatment with this new system of health care. Both patients and physicians benefitted from the 3rd party payment system. Patients had a reliable way to access care. Physicians had a guaranteed source of income. However, this very system created the means for unchecked cost growth.

Government Health Care

The government dramatically reformed the health care system with the creation of Medicare and Medicaid in 1965. Almost overnight, the government became the largest health care financer. The need for government health care arose from the number of people left out of the private insurance system. Before the creation of Medicare only 56% of elderly people were covered.[5] The elderly had an especially difficult time affording

health care as 47% of elderly families were below the poverty line.[6] This was especially a problem as elderly Americans are in need of the most frequent medical care.

There were several reasons the elderly lacked access to insurance. First, the employer-based insurance system meant that once seniors retired they lost their normal source of health insurance. Purchasing insurance individually had far more prohibitive costs, as retirees were no longer eligible for the reduced rates of group pool insurance. In addition, the elderly were unwanted customers by the insurance industry. The elderly naturally need more care as they age. In order to account for the extra use of care, insurance companies significantly increase their premiums for the elderly. [7] The need for extra care is evidenced by the fact that 23% of the elderly population in Medicare accounts for 85% of Medicare costs.[8]

President Johnson's Great Society programs created in 1965 greatly expanded access to health care for both the elderly and low-income Americans through Medicare and Medicaid. Medicare as it was originally passed had two main parts. Medicare Part A provides coverage for hospital care of the elderly as well as skilled nursing care, and extra services for the terminally ill. Medicare Part A is paid for by a 1.55% payroll tax. In 1965 there were 8.6 workers per Medicare beneficiary. Today there are three workers per beneficiary and this is expected reach just 2.4 workers by 2030.[9] Medicare Part B pays for doctor bills and other outpatient costs. This includes services such as going to physicians, laboratories and x-rays. Medicare Part B is a voluntary program and is partially paid for by seniors paying a premium that covers about 25% of the costs. The rest of Medicare Part B is paid for out of general tax revenue.

Congress has continued to expand Medicare since its creation. Medicare Part C (Medicare Advantage) was established in 1997. Part C coverage allows for the same benefits of Parts A and B but it is administered through private insurance companies. Seniors are offered extra benefits through these plans. The most recent expansion occurred in 2006 with Medicare Part D, which provides seniors with voluntary coverage for prescription drug. After a deductible and 25% coinsurance rate, Part D pays for enrollee's drug costs up to $2,830. Enrollees are responsible for all payment until the costs reach $4,550. As of 2011, Medicare covered 47 million Americans.[10]

Medicaid is the other half of the government's role in the health care market. "Medicaid was intended to 'pick up the pieces' left over by Medicare."[11] The elderly poor, the disabled, poor families with children, and pregnant women are the main Medicaid beneficiaries.[12] States are primarily responsible for running Medicaid, which is funded through matching grants from the federal government. State governments are in charge of determining benefits beyond a certain baseline of coverage. Over 58 million Americans enrolled in Medicaid.[13] The numbers of Americans eligible for Medicaid is set to significantly expand in the near future. The ACA provides for the federal government to fund Medicaid coverage for all adults who family income is below 133% of federal poverty level. This is expected to add 16 million people to Medicaid according to the Congressional Budget Office (CBO).[14]

Rising Medicare and Medicaid Costs

Once Congress created Medicare and Medicaid the federal government has become the largest single health care insurance provider in the U.S. Together, Medicare and Medicaid account for 38% of total U.S. health care spending. This is an especially

large financial responsibility for the government. Medicare originally cost $4.2 billion and then more than quadrupled in cost from 1967 to 1977.[15] From 1975 to 1997, the overall cost of Medicaid grew from $12 billion to $160 billion. As of 2009, Medicare cost $499 billion[16] and accounted for 22% of total national expenditures on health care."[17] Overall, from 1975 to 2009, federal spending for Medicare has grown from 0.9% to 3.5% of GDP.[18] The growth of cost of operating Medicare has made it one of the largest government programs.

Medicaid has also grown dramatically more expensive. Total expenditures on Medicaid have grown from $5.3 billion in 1970 to $24.8 billion in 1980 and reached $71.7 billion in 1990. Today Medicaid costs $347 billion, $251 billion of which came from the federal government. From 1975 to 2009, federal and state spending on Medicaid increased from 0.8% to 2.7% of GDP.[19] The rate of government health care cost growth is likely to continue into the future. The CBO has projected that from 2021-2084; the average excess cost growth rate (how much faster health care grows compared to the economy) will be 1.3% for Medicare and 0.8% for Medicaid.

Private Health Insurance

The creation of public insurance did not end the system of private insurance. Private health care spending still exceeds the government's spending. The costs of the private health insurance market have alarmingly grown in relation to government spending while covering a lower percentage of Americans. In 1970, private health expenditures totaled 46.8 billion dollars while totaling 62.3% of all health care expenditures. Today, private insurance and out of pocket spending costs over $1 trillion

and accounted for 55% of total U.S. health expenditures.[20] The dramatic growth in costs has occurred while covering less health care coverage.

National Health Care Spending

The combination of high health care costs in both the public and private sectors has made health care spending an enormous part of the U.S. economy. The nation's spending has consistently risen ever since the current health care system was created. From 1960 to 1970, national health expenditures increased from $26.9 billion to $73.2 billion and 7.6% of GDP.[21] By 1980 national health expenditures totaled $247.3 billion a year.[22] In the 1990s, total national health care expenditures had reached 12.2% of GDP. By 2009, health care spending had reached approximately $2 trillion a year constituting 17.4% of the economy.

The Problems of High Health Care Costs

Government Budget Concerns

The growth of health care costs far beyond the rate of inflation has placed a serious strain on the financial strength of the U.S. To start, health care cost growth outpaces the growth of all other sectors of the economy. "In 59 of the 73 years from 1936 to 2008, including an unbroken period from 1981 to 2007, the inflation rate for medical care, as measured by the Consumer Price Index, increased more than the rate for all items."[23] These trends are expected to continue into the future. "National health spending is expected to grow 5.8 percent per year for the period 2010 through 2020, 1.1 percentage points faster than the expected average annual rise in GDP. As a result, the health share of the GDP is projected to increase from 17.6 percent in 2009 to 19.8 percent in 2020."[24]

The rise in the cost of health care makes the government responsible for paying for 40% of increased health care costs while still providing the same services.[25] These increases often occur without with raises in payroll taxes or general revenues to fund the government's health care programs. Based on these shortcomings, the 2009 Medicare trustees report, Medicare Part A will be insolvent by 2017.[26] The government takes on the largest portion of these costs because they are both the largest insurer and the primary insurer for the elderly. In 2011 health care accounted for $898 billion, 23% of all federal spending. This makes health care spending the second largest category of spending next to defense.[27] In terms of GDP, health care has grown from 5% of GDP in 1960 to 15% in 2008.

The majority of the federal government's increased responsibility for health care financing comes from Medicare and Medicaid. Medicare rose from 2.2% of the federal GDP in 1985 to 5.3% in 2009. Medicare's rising costs are likely to continue as enrollment is expected to increase from 47 million in 2010 to 80 million by 2030.[28] Medicaid will also see a significant expansion. "In 2014, Medicaid spending is projected to increase substantially (20.3 percent) as a result of the expansion in Medicaid eligibility under the Affordable Care Act."[29] Looking to the future the Congressional Budget Office has projected that federal spending for Medicare and Medicaid will grow from "5.5 percent of GDP today to about 10 percent of GDP in 2035; about 6 percent of GDP would be devoted to Medicare... 4 percent would be spent on Medicaid."[30]

The U.S. faces several financial problems because of the combination of both the rise of health care costs and the upcoming expansion government health care. To start, the unrestrained growth of health care means that the federal debt continues to increase.

In 1965 the U.S. had a budget deficit of $1.4 billion dollars and a total debt of $260 billion.[31] Since 1965, budget deficits occurred almost every year with the only extended period of surpluses lasting from 1998-2001. As of 2011 the deficit for fiscal year 2011 was $1.3 trillion and the total debt had reached $14.86 trillion dollars. The amount of debt held by the public as a percentage of GDP reached 53% in 2009. The only other time the debt to GDP ration exceed 50% was during WWII. "For a combination of federal spending and revenues to be sustainable over time, the resulting debt must eventually grow no faster than the economy."[32] The U.S.'s growth of spending on health care alone far exceeds the growth of the economy.

The debt problem in the U.S. is not easily addressed because Medicare and Medicaid are entitlement programs required by law. Funding for entitlement programs are guaranteed and determined by law. The amount of money spent is by Medicare and Medicaid is determined by formulas and the cost of services provided each year. Congress cannot make changes to the amount of Medicare or Medicaid spending through the normal budget process. This creates structural debt that occurs every year. Without significant changes to these programs, Medicare and Medicaid will likely run annual deficits.

This massive a continuous growth of the U.S. debt is unsustainable for several reasons. First, high amounts of debt drastically reduce the amount of money available for discretionary spending by the federal government. Health care funding is largely guaranteed because it's funding is guaranteed by law and determined by a formula. When debt is high, politicians can also be wary about passing budgets that create new programs or continue expensive programs that would further expand the debt. Debt has come to be

a contentious issue for many Americans and Congressmen want to keep their constituents happy. An alternative means funding, passing new taxes, is just as unpopular. In the current political environment in Congress proposing taxes is a sure way to incite controversy and is sure to inspire a challenger in the next election.

The much more likely occurrence is that when debt is too high programs are cut from the budget and future discretionary spending is frozen. Additionally, Congressmen are unable to create new programs. The impacts of reduced discretionary spending are enormous. In the 2011 budget alone, $38 billion was cut from the budget. These cuts included terminating a $2.5 billion highway construction fund, cuts in subsidies to farmers, $5 billion from capping compensation to crime victims, $2 billion in cuts to worldwide aid, and even more cuts in education, transportation, the environment, and health care spending.[33]

All of these areas of spending offer the potential for social and economic growth. Discretionary spending, however, can be used to create future growth. For example, funding for Department of Education has the potential to create students who will be future scientists and innovators. Investment in higher education can provide targeted research in emerging technologies. Discretionary spending can also by used on building up infrastructure. Investment in infrastructure such as roads can create more efficient transportation and lower the cost of business and travel. Investing in the infrastructure such as factories can increase the economic output of the U.S. Infrastructure spending can also prove be a source for employment. The 2009 American Recovery and Reinvestment Act were largely focused on creating new sources of jobs through new infrastructure. These investments create the potential for more a more productive economy and more tax

revenue generated. When the federal debt is too high, these opportunities begin to disappear.

Entitlement spending does not create these same opportunities for future economic expansion. Medicare spending goes almost entirely to the elderly who have already retired. Medicaid spending often goes to those who are chronically sick and are unable to work. The elderly and the chronically sick are unlikely to reenter the workforce therefore there is little chance that this money will come back to the government through taxes. Next, the nature of the health care industry is that it is consumption based. While new technologies are developed they are generally only applicable to the health care system. The research that occurs in the medical sector does not unlock economic growth anywhere. In fact, these technologies raise medical costs by creating more services for patients and for keeping patients alive longer. Even for spending for the non-elderly there is no potential for expanded economic benefit from health care spending. Some one who gets sick is temporarily removed from the workforce. Once they return they are not likely to be extremely more productive than they were before they were sick. Overall, health care is an industry that consumes far more than it expands economic potential.

High debt has severe consequences outside of government spending. The large debt created by health care spending is also of concern to the federal government because debt can create higher interest rates for both government and the private sector for borrowing money.[34] Borrowers have a harder time securing money when there is already a large existing debt. Higher interest rates are a way for lenders to protect themselves from the risk of a default on the loan. For example the recent credit downgrading of the U.S. has raised the interest rate for home mortgages and credit card loans.[35]

One of the largest problems caused by a large debt is an increased chance of an economic crisis. High debt can also cause investors to lose confidence in the government's willingness to fully honor the its' debt obligations. In order for the government to continue to secure loans debt financing rates and interest rates would have to be raised. Otherwise investors would feel investing in the government to be too risky. "If interest rates on government debt spiked, the value of outstanding government debt would fall sharply."[36] This creates a broad financial crisis that can lead to losses in the value of mutual funds, pension funds, banks, and other holders of government debt. The point at which this rate becomes too high to be sustainable is unknown but it is problematic nonetheless. Once investment is considered too risky too pursue, the U.S. economy could quickly stagnate.

These economic concerns are made even worse because the high debt reduces the ability of the U.S. to respond to economic crises. The implications of economic crisis become magnified when the government cannot absorb the consequences. "Greater debt in the future would increase the risk that investors would be unwilling to finance all of the outlays or revenue reductions needed to deal with unforeseen events unless they were compensated with very high interest rates."[37] The inability to borrow high amounts of money means that the government would be unable to fund bailouts or take out the loans to do so if there are high interest rates and little discretionary funding available.

Complicating all these debt concerns for the government is the reality that the longer that the federal government does not deal with the problem of debt, the harder it becomes to solve. As interest accumulates, paying down the debt becomes more difficult. When debt exists for too long investors are more likely to lose confidence in whether

they will be paid back. The federal budget will continue to face large deficits as long as health care costs continue to grow.

Economic Concerns

The high of cost of health care premiums also has an enormous impact on the financial strength of the American economy. As of 2009, 162 million Americans, or about three-fifths of all Americans, received their insurance from their employers.[38] The responsibility of employers to provide health care to their employees makes a health care cost a responsibility that directly affects them. "Ninety-five percent of employers with more than 50 workers and almost three-quarters of companies with 10 to 24 workers provide insurance."[39] The average employer-based health insurance plan costs $13,375 for a family and $4,824 for an individual. However, the amount paid by the employer varies by company.

For business that cover significant portions of the costs of their employees health insurance plans the cost can be prohibitive. General Motors, who needed a government bailout in 2009, spent $103 billion over the last 15 years on health care on post-retirement health care benefits[40] and averages $5 billion every year on health care.[41] "GM says healthcare costs add between $1,500 and $2,000 to the sticker price of every automobile it makes."[42] Adding billions of dollars to the cost of business for international corporations like GM places them at a significant disadvantage to countries with socialized medicine. Foreign automobile producers do not have the same cost of business as GM does.

Increases in the costs of health care hurt business because they increase their overhead costs. A study examining the impact of health insurance costs in 32 industries found that "a 10 percent increase in excess growth in health care costs would have resulted in 120,803 fewer jobs, US $28,022 million in lost gross output, and US $14,082 million in lost value added in 2005. These declines represent 0.17 to 0.18 percent of employment, gross output, and value added in 2005."[43] These figures represent the economic consequences if employers take not action to protect their profits. Unfortunately for employers, they are not always able to find ways to compensate for the loss of profits. "Rapidly rising health insurance premiums exert pressure on employers to increase total employee compensation, as employers cannot easily reduce wages to completely offset premium increases."[44] For industries with unionized workers decreasing employee benefits can be especially difficult. Even if workers are not unionized, competition for employees can make cutting benefits unavailable as an option.

With health care costs increasing every year, millions of dollars are lost in profit every year. Limiting the profits of businesses can be problematic for the U.S. economy. Companies can be severely limited by the financial burdens of health care. Especially during tough economic periods, it can be difficult for enough economic growth to occur if health care takes up one-sixth of the spending in the nation.

Concern for Individuals

The high cost of health care should also be of concern to the U.S. because of the impact that it has had on the financial security of American families. Most importantly, out-pocket expenses, such as co-insurance, co-payments, deductibles, and other medical

purchases not covered by insurance, have significantly increased. "People using health services spent an average of $741 per person in 2005 for health care services, compared to $427 in 1996. After adjusting for inflation, this represents a 39.4 percent increase in out-of-pocket spending per person."[45] Premiums have also seen growth as prices since 2000 have risen anywhere from 8% to 14% every year. In addition, American families' payments for health care rose across-the-board from 1999-2009. Out-of-pocket health care costs reached $235 per month, an increase of 78%. Co-pays for a doctors visit rose from $5-$10 to $20-$30 and emergency co-pays went from mostly nonexistent to $100 or more.

This increase in health costs has not been matched by an increase in income. "Between 1999 and 2009 [the family's] before-tax monthly income grew by nearly $1,910, from $6,350 to $8,260. About 43 percent of that increase ($820) went to higher payments for health care, including taxes devoted to state and federal health care programs."[46] While business may not able be able to cut spending, they can make up for extra health care costs by not increasing employees salaries. This problem is further defined by the comparison of inflation rates to health care costs growth. Median family income grew 30% from 1999-2009 while [47] at the same time, monthly premium for families' private health insurance grew by 128 percent, from $490 to $1,115."[48]

This burden that insurance system put onto American families meant that they could easily be financially devastated by the costs of health care bills. According to a study from the American Journal of Medicine, "illness or medical bills contributed to 62.1% of all bankruptcies in 2007."[49] The largest medical sources of out-of-pocket expenses were hospital bills, followed by prescription drugs, doctor's bills, and

premiums. Families are unable to pay bills when private insurance company refuses to do so; the costs are far too high. Plus, as poor health limits the ability to work, medical bills create a cycle where Americans are unable to afford the treatments that would allow them to recover and pay off the cost of health care bills.

All of these statistics indicate that rising health care costs are being consistently passed onto individual payers. With both premiums and out-of-pocket spending increasing, health care quickly becomes a financial burden on families, especially in times of major health incidents. Much less income is left for families every month after health care spending. This makes it hard to afford medical emergencies and exacerbates the propensity for bankruptcy.

The high costs that families' pay for health care also exacerbates the economic problems that the U.S. is facing. With health care demanding one-sixth of the total economy, health spending is integral to the continuing function of the economy. However, with health spending accounting for more of families' disposable incomes every year there is less money left over for discretionary purchases. This becomes especially devastating in hard economic times in which consumer spending is essential to grow out of a recession. When income is already tied to health spending, the economy is dependent on that one pillar remaining especially strong. While spending in additional sectors of the economy is needed families do not have the income.

International Comparisons

The high cost of health care is even more egregious when health care quality is compared internationally. The most expensive health care system in the world has failed to create the best health care system in the world. The nearest OECD country was the

Netherlands at 12% of GDP; France, Germany, Britain, and Italy are all approximately half of the amount the U.S. spends. This is not just an effect of the large population in the U.S. Health care spending per capita spending in the U.S. at $7,960 was more than twice the median per capita expenditure of OECD countries and significantly higher than second place Norway at $5,352. This statistic is alarming when the U.S. does not have universal coverage. "Public health care spending per capita in the U.S. ($3,794) exceeded total health care spending per capita in half of the other OECD countries, and yet public programs in the U.S. covered only 27 percent of the population."[50] Health care is a far greater burden on the government and economy of the U.S. then the rest of the world despite covering fewer citizens than other countries.

Examining the quality of U.S. health care, a 2010 study from the Commonwealth Fund, the U.S. ranked last or next to last in the five dimensions of a high performance health system compared to Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom: long, healthy, productive lives, quality, access, efficiency, and equity.[51]

Americans are not living comparatively long, healthy, or productive lives. To start the U.S. infant mortality rate was 34th in world at 6.81 deaths per 1,000 live births.[52] The U.S. total life expectancy in from 2005- 2010 was 78.3 years, making it 36th overall in the world. To put these rankings in perspective, the 2005 predicted life expectancy for the US based solely on income was 80.9 years, which would place it in the top 10 countries.[53] The U.S. also has a high rate of preventative deaths. "Among 19 countries included in a recent study of amenable mortality, the United States had the highest rate of deaths from conditions that could have been prevented or treated successfully."[54] In the most basic

factors of health care—birth, death, and keeping people alive, the U.S. is one of the worst performers among peer nations.

The U.S. also comes up short in the quality of the health care system. Medical errors are especially significant as the U.S. ranked third highest among deaths due to medical errors. The U.S. health system lacks overall quality because of poor performance on chronic care management, preventing medical errors, avoiding injuries, and the overall safety of medical care. Thirteen percent of patients were likely to report being given a wrong medication or dosage compared to 10% in other OECD countries.[55] All of these errors that occur in the U.S. make its health care riskier than much of the rest of OECD countries.

U.S. citizen's access to health care falls behind the rest of the world due to the lack of universal coverage. While U.S. patients may have quicker access to specialized services, the U.S. still ranks low on the overall accessibility of appointments with primary care physicians. In a 2004 survey of five OECD countries, "U.S. respondents were the second-least able to make a same-day doctor's appointment when sick and had the most difficulty getting care on nights and weekends."[56] Furthermore, these concerns are exasperated by the high cost of health care. Over half of those surveyed said they had problems visiting a doctor, filling a prescription, etc. due to cost.[57] Both high costs and a lack of insurance combine to make Americans access to primary care relatively poor.

The U.S. health care system also falls behind in terms of efficiency. High administrative costs, re-hospitalization rates, and duplicate medical testing all contributed to the low efficiency rankings. The lack of access to coverage also creates efficiency problems. U.S. patients are more likely to use the emergency room for services that could

have been provided by a regular doctor. This creates problems for quick access to care as people using care inappropriately creates difficulties for the rest of system.

Finally, the U.S. ranks low on the equity of its health system. "Americans with below-average incomes were much more likely than their counterparts in other countries to report not visiting a physician when sick and not getting a recommended test, treatment, or follow-up care; not filling a prescription; or not seeing a dentist when needed because of costs."[58] Even among the higher-income population in the U.S., patients were more likely to report difficulty obtaining health care because of costs. The prohibitive costs of health care make it so that treatment becomes a choice with significant tradeoffs that people can be unwilling to make.

Political Challenge to Controlling Costs

With both costs and quality hurting the U.S. health care system some politicians are aware that something needs to be done. In fact there is a long history of attempts by the federal government to try to reign in the costs of health care is unable to sustain the high level of debt far into the future. Unfortunately, politicians have been unable to pass policies or programs that flattened the growth of health care costs.

One of the first attempts at cost containment was Professional Standards Review Organization (PSRO) program established by the Social Security Amendments of 1972. "The PSRO program was designed as a peer review mechanism to promote effective and financially efficient delivery of health care services for Medicare and Medicaid."[59] Over 200 PSRO programs were created to improve Medicare and Medicaid. PSRO's had the

authority to deny approval of payments for services provided if they were found to be unnecessary.

The PSRO organization was found to be ineffective at controlling costs by a 1981 study by the CBO. Even though the program slightly reduced the costs of Medicare utilization, the program cost more than the amount of money saved.[60] One factor that may hurt the program was that there was little incentive to reduce utilization of services because that meant less federal money for those doctors. Doctors did not want to negatively affect other doctors, as they wanted to keep profits high for themselves. Next, the program had a natural conflict between reducing costs and improving care at the same time. It is difficult for doctors to reduce care if they are concerned about making sure their patients get all the treatment they need.

The federal government again tried to flatten the cost curve with The National Health Planning and Resource Development Act of 1974. The law required all states to establish certificate-of-need (CON) laws that "require hospitals to document 'community need' to obtain approval for major capitol expenditures for expansion of physical plants, equipment, services. The primary purpose of these laws was to prevent unnecessary investment in facilities and services."[61] There seems to be little evidence that costs declined after the passage of the law. Provider interests heavily influenced Health System Agencies that were established to administer CON laws. The pressure coming from providers heavily outweighed the general public's desire for contained costs. This problem was exasperated by lack of public recognition or support of the CON laws or Health System Agencies.

The federal government also tried to regulate the behaviors of providers to reduce costs. Health Maintenance Organizations (HMOs) became of significant focus of the government's as a way to control costs. "A HMO is a prepaid medical practice delivering a comprehensive set of health care services to enrollees for a fixed fee paid in advance."[62] HMOs try to reduce health care costs by creating incentives to move treatment from inpatients setting such as hospitals to the outpatient setting of a doctor's office, promoting HMO competition with traditional health care delivery, and trying to obtain preferential pricing from health care providers.[63] By replacing the fee-for-service fee with a fixed amount of compensation, health care providers would have a natural incentive to contain costs. The Health Maintenance Organization Act of 1973 provided $375 million over five years to help provide start-up costs for HMOs. Beginning in the late 1980s the federal government encouraged Medicare recipients to enroll in HMOs that used managed care. Medicare Managed care enrolment increased about 50% from 1994 to 1997[64] and enrollment In HMOs increased from 39 million to 79 million from 1992 to 1998.[65]

HMOs had some success in cutting costs but it did not bend the overall cost curve. Studies indicated that HMOs cut total costs for enrollees from 10% to 40% and those HMO enrollees had 20% to 40% lower hospitalization fees.[66] However, enrollment in HMOs has not been high enough to curb the costs. "In 2004, only about half of firms with fewer than one thousand employees offered their employees a choice of health care plans; for firms with fewer than two hundred employees, fewer than 15 percent."[67] HMOs never became a significant enough part of the health care industry to control costs. They had the entirely unpopular task of reducing the amount of services provided to customers. HMOs gatekeepers reduce services and restrict available services in order to

ensure that doctors and hospitals still made a profit. Physicians disliked the model because there incomes were guaranteed only if they contained their costs. The potential for profits in HMOS was much less than under a fee-for-service model.

The next major attempt to control health care costs by Congress was The Balanced Budget Act of 1997. "To control spending on services already paid prospectively, such as the services provided by hospital inpatient departments, the Act reduced payment updates in relation to what they would have been." The act also established new prospective payment systems for outpatient services and created the Medicare + Choice program. Like some previous reforms, there was limited success by the Balanced Budget Act. In 1998, total outlays for Medicare rose by only 1.5 percent compared to the average rate of 11 percent from 1980 to 1997.[68] In total, the Balanced Budget Act reduced Medicare payments to hospitals by $189 billion from 1998 to 2004. However, these reductions were modest and only created a temporary slowdown in the cost of health care. By 1999, the annual growth in overall health care costs had risen back to 7% as to just 3.3% in 1997.[69]

The problem with these attempts to control health care costs were twofold. First, physicians are unlikely to embrace cost control measures because this reduces their income. A dollar spent on medical care is a dollar of income. National health expenditures constitute the money that the medical care industry including physicians, nurses, and hospitals to drug companies, insurers, lawyers, and sales and marketing staff. Controlling health care costs requires restraining the industry's potential income.[70]

Congressional Limitations

The individual concern of politicians magnifies both of limitation to controlling health care costs. With one out of six of every dollar spent in the U.S. going towards health care, it is no wonder that health care is consistently a top political issue as so many jobs are dependent on health care spending. For Congressmen, protecting health care is often critical for the interests of their district. Protecting and expanding health care jobs is good way to bring benefits to a district. According to the bureau of labor statistics, health care provided 14.3 million jobs in 2008 and 10 of 20 fastest growing jobs are in the healthcare industry. "Employment in the health care sector, which includes related industries such as pharmaceuticals and health insurance, grew by 21 percent between 1998 and 2006, whereas employment across all sectors grew by only 6 percent."[71] Additionally, health care is expected to generate 3.2 million new jobs from 2008 to 2018.[72] The roughly $2 trillion dollars that goes into health care every year is the income source for huge amount of health services workers. Almost every Congressman is likely to have jobs in the health care industry in their district. Limiting the profits of the health care industry could directly limit the profits of their constituents.

Health care is also of significant interest to politicians because of the voting habits of elderly voters. "Politicians at all levels know that older persons vote at a higher than other age groups and that they are a steadily increase percentage of voters."[73] Members of Congress are careful of upsetting elderly voters or drawing the ire of the lobbying groups such as the AARP. This desire to see their existing coverage protected expands to all voters. It is far more attractive for a Congressman to work toward protecting the benefits of the health care system.

Any attempt at cost control for health care also elicits resistance from the enormous number of stakeholders who is income is dependent on health care costs. The importance of health care spending as a source of income can be seen through massive efforts of the health care industry to lobby Congress. "Since 2006, the health sector has spent $1.7 billion lobbying Congress and federal agencies – more money than any other sector of the economy."[74] Overall there are 3,000 registered health care lobbyists with access to Capitol Hill.[75]

The difficulty to control health care costs for the federal government can be seen in the Joint Select Committee on Deficit Reduction. When trying to identify areas to cut spending in 2011 Congress largely left health care spending untouched. Common ground was non-existent between the Democrats and Republicans on ways to reduce health care spending. The only way significant cuts were likely to occur is through an automatic cut to Medicare if the Super Committee failed to reach deal. Regardless, these cuts only amounted to $123 billion in savings over 10 years.[76] Asking politicians to create savings has long been a dead end. Reelection depends on the approval of constituents not an objective performance evaluation. When the government has started down the right path the political interest from Congressmen has largely left them unwilling to continue the actions that may actually flatten health care cost growth.

Conclusion

The problems of high health care costs are clear throughout the U.S. Costs continue to grow almost every year. Continuing on this path is likely to create financial devastation for the U.S. government, businesses, and individual Americans. Unfortunately, what efforts so far to constrain costs have not been nearly robust enough

to begin bringing the cost of the system under control. The future financial stability of the U.S. is largely dependent on finding a way to make health care costs more manageable.

Chapter 3: Incentives and the Health Care Market

Health care cost growth has been so dynamic because of the unique nature of the health care market. First, the market does not have the same natural factors pushing down costs as other markets do. Next, the cost of health care rises even higher because of the incentives of the participants in the health care market and their ability to profit from the system. The combination of these factors makes America's health care system the most expensive in the world. Without the normal limitations of a market, the health care system experiences uncapped growth.

An analysis of the health care market and the incentives of the participants in the health care market will make it clear why health care is so expensive. The lack of a free market sets the stage for participants to use the health care market for their own rational self-interest. The comparison of a traditional or free market to the health care market will put into perspective the many unique market factors of the health care system and help delineate how participants are able to use high costs to create personal benefits.

Free Markets

If the health care market functioned as most other markets do, supply and demand would prevent the price of a product from rocketing in cost. "A market can be simply defined as a social system in which individuals pursue their own welfare by exchanging things with other whenever trades are mutually beneficial."[77] In most cases, customers money is exchanged for a good or service provided by a producer.

The most important interaction in a free market is the one between the seller and the buyer. Both players attempt to maximize their own benefits during the transaction.

"In the market model, individuals act only to maximize their own self-interest."[78] Consumers purchase products when they believe they are better off by purchasing that product at the price. Producers will sell products at a price where they can attract more customers than their competitors and make a profit. When supply and demand determine the makeup of a market, the result satisfies both consumers and producers. Both consumers and producers benefit from the transaction because what they receive will has value to them then the good they gave up.

The attempts of sellers and buyers to get to the point where they have the most marginal utility from their interactions drives prices lower. The rational self-interest of producers and consumers directs the market to equilibrium where consumers receive their product at the lowest price possible while producers are still able to make a profit. For producers a lower price makes their product more attractive then their competitors. In order to create a lower price, producers seek to be efficient. "Efficient organizations are ones that get things done with a minimum of waste, duplication and expenditure of resources."[79] The organizations that are the most efficient are able to produce more resources at a lower cost, giving them a competitive advantage. This competition for the consumer's money is great for the consumer. As long as the product is of similar quality the consumer will almost always purchase the product with a lower price. Consumers acting in their rational self interest forces the market to meet their demands.

In order for a free market to exist, several market conditions must be met. First, both parties in a free market must be able to make the transaction voluntarily. Given the choice, consumers can be trusted to make the decision that benefits them.[80] The goal for producers is to set the price of their product at the point where the consumer will choose

to purchase their product when they are given a choice. If a consumer is compelled to purchase a product the consumer looses the ability to demand a lower price. Once the consumers must purchase a product, they lose the leverage to demand a lower price. If a consumer can be compelled to make a decision, the producer only has to factor in the price the consumer is capable of paying instead of what they are willing to pay.[81]

The knowledge and information that the consumer possesses is also a critical factor for keeping the playing field level between consumers and producers. Consumers are best able to make decisions that benefit them when they are knowledgeable about the product they are purchasing. "There must be full information about the available alternatives, so that exchanges truly result in the best situation for everyone."[82] If consumers are informed about the alternatives to the product they desire they know when it is advantageous to switch to another product. Producers have to be mindful of this when determining the cost and quality of their product. This can be down offering a product with a lower price or better quality, ideally both. Without full knowledge of the product, a consumer can be induced into purchasing a product when there is a more beneficial alternative.

Limiting the number of parties in a transaction is also beneficial for an ideal market for both consumers and producers. When a third party is introduced to consumer-producer interactions they have the capability to change the decision-making process of the producer and consumer. Outside parties change the decision-making process of the producers and consumers. For example, insurance removes the risk of a transaction for one of the parties. If consumers are protected from risk from a transaction, they can spend more on a product.

Third parties can also greatly expand or a contract a market. For example, without government intervention, markets will arrive at a point called Pareto efficiency--resources will be allocated so that no person can be made better off without making another person worse off.[83] At this point, all the consumers who want to purchase a product are able to and all the producers who want to sell their product at that price are also able to do so. The government is one third party that has the ability to enter a market and limit who is allowed to purchase a product or significantly expand the availability of product to people who otherwise could not afford it. The creation or removal of barriers for entering a market fundamentally changes the market.

Finally, a perfect market has a large number of producers with near identical products. When a single market has a large number of firms, they compete with each other for a large enough market share that will allow them to make a profit. In order to attract a large market share, firms will make their products both cheaper and of a better quality. It is important that the products are near identical so that they are still competitive. If products are too different and fulfill differ roles than they no longer directly compete for the same customers.

Health Care Market

Health care proves to be an exception to nearly all of these conditions for a perfect market. These exceptions prevent the normal price controls from occurring. Factors unique to the health care system includes its' source of funding, the needs and limitations of consumers in the health care market, and America's desire for its' health care system.

The role of private insurers in the health care market alters the market to the point where consumers that have purchased insurance makes decisions almost entirely independent of cost. Insurance plays two main roles in the health care system. First, it facilitates that payment to physicians when people use care. The private insurance industry provides a significant portion of the financing of the health care system-- in 2007, 67.5% of the U.S. was covered through private insurance. [84] Secondly, it pools the risk of illness in order to reduce the risk to individuals that they will get too sick to be able to pay for their illness.[85] Patients with insurance are almost entirely removed from the financial health care process.

Making health insurance affordable is a direct factor in high health care costs. Because health care is too expensive for even the wealthy to afford without insurance, health insurance provides a way for care to be provided in the face of enormous costs. While 50 million Americans are currently uninsured, this is a dangerous financial situation. Two-thirds of all bankruptcies are caused by health care costs. Usually the uninsured are unable pay for health insurance and the inability or qualify for government programs. Without insurance, millions more of Americans could be financially devastated. "Most people prefer to avoid financial risks, and will seek insurance against them. This provides the primary motivation for purchasing health insurance."[86] This creates a lack of leverage in forcing down prices. Insurance companies know that they have a product that people have to purchase. This spreads out the financial risk of getting sick so that the insured pay a set amount every year instead of facing enormous payments when they are significantly ill.[87]

Once patients become insured, they become the stimulus that allows health care funding to grow rampantly. Patient's rational self-interest takes little consideration of the price of treatment they receive. The position of patients in the health care market prevents the health care market from operating as a perfect market would. By using a third party—either an insurer or the government—the effective price of health care for patients becomes almost zero.[88] With no effective price to accessing health care after premiums are paid the natural limit to patient's demand is removed.[89] "If insurance makes price no longer an issue, and the patient's physician recommends the procedure, the patient is unlikely to resist."[90] There is no incentive to say no other than the amount of time and personal discomfort it takes to receive the treatment. Without limitations to patient's demand, "the costs and quantity of services delivered becomes determined largely by the supply system, the medical care system."[91]

Patients also have an extremely high demand for health care because the most important consideration for patients when they go to visit a doctor or a hospital is recovering or preserving their health. Health is of course highly valued because without good health it is extremely difficult to work, live, and function in society.[92] It is natural for the patient to request relevant treatment for their condition. For example, requesting a MRI to investigate a bad headache that costs $2,000 dollars per use has no negative consequences for themselves. The patient wants assurance that they are healthy and the insurer covers the cost. The potential for a headache to actually be brain tumor is motivation for patients to receive all relevant medical services.

Furthermore, when a patient is seriously ill, they are unable recover without treatment. Waiting for a better price is hardly an option. Once you need treatment, it is

difficult to shop around for a better price. Someone with a broken leg cannot wait a couple months until it is cheaper to have the bone set. Any delay increases the amount of time before the patient can return to work or even increases the risk of death. It is in the best interest to quickly recover once their health is compromised. The exchange nears the point where it is involuntary for consumers.

Next, patients do not have an equal amount of knowledge as the other participants in the health care system. This imbalance in knowledge is perfectly understandable as there is little opportunity for the patient to bridge the knowledge gap. A customer is normally able to research a product themselves in order to make the best decision. For example, a customer could make a decision to choose whether to buy a new computer based on the their technological needs, price, etc. Learning your preference would take some time and could be decided by consulting consumer reports. When it comes to health care only physicians are likely to provide a trusted answer. When a patient is sick often times they only know that something is wrong. Physicians have received a minimum of 4 years of specialized education. A patient is extremely unlikely to have the knowledge to disagree with a physician. Additionally, when patients visit a physician "patients are told about the package of services that a physician recommends for a condition, not offered an a la carte menu."[93] The direct recommendation that comes from the doctor is not likely to be disregarded by the patient because the doctor is the expert. Patients trust the treatment they get. A study found that regardless of payment method, 84% of patients trust their physician to put patients' interests first.[94]

This information imbalance prevents the health care market from reaching the lowest price possible. Once the patient enters the physician's office they are almost

certain to get treatment no matter the price as long as they can still afford it. Patients do not generally shop around for the best price possible. Patients do not want wait out for a better price. When demand is constant for a product regardless of price providers will take advantage of the opportunity.

Competition

Finally, the ability of the health care market to function at a low cost is also limited beyond the removal of the normal rules of supply and demand. "In 2007, a survey conducted by the American Medical Association found that in more than 95 percent of insurance markets, a single commercial carrier controlled at least 30 percent of the insurance market."[95] This means that across the United States, many insurers control a large enough portion of the market to not have to worry about other competitors' prices. They can charge high prices to their customers with little concern about losing them as customers. Additionally, overwhelming market share allows health insurance companies to conduct practices such as denying coverage based on pre-existing conditions and placing annual caps on insurance policies because they customers have no alternative. Most importantly, no competition means that insurance companies do not have to be worried about being price competitive.

Competition is also lacking because of the role of employers in the health care market. Two-thirds of the population under 65 receives coverage through their employer.[96] The nature of purchasing insurance limits the ability for health care consumers to find the best insurance coverage at the lowest coverage. Employer insurance is a convenient source of health care as it part of the perk of having a job. It can also be financially advantageous as it is offered as a benefit at a job that is deducted from

your taxable salary. Employer insurance is also cheaper than purchasing insurance on your own. By creating a large pool of customers for insurance companies employer sponsored insurance further spreads the financial risk. Because consumer's easiest and cheapest choice is to purchase the insurance provided by their employer, insurance companies only have to make this insurance cheap compared to purchasing on your own to attract customers. This means that shopping for the best price is largely left to employers.

Reasons for the Limitations of the Health Care Market

These conditions that shape the health care market away from a free market exist because consumers are also citizens. "In the market, commons problems are thought to be the exception rather than the rule. Most actions in the market model do not have social consequences. In the polis, by contrast, commons problems are everything."[97] In a normal market if someone cannot afford a product like a computer they cannot access some privileges. In the health care market a person without care can die.

When consumers reject efficiency for equity, they are rejecting the negative externalities of the market. Normally, not every person who desires a product will be able to purchase the product. When people have high demand for a good the market responds by increasing the price of the good. Goods essential to survival are of course in high demand. When consumers embrace equity, it also out of the motivation of security. Citizens consider the products to be public or merit goods that a third party, usually the government, to guarantee for them. Consumers believe that everyone should have at least some access to the good because of how important it is to people's lives. Americans view

health care as a merit good rather than a market good.[98] However this means that health care providers are guaranteed consumers. This makes the even less responsive to price. Consumers expect a third party, the government or their employer to guarantee health coverage. This guaranteed health care market means that insurers do not have to worry about losing consumers based on price.

Incentives

The sources of the high costs of health care go beyond the conditions of the health care market that violates a perfect market. The conditions that prevent a perfect market from emerging only set the stage for the high health care costs. The real source of costs comes from participants in the health care market acting in their own rational self-interest. For many of the participants in the health care market, their incentives are overwhelmingly lined up towards creating higher costs because their livelihood is determined by the amount of services they provide. "Each dollar spent on health services represents an expense to payers and revenue to providers and suppliers."[99] The template to increase personal income is unconstrained because the health care system is unique in the amount of spending that it can absorb. "The medical care system can legitimately absorb every dollar society will make available to it."[100] For the most part, the participants in the market operate regardless of price and demand. "With price and demand no longer the arbiter, the cost and quantity of services of services delivered become determined largely by the supply system, the medical care system."[101] In a service-based system, the volume of services that can be given is extremely high.

Without a natural limit, the cap on spending in the health care system is almost entirely self-imposed.

The inability to control the costs of health care makes cost growth exponential. Health care has grown to 17.4% of the U.S. GDP in 2009 from 5% in 1960. The costs of the health care system is the total of the quantity of people treated (Q) multiplied by the price of treatment (P) multiplied by the intensity or amount of that treated provided (I). (Total costs = Q x P x I). Under the health care system, it is easiest for health care providers to increase both the quantity and intensity of care. The more these two factors rise, the more profits are available in they system for health care providers. It is important to look deeper into how the participants in the health care system tap into this demand. The propensity for cost escalation "is deeply rooted in the structure and incentives of the present medical care system and its financing, and on its own the system has no adequate mechanisms to cope with it."[102] For other market participants, they do not have strong incentive to control costs because they are largely able to avoid the consequences of high costs. Examining how incentives operate in the unique health care market will help explain the astronomical growth of health care costs.

Employers

Employers are torn between two different motivations when providing insurance. On the one hand, providing insurance can attract talented employees to your business. At the same time, the cost of providing insurance can also be financial burden on businesses. As the source of health insurance for two-thirds of Americans under age 65 controlling health care cost would save a lot of money.[103] However, the expectation of employees to

receive insurance from their employer makes it difficult for employees to control health care costs. Health care has become a benefit that many employees expect and need to be part of their salary. This makes employers consistent customer who are unlikely to stop offering insurance. Insurance companies are able to exploit employers need to provide health insurance through higher prices.

Employers rectify this problem by shielding themselves from the full repercussions of high health care costs. Much of this is done through passing cost onto employees. "Employees now pay an average of $3,997 as their share of the annual family health insurance premium— about $1,000 more than in 2006 and twice the 2001. For single coverage, employees this year pay an average of $899 -- nearly triple the price of a decade ago."[104] Though projected as a benefit by employers, health insurance is factored into overall worker compensation.[105] By passing costs to employees, employers insulate themselves from health care costs.

Physicians

Once the patient enters the physician's office, the amount of treatment that they receive is almost entirely determined by the physician. Physicians are immediately pulled in different directions when they decide how what course of treatment is best for patient. "Patients have an interest in having physicians act as their agents in providing information and services… providers of insurance are interested in having doctors economize on the use of health services, since this reduces their expected claims cost."[106] Physicians are called to act as 'double agents' by providing comprehensive services to patients while at the same time keeping costs low for insurance companies.

The physician's first role in the health care system is their responsibility to the patient as they are responsible for providing the treatments the patient needs to fully recover. With this obligation, the physician is going to make sure that they properly treat the patient. If doubt remains about a health issue, the physician will order more tests to make sure that they prescribe the right course of treatment. The more services and tests provided for a patient, the more confident physicians can be that they have done their job. Many physicians enter the profession because of their desire to help people and improve their lives. "One interpretation of medical ethics is that in a situation in which there are many choices of how to treat a patient, ethics dictate that the physician chooses the 'medically correct' way to proceed."[107] It is critical to notice that price never factors into the ethical considerations of the physician.

This desire to provide the best treatment possible also incentivizes doctors to use the best technology possible. The latest technologies are both appealing to the doctor and patient as they provide cutting edge diagnosis and treatment. However, these technologies come with their own costs. "Technologies can lead to increases in costs, either because they are simply more expensive than previous treatments or because their introduction leads to an expansion in the types and numbers of patients treated."[108] The example of the evolution of the treatment of coronary heart disease is a perfect example of how medical technology directly increases costs. Up until the 1960s little could be done for coronary heart disease. Patients that had heart attacks were prescribed bed rest and painkillers. Since then several technological advances have allowed new treatments to be made. A coronary angiography allows for a better view of blood flow and better diagnosis of heart disease. The heart-lung machine enabled physicians to perform

coronary bypass surgery. Today, coronary stents, which are used to make the surgery safer, increase the cost of the surgery and make the surgery accessible to more Americans. All of these advances increased the number of people receiving both angiographies and angioplasties by 1 million from 1970 to 2004.[109]

Personal ethics also enter into physician's calculations for providing treatment. Moral problems exist when physicians are asked to make decisions based on factors other than improving a patient's health. The physician's primary goal is to prolong and improve people's lives. Having to limit treatments based on cost or telling severely ill patients that they can longer receive treatment puts the physician in a tough and morally undesirable position. At the moment of choosing a course forward, reducing costs is always of secondary importance to improving a life. Overprescribing is a much easier decision than under prescribing as it allows physician's to know that they did everything they could to save the patient. "By placing the locus of decision making in the hands of physicians, policy makers unload the unpleasant task of deciding who should not receive various health care interventions."[110] The physician is no more likely to make the unpleasant decision than the politician. The physician's career is centered on improving and saving lives. Death is a failure. The physician will almost never stop treating a patient. Any acceptance of death would be a violation of the physician's moral compass.

Consider the example of end of life care. The physician's moral incentives push them to provide all the care possible and the physician's job is to prevent their patient from dying. Prescribing all the necessary surgeries and drugs is of course the physician's plan of action as death represents failure. Even if it only possible to temporarily extend

the length of life, it is worth it to the patient and the physician is properly doing their job. Accepting that a patient is going to die goes against the physician's thought process.

As physicians try to provide the best treatment possible they are also making a profit. In fee-for-service plans, physicians are paid a fee for every service they perform. Therefore, the more the physician treats a patient, the more they are paid. The physician is financially incentivized to do their job until no other option is available. As physicians are both laborers and entrepreneurs, they are in direct control of how much revenue they make. This provides a financial incentive for the physician to provide services that might otherwise be considered unnecessary.[111] After essential treatments are given to a patient, there are still relevant services that remain available to be prescribed by the physician that also increase the physician's income.

Another example that puts the physician's financial motivation into perspective is treating gallstones. In the case of a sickness such as gallstones, the pain can go away permanently if patient changes to a more low fat diet. In some cases though, reoccurring pain can occur that requires surgery. Here there is choice between and inexpensive treatment route or the permanent solution using surgery. For the physician, the surgery is beneficial to the patients and more profitable to themselves. The opportunity to both improve a life and make more money makes it easy for the physician to recommend surgery instead of a change in diet.[112] Here the physician has done no disservice to the patient. The pain is gone and the quality of life has been improved at the cost of the insurance company.

This choice to perform surgery is not necessarily unethical but it adds to the costs of an enormously expensive health care system. The hundreds of thousands of physicians

face this situation every single day. Every time a patient enters the office the physician has the ability to potentially add to their profits every single day. Furthermore, the extra treatment provided offers better treatment for their patients. With it so easy for physicians to justify the decision to provide extra services, billions of extra dollars in services easily occurs every year.

Hospitals

As a health care provider, hospitals posses many of the same incentives as physicians. Care provided to patients helps saves their lives and brings in revenue for the hospital. At $718 billion per year, hospital expenditures were the largest category of health care expenditures. They represent 36.8% of all personal health care expenditures.[113]

One unique factor that separates hospitals from physicians is the fact that approximately 62% of hospitals are non-profit.[114] Without the need to be entirely focused for large profit margins "hospitals may not be interested in operating in a cost-efficient manner."[115] Instead, non-profit hospitals seek to provide a public good to the community. Even if non-profit hospitals save enough money to have a profit, they have to be distributed to someone else.[116] These savings do not have to go back to patients. Left over margins are more likely to go to resources within the hospital, employee's wages, or doctors as they help keep the hospital operating.

Much like physicians, the access to insured patients allows the health care industry to operate without cost control in mind. "Price matters only a little, if at all, to many patients, because their health insurance offers to pay for any costs billed by the hospital."[117] This is especially true because of the intense nature of care received in a

hospital. Patients have no incentive to leave the hospital early because the fact that they are in the hospitals means that had a serious health problem. Price is also largely a non-issue as premiums have already been paid. For patients with chronic conditions, hospitals are especially attractive as they provide personal care that they would not receive if they were working on their own such as being fed and bathed.

Hospital's dependency on physicians for patients also factors into their incentives to use expensive care. "Patients cannot admit themselves into a hospital—a doctor who has admitting privileges in the hospital must admit each patient."[118] This means that hospitals must find a way to incentivize physicians to send patients to their hospital. "The solution has typically been for the hospital to compete, where necessary, by providing the doctor with facilities and services that make the doctor's practice more profitable."[119] This creates a symbiotic relationship for the hospital and physician.

Hospitals are also incentivized to use special technologies or specialize in certain treatments in order to distinguish them from other competing hospitals. Becoming a leader in a specialized part of health care can give hospitals a unique access to patients.[120] New technologies are both expensive to purchase and to operate. This means that cost must remain high in order to afford the use of the specialized machines. Plus, the more specialized they are, the less likely they are to face competition. Once the hospital is the leader in its region in its unique medical field, they are able set their own high prices. Ultimately, high costs for treatment are either of little consequence because the hospital is a non-profit or the high costs of specialized treatment is what sets the hospital apart from other competitors.

Drug Companies

The pharmaceutical industry also sees an incentive to keep prices for drugs high. Drugs have come to be a very significant part of the industry with "total drug expenditures reach[ing] $234 billion in 2008, more than two and a half times the $88 billion spent in 1998."[121] Prescription drugs rose from 4.9% of total health expenditures in 1980 to 10.7% in 2003."[122]

High prices are integral to the pharmaceutical industry's business model. The cost of researching and developing pharmaceutical drugs is expensive as it often takes years for a drug to be developed and approved by the FDA. The high cost of developing drugs is worth it for manufacturers because of the monopoly given to drug developers. U.S. drug patents last for 20 years before clinical trials and have an effective sales life of 7 to 12 years. "A company that is able to bring a new drug to market under patent protection stands to make a tremendous profit."[123] They are only able to sell that version of the drug. New drugs are naturally going to cost more because they corner a new area of the health care market. Besides being on the cutting edge, the drug company has a monopoly on the product. They can charge whatever price they believe will get them the most business without worrying about competition. The unique product allows the drug to be marked up in price.[124] "If the government weakened that patent protection or adopted policies that reduce the price of drugs, pharmaceutical manufacturers could no longer afford to take the risk involved in developing new drugs."[125] It takes millions of dollars and years of effort to research and develop a drug. This locks the U.S. into paying for expensive drugs.

The influence of insurance affects the pharmaceutical industry as well. Between Medicare, Medicaid, and private insurance, "About two-thirds of the U.S. population has

insurance to pay for prescription drugs."[126] Similar to physician care, patients will use all of the prescription drugs that are prescribed to them. More drugs likely make patients feel more secure about their health. With insurance paying for the costs, patients use as many drugs as they are prescribed. This was furthered financed by the government creation of Medicare Part D. With Medicare providing insurance coverage for prescription drugs, pharmaceutical industry has guaranteed financing from seniors.

Private Insurers

The presence of insurance is perhaps the main factor allowing health care costs to soar out of control. However, because insurance companies are responsible for financing the health care system, it is one of the few players to have any incentives to control their costs. The insurance industry's profits are dependent on the amount of treatment used by patients being less than the cost of the premiums they collected. The amount and expense of services used by patients determine how much insurance companies will have to pay. When insurance companies pool risk, they take on the financial liability as well as the risk of too much use of treatment. Essentially, insurance companies are incentivized to provide insurance coverage to as many people possible while having their customers use as little coverage as possible. If the consumption of health care is too high the insurance company is unable to make a profit, but insurance companies are also unable to make a profit if enrollment is too low.

Faced with this conundrum, the insurance companies to use several strategies to keep their costs under control. One of the easiest ways to control cost is for insurance companies to select who they are going to be cover. "Health coverage providers take steps to avoid attracting a disproportionate share of people in poor health into their risk

pools."[127] This is called adverse selection. In order to keep away consumers who will use a lot of coverage insurance companies charge chronically sick or elderly customers significantly more to be covered. By keeping out unhealthy customers, insurance companies are able to save costs. Healthier customers will use their coverage less often and when they do need to be treated, it is likely a one-time event. This is especially the case for plans that provide excellent coverage. Because the services covered are so many, these plans attract those who need the coverage most. In order to find the healthiest customers, insurance companies use tactics such as excluding insurance coverage for pre-existing conditions, requiring tests to be performed before coverage, and requiring minimum waiting times before certain services are covered.[128] These practices allow insurance companies to identify risky patients and either refuse them coverage or charge them enormous premiums.

Insurance companies have also created several practices that have limited their responsibilities for patients they have already insured. To start, insurance companies often deny coverage for pre-existing conditions consumer had before they purchased insurance. There are also lifetime caps on the amount of coverage you could receive from a plan, leaving Americans with costs when they needed the help the most. Approximately 24,800 Americans hit this lifetime cap every year.[129] Another practice insurance companies used to save money was dropping coverage for people once they became sick. An estimated 10,700 Americans were dropped from coverage every year.[130]

Insurance companies also resist the high costs they face by passing the costs onto their customers. From 1999 to 2009, a family's average monthly premium for private health insurance grew by 128 percent, from $490 to more than $1,115.[131] This was

accompanied by a 78% increase in our-of-pocket spending and a rise in co-pays. At the same time, insurance companies have continued to see massive profits. In 2009, 2.7 million Americans lost coverage while the top 5 insurance companies had a combined profit of $12.2 billion in 2009, a 56% increase from the previous year.[132] Insurance companies take advantage of people's need to be covered. As high as premiums costs are, they are still cheaper than going without insurance and getting sick.

These protective strategies are used because the limited influence insurance companies have on providers. For insurance companies to control their costs health care providers would have to do the same. "Insurers ineffectiveness lies in their inability to influence their insured's choice of hospital, an inability that allows hospitals to ignore the insurers' pleas for lower prices."[133] Once the hospital has the patient, they have the business and are able to charge them freely. Insurance companies are unable to force patients to shop around once they enroll because they need care. "Insurance companies would be able to reduce their costs for medical services if they are able to purchase hospitals and physician services at lower prices or have their subscribers us fewer such services."[134] But because physicians benefit from the high prices and large quantities of service this is unlikely.

Ultimately for private insurers, their business model depended expensive coverage that was not used a lot by consumers. Insurers hoped to tap into people's need for health care security while making sure their customers did not use the product. While this was working in the short-term for insurance companies, it left the government insurance to pick up the pieces.

Government Insurance

Collectively, federal, state, and local government in the U.S. pays for 47.8% of all total health expenditures.[135] As the largest insurer in the U.S., the government has enormous incentives to control the cost of health care. The Federal 2011 budget spent $898 billion, or 23% of the total budget, on health care.[136] Most of this spending comes from Medicare and Medicaid. Government insurance, primarily Medicare and Medicaid have been behind some of the largest drivers of health care costs. "If we simply continue extending a third party insurance coverage without attention to the response of the medical system, we run the risk of our medical care system becoming a kind of vacuum cleaner, sucking uncontrollable amounts of GNP and scarce tax dollars."[137]

The potential for financial bankruptcy is a huge incentive for the federal government to try to control the costs of health care. The U.S. federal government is already facing a $14.96 trillion dollar debt that is growing every year due to deficits. Health care spending is projected to continue growing as well. Medicare and Medicaid alone are expected to reach 10% of the total GDP by 2035.[138] As the largest provider of health insurance, the government feels the impact of cost growth most directly.

The expanding number of Americans who are eligible for Medicare and Medicaid also make controlling health care costs attractive to the government. 2.8 million seniors will qualify in 2011 and the number of those eligible for Medicare will rise to 4.2 million a year by 2030. In total there are 76 million baby boomers and Medicare is likely to grow from 47 million patients to 80 million by 2030.[139] This expanded population means that government has a massive amount of new health care patients that it needs to find a way to pay for. Essentially, the American government faces the possibility of being unable to

pay for anything besides health care. Furthermore, the debt that results from the costs of health care may limit spending options of the government in the future.

Despite the desire to control costs, the government is seriously limited in its' ability to control the costs of health care. To start, the government insures the most expensive group of Americans through Medicare. In the U.S., 5% of the population accounts for almost half of the total amount of health care expenditures.[140] The elderly comprised 13 percent of the U.S. population in 2002, but they consumed 36% of total U.S. personal health care expenses.[141] Medicare and Medicaid have a higher proportion of these expensive patients. "Five percent of Medicare fee-for-service beneficiaries accounted for 43 percent of total spending, with 25 percent accounting for 85 percent of all spending." Chronic conditions were a large source of these high costs as 75% of high-cost beneficiaries had a chronic condition. In Medicaid, the elderly and disabled are 25% of the populations but use 70% of the funding. The elderly and disabled, who constituted around 25 percent of the Medicaid population, accounted for about 70 percent of Medicaid spending on services in 2003.[142]

The government is tied to these costs because they are not able to use adverse selection when choosing patients. Medicare was specifically created to insure seniors because insurance was too expensive for them to afford before 1965. It is because senior's need so much health coverage that the government had step in. Through payroll taxes, the government was able to make sure that everyone with a job was helping contribute to the payment of Medicare. Even though Medicare and Medicaid are extremely expensive, reducing these costs may not in the political interest of politicians. "Legislator's cost-benefit calculations are not the costs and benefits to society

of enacting particular legislation."[143] Rather, their incentives are focused on how they can get re-elected. "Electoral logic inspires members to promote narrowly targeted programs, projects, and tax breaks for constituents and supporting groups without worrying about their impact on spending revenues."[144] Medicare and Medicaid offer several ways for legislator's to bring specific benefits to their districts.

Additionally, entitlement programs are extremely popular throughout almost all Congressmen's districts. A 2011 poll found that 88% of Americans supported Medicare and 74% supported Medicaid.[145] These programs offer now or in will offer in the future specific benefits to almost every family in the United States. By helping providing health care to those who need the most help affording it, the program has a favorable among the millions of American helped. Legislators have a clear incentive to protect programs that are this popular. Reducing the funding of Medicare and Medicaid would decrease the number of people who are available to receive benefits from the program. There is little financial incentive to bring less money from the federal government to a Congressmen's district. This makes it easy for government attempts to reduce the costs of these programs to fail.

Congressmen also avoid efforts to control the costs of health care spending because of the influence of seniors in the political system. As of 2008, there were approximately 40 million Americans over the age of 65.[146] Seniors generally turn out to vote at rates much higher than the rest of the population. Approximately 68% of senior voters turned out to vote in 2008, making it the highest rate of turnout by age group.[147] Because seniors are so likely to turn out, elected officials look to promote policies that attract their votes. Protecting Medicare is a priority issue for senior voters. It is very

politically risky for a legislator to propose reducing these benefits. Any Congressmen who took a position cutting the benefits provided by Medicare would face opposition in the next election looking to cash in on the senior vote.

Finally, a lot of the particular benefits that legislator's bring back to their districts come through health care. With one-sixth of the economy is tied to health care there are guaranteed to be numerous stakeholders. This means that almost every Congressman has an interest in protecting the economic benefits that are available for their district through the health care industry. For example, Medicare and Medicaid provided $898 billion in payments to the health care industry.[148] Without this source of income, many health care providers who lose a significant portion of their revenue. Limiting their constituents' profits by reducing spending on health care would make it extremely difficult to get re-elected.

While there have been many attempts at cost control by the government in the past, none of them have been expansive enough to bring on board enough to change the incentives of the players to reign in costs. The ability to control costs is dependent on Congress to reign in costs. Legislators are much more interested in getting re-elected than controlling costs. Expanding access is much more appealing than telling patient's on government health care that the coverage they expect is no longer available.

Conclusion

The consequences of this health care system are quickly catching up to the health care system. Customers and patients are insensitive to the price and intensity of health

care, which benefits health providers. Private insurers pass the costs along and the government insurance programs picks up the pieces in the meantime.

The reality of the current health care system is that as long as Americans continue to get sick, they are part of the process that allows for thousands of extra dollars of treatment to be provided each time they are in need of serious care. With insurance companies having to cover this extra treatment, premiums were raised in order to protect profits. If both insurance companies and employers continue to pass health care costs onto consumers, premiums will reach a point where it was too expensive for healthy Americans to afford insurance premiums. Risking getting sick could possibly be the more financially attractive option for individuals.

The incentives of health care providers had reach the point where it is no longer the reality to simply bear the burden of increased costs. The unsustainable nature of the health care caused by the incentives of the system has reached a point where something had to be done. The Patient Protection and Affordable Care of 2010 represented an attempt to try to bring the costs of the health care system under control.

Chapter 4: Participants, Politics, and the Passage of the Affordable Care Act

The passage of the Affordable Care Act (ACA) in March of 2010 marked an incredible accomplishment for President Obama. The ACA included a massive expansion of health care coverage to Americans and created many policies that attempt to bend the cost curve of health care growth. It is remarkable about health care is that is passed at all. The most recent attempt at health care reform under President Clinton had failed spectacularly. His efforts did not even create a final bill for Congress to vote on. The attempt at health care reform would overhaul the health care system that was so profitable for many powerful stakeholders.

With all of the financial benefits powerful participants in the health care market were receiving, it begs the questions why did health care reform pass at all? Participants were profiting from the system and the government largely lacked the political will to accomplish significant reform. Fortunately for President Obama, then economic reality that the participants of the health care system faced made the status quo of the health care system no longer tenable. The health care system had reached the point where participant's income security was in jeopardy. The burden of the uninsured had created massive negative impacts on the industry as a whole. Next, President Obama's administration reached out to the major players in the industry in order to secure their input and support for the ACA. Engaging the players that would be most affected by health care reform limited opposition to the bill. Finally, the political leadership of President Obama, Majority Leader Reid and Speaker Pelosi saw the bill through Congress.

Health Care Market Participants

While important players in the health care system such as physicians, hospitals and the pharmaceutical industry had financially benefitted from open-ended financing for the health care system, the impact of uninsured patients created a very uncertain future for their business models. In 1990 there were 30 million uninsured Americans. By 2009, America's patchwork public-private hybrid health care system had created a health care system where 47 million Americans were unable to afford insurance or decided to go without coverage.[149] The uninsured had become a significant drain on health care providers, as they often had to treat the uninsured without adequate compensation. The uninsured also represented massive revenue that had yet to be tapped into. Without insurance, only the very wealthy are able to afford to pay for medical bills completely out-of-pocket. In fact, "In 2008, the average person who was uninsured for full-- year incurred $1,686 in total health car costs compared to $4,463 for the nonelderly with coverage." Incomes are significantly higher when all Americans are insured. Profits, both immediately and in the future, motivated the health care industry to support the ACA. Making insurance affordable and adding to the number of insured would add to the incomes of providers.

The problem of the uninsured was further exasperated by the poor economic conditions after President Obama took office. The recession left the health care industry frightened by the large drop in both the number of people who had insurance and the scope of the insurance. Because the health care system is largely dependent on employers to provide coverage for the majority of Americans, when unemployment soared the number of insured plummeted. Even the employed are not guaranteed health insurance.

Of the 47 million uninsured Americans, three-quarters work and half of them work full-time.[150] With employers providing insurance to fewer employees the number of insured Americans was likely to continue to shrink.

In general, health care provider's income is determined by the price of the care they are providing multiplied by the quantity of patients being treated multiplied by the intensity or amount of care provided to the patients. For health care providers, the health care system had put these factors out of synch. The quantity of paying customers in the system was decreasing every year. Providers made up for the loss of patients primarily through price. However, raising the price was really on a stopgap solution. Raising prices pushes even more consumers out of the health care system over time, as health care would be even harder to afford.

Insurance Companies

The increasing numbers of uninsured Americans meant that insurance companies business models were slowly failing. If the employer-based system were not able to adequately insure Americans, the profitability of the health care system would be in serious jeopardy in the future. In 2009 alone 2.7 million people lost their insurance.[151] If this trend continued, the number of insured would not be enough to over medical costs. The 47 million Americans were an indication of the overall market failure of the health care system. Health care is a product with inelastic demand to most Americans. Consumers are not as likely to be responsive to price concerns as they would be with other products. The health care market had effectively priced itself to the point where it was preventing customers from entering the market. Furthermore, many of the customers

insurance companies were losing were young adults, customers that have generally low medical costs. The system was not sustainable if the number of insured declined.

Hospitals

The 47 million uninsured were especially harmful for hospitals. In 2008 there were $56 billion in uncompensated health care costs, only 75% of this total is paid by federal, state, and local funds appropriated for care of the uninsured.[152] When forced to cover costs, hospitals compensate for the loss of income by raising prices and overcharging. "Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services." Hospitals hope to get whatever they can back from the patient or from government compensation for serving the uninsured. Overcharging uninsured patients makes is an attempt to make the most profits possible out of already sunk costs. Hospitals also charge the uninsured more because they do not have to negotiate with insurers over compensation rates. However, this in turn raises premiums as hospital prices have gone up. Hospitals have to make up for what they already lost covering the uninsured. In order to do so, costs are passed onto insured patients because their insurance can cover the costs. In 2004, private sources including insurance paid $6 billion or 15% of total payments for uncompensated care. This plus the general rise in health care costs because of the 25% of uninsured patients that are not pad for at all contributes to the cycle of high health care costs. The more uninsured patient's they had to treat, the higher prices they had to charge. Raising prices in turn raised insurance premiums, creating even more uninsured and continuing the cycle.

Physicians

Physician's faced a similar challenge as hospitals. The high number of uninsured meant that these patients never came into physician's practice. The uninsured avoid going to the doctor's for minor illnesses. The lack of regular doctor's visits means that the uninsured are only likely to use the doctor for emergencies. This creates a problem for physicians as emergency physicians reported that 61% of their unpaid bills came from emergency care.[153] Without insured patients, physicians were worried that they would not have enough patients in the future.

Physicians are also concerned about how Medicare payments will affect their business. If payments. The sustainable growth system has been consistently overridden by Congress to preserve physician's profits. Physicians don't want to lose the consistent business that comes from government payments for treating the elderly but they are worried that the costs could easily become unsustainable. Physicians were afraid that they faced an unsustainable future without a permanent solution for Medicare payment rates.

Drug Companies

The pharmaceutical industry is heavily dependent on insured Americans for their business model. America has the highest drug prices in the world. For many Americans, drug prices are often the most cost prohibitive part of health care. The U.S. spent $307 billion on drugs alone in 2010.[154] Individuals cannot afford these drugs on their own. With the number of insured decreasing, drug companies stood to lose billions of dollars.

Employers

One of the largest problems for the health care industry was inability for employers to afford to keep their employees insured. "The cost of employer---sponsored coverage is the most common reason employers cite for not offering health coverage." In

2011 annual employer sponsored group premiums averaged $5,429 for individual coverage and $15,073 for family coverage"[155] and from 1999 to 2009 Employers saw a 131% increase in premiums.[156] As President Obama stated in speech to American Medical Association, "Our largest companies are suffering as well. A big part of what led General Motors and Chrysler into trouble in recent decades were the huge costs they racked up providing health care for their workers; costs that made them less profitable, and less competitive with automakers around the world."[157] The burden of expensive health care only added to the financial burden of employers already struggling during a recession. Employers had passed these costs onto employees in order to preserve their profits. Passing costs onto employees meant that even insured and employed Americans could not afford their health coverage. Simply, if consumers cannot afford health coverage there would not be enough patients to continue the health care system.

Overall, the reality of a system hemorrhaging insurance customers forced participants in the health care market to choose between staying in a slowly failing system or embracing a new system that would offer new opportunities for income in exchange for some limitations on their operations. The federal government was already aware that health care costs were causing unsustainable budget responsibilities. Health care costs had risen to the point where they were even detrimental to the players who prefer were indifferent to high costs. If patients cannot afford coverage at all, there is no opportunity for income for any of the participants in the health care market. The 47 million uninsured Americans had to be brought into the system. The cost control concessions required by health care reform would be bearable if there were millions of new customers added to the health care system.

The Affordable Care Act and Interest Groups

Even though the health care system was unsustainable for many of the players they did not easily come on board to support health care reform. The Obama administration was aware of the fact that if the major players of the health care system were on board, it would be far easier for a bill to pass. Congressmen would already know that influential interest groups were in support of reform. "The strategy, as articulated by [Rahm] Emanuel, was to disarm—if not outright co-opt—potential opponents."[158] The Obama administration sought to use the insecurity of the health care industry about their financial future to bring them onboard with health reform. President Obama also wanted to avoid a united front of businesses and interest groups against health care reform. "This choice was, in part, just another manifestation of how the President and his advisers—Chief of Staff Rahm Emmanuel foremost among them—saw the central goal: winning over key interest groups and pivotal Democrats, not voters."[159] With their input already in the bill, health care interest groups would be much less likely to oppose the bill.

The negotiation turned out to be beneficial to many sides. Overall, $2 trillion in government health care spending cuts over 10 years were identified.[160] In return, individual industries were rewarded. Specific payouts were put into the ACA to increase the probability of the industry in these areas. On top of this, the reward of nearly 50 million new customers remained consistently available. The incomes for the participants in the health care industry are dependent on the price of care, the quantity of patients treated, and the intensity of the care provided. America's health care system before the ACA was declining in terms of the quantity of care that could be provided because the

numbers of uninsured increased every year. In order to make up for these lost revenues, providers increased the factor they had the most control over, price. The ACA created cost cutting measures in return for a huge increase in the quantity of insured Americans. In fact this health care market created could be even more appealing as it created the potential for more care to be provided.

Drug Companies

The very first industry to support health care reform was the pharmaceutical industry. The Pharmaceutical Research and Manufacturers of America (PhRMA) was willing to be part of the process as long as the restrictions were not too harsh.[161] Estimates of benefits for the new health care law were **"**that the drug industry stood to make up to $100 billion over ten years if reform expanded coverage."[162] In exchange for this revenue, Senator Max Baucus asked PhRMA to reduce its revenues by about the same amount. After negotiations with the Senate Finance Committee chaired by Senator Baucus and the Obama administration, PhRMA agreed to lower drug prices and to pay fees that amounted to $85 billion, some of which came though reduced government spending on public insurance programs. In exchange for this concession, PhRMA received a closing of the doughnut whole in Medicare Part D. This would provide tens of billions of dollars to the industry through new prescriptions.[163] PhRMA enthusiasm for closing the doughnut whole can be seen by the fact that they spent $100 million in advertising and support for health care reform.[164] PhRMA also got rules protecting them against new competitors from making cheaper generic drugs. The White House and Senator Baucus were able to trade access to million of new customers for a reduction in the cost of government payments to drug companies.

Private Insurers

Private insurance companies were most affected by the ACA. The ability to make insurers part of the process was an impressive achievement by the Obama administration. While insurers were never vocal supporters for the new health care law, bringing their input into the process of health care reform helped prevent a united and motivated opposition against the effort.

The key point for insurers, much like hospitals and doctors, was the individual mandate imposed by the law. "Insurers muffled its opposition when it looked as if draft legislation would impose a mandate with teeth."[165] The government had the power to enforce what the health insurance industry desired most, **"**the power to require that people had health insurance—and it was this requirement that the insurance industry in particular wanted to harness."[166] An individual mandate guaranteed that millions of Americans who had gone without private insurance were now a part of the insurance market. "The Affordable Care Act of 2010—promises to cover approximately 32 million uninsured people over the next 10 years, including the majority of uninsured young adults."[167] This creates a huge windfall in the short term and insured the sustainability of the insurance industry. **"**Insurers were willing to accept stricter regulations… *if* these regulations were accompanied by an individual mandate. An individual mandate would also bring young, healthy people into the system to help pay the costs of older, sicker people."[168] In 2008, young adults 19-29 represented 14 million of the uninsured, nearly three of every 10 uninsured persons in the United States.[169] The ACA enabled young adults up to the age of 26 are allowed to stay on their parent's coverage. Not only did the

ACA bring in new patients, it also brought in young patients that have far less costs for insurance companies.

The insurance industry also worked to see that ACA did not include a public option. "Fearing that a new public program could outcompete private insurance on price and quality, insurers launched a campaign against it, arguing that a government-run plan, with its favorable tax and regulatory treatment, would undermine the private insurance industry."[170] While the liberal wing of the Democratic Party desired the public option, Democrats allowed private insurers to remain as the major source of insurance in exchange for almost universal coverage and new government regulations.[171]

The huge expansion of customers through the individual mandate came a great cost to the insurance industry. The new regulations imposed on insurance companies include a requirement to spend at least 80 percent of premiums on medical benefits for by patients by 2011, prices controls, and end to annual and lifetime caps on coverage among others. Most significantly, the ACA ends denial of treatment based on pre-existing conditions. This is an especially significant new restraint put on insurance companies as it changes their entire business model. "Before 2010, the private insurance business rested on decoding the traits of individuals to determine who would be profitable to cover, and at what price… The perverse fact was that the bottom line for private insurers depended on avoiding the sick."[172] The ACA and the individual mandate have completely changed the structure of the insurance industry.

Physicians

One of the most significant players brought on board was the American Medical Association (AMA), the largest association of physicians in the U.S. The AMA had long been a force opposing government efforts to reform the health care system, including opposing the creation of Medicare and Medicaid as well as President Clinton's efforts at reform.[173] This time around, the AMA saw that it could do more from shaping the legislation than opposing it. The AMA no longer had the influence to significantly influence health policy. "By the 2000s — unlike the 1960s, when the American Medical Association (AMA) represented the vast majority of doctors — physicians were divided among numerous specialty and special interest groups."[174] Some of these interest groups such as the Physicians for a National Health Program (PNHP) were actually in favor of a single payer system. In order to create benefits for doctors, the AMA need to be part of the reform effort.

By participating in health reform, the AMA was able to secure financial security for physicians. The ACA increases physician's income by increasing the number of insured patients and increasing payments for Medicare and Medicaid primary care. Physicians will see more patients because pre-existing conditions cannot be used to deny insurance payment, young adults up to 26 can stay on their parent's coverage, and there cannot be limits on insurance coverage.[175] Physicians will also see increased financial security through Medicare bonus payments, increased Medicaid compensation rates, and new grant programs.[176] The AMA also worked to secure several key exclusions from health reform including the public option; payment cuts to physicians whose utilization was outside the norm, and taxes on elective cosmetic surgery.[177]

In exchange for new patient's there are numerous provisions from the ACA affecting the way that physician's practice and to try to reduce costs. These include expanding the use of electronic records, accountable care organizations, preventative care, and collaborating with hospitals to reduce admissions.[178] The ACA may also change physician practices to control costs through programs that search to find best practices. Here again, regulation and cost cutting measures were traded for million of new patients.

Hospitals

Hospitals also saw that they had more to gain by being a part of the process to pass health reform. The ACA would change the structure of health care to protect revenue. To start major hospital groups agreed to accept $155 billion payment cuts over ten years.[179] The $155 billion cut in payments to hospitals was reduction from the $220 billion dollar cut that the Obama administration had originally proposed. Hospital negotiated for cuts to be "timed to coincide with expanded insurance coverage."[180] The largest benefit that brought hospitals on board for health reform was the expansion of Americans with insurance.[181] "One-fifth of the 120 million hospital emergency room visits in 2006 were by uninsured patients." Having to treat uninsured patients significantly limits the income of hospitals. With millions more insured, hospitals would have a significant burden on their operations reduced. The expansion of insured also meant that hospital's would have more patients overall, further increasing their income.

Employers/Businesses

Finally, while not specifically made part of the negotiation process, business also saw reasons not to vigorously oppose health care reform. For business interests, there were a lot of specific benefits meant to help ease the burden of providing insurance

coverage. Health care was sold as being critical to reviving business. President Obama stated the health reform was " a prerequisite to improving the competitiveness of American business by reducing its high and rising health costs."[182] Reforms to help employers afford insurance included a temporary tax credit for small employers that offer insurance, have fewer that 25 full-time employees, and have average salaries of less than $50,000 per year.[183] The development of health care exchanges also offers an easy and hopefully cheaper option for finding coverage. While there were no short-term financial windfalls for businesses, the potential for future savings from the policies created by the ACA exists.

Politics of Health Reform

Even with the unsustainable health care system and the efforts by the President to bring industry support health care reform, there still remained the challenge of Congress. Many politicians saw addressing health care reform as an extremely risky process. Congressmen were afraid of the repercussions of an overhaul of the health care system in their districts. Even with major participants in the health industry on board, Congress offered a difficult challenge for the Obama administration to overcome.

President Obama was of course a central player in the health care debate. It was his desire to see health reform to finally occur that brought the issue about in the first place. President Obama had stated, "I am not the first president to take up this cause but I am determined to be the last." The President was determined to both bend the cost curve and expand insurance coverage to millions of Americans. Throughout the health care debate, President Obama used the bully pulpit to keep the process moving. The

President's persuasion of many Congress members was essential to seeing that health reform finally passed.

President Obama's focus on health care reform was twofold. First, health care reform was a campaign promise from President Obama and priority for the Democratic Party. The chance to expand the number of insured Americans and improve the quality of insurance was something the liberal wing of the Democratic Party could be very excited about. The massive changes to the system would make the health care system provide far more benefits to many more people.

Second, health care reform was also a chance to address some of the budget challenges the United States faced. President Obama consistently made it a priority for the bill to be either deficit neutral or reduce the deficit. The President was of course aware of both the growing debt and health care's contribution to the federal government's financial struggles. Obama's advisers had several ideas about their cost control including an independent commission to calibrate what Medicare pays for treatments.[184] The Obama administration was adamant that health reform cost less than $1 trillion and that new revenue and spending cuts to offset the costs. The battles for scoring the costs of health care reform were fought in the Congressional Budget Office (CBO).

In order to ensure that health reform passed, President Obama pursued a different strategy then previous Presidents. "President Obama came into office vowing not to repeat President Clinton's big mistake and dictate to Congress exactly what it should produce. Instead, he would facilitate a congressionally centered process, weighing in when necessary to ensure key goals were met."[185] With Congress being an integral part of

determining the majority of the details of the bill, they would be less likely (though not unlikely) to let the bill fail.

It would take the herculean efforts of President Obama, Speaker of the House Nancy Pelosi, and Majority Leader Harry Reid to bring the ACA through Congress. In fact, the opportunity for reform had arisen because of political stars aligning for the Democratic Party. "In the hyper partisan environment that currently exists in Washington D.C. today is extremely difficult to rely on bipartisan support for bills."[186] Furthermore, a super majority was needed in the Senate in order to ensure 60 votes to invoke cloture. Reform became possible with the election of a Democratic president, the Democratic capture of Congress in 2006, and the strengthening of that majority in 2008. Without the 60 Democratic votes, Senate republicans would have been able to use a filibuster to completely block health care reform.

Speaker of the House Nancy Pelosi got health care reform started rather quickly. The Speaker begin by bringing the three House Committees working on health care reform, Ways and Means, Energy and Commerce, and Education and Labor, together into a "Tri-Com." This move was a great way to keep the entire Democratic Party in line to pass the bill as they many Representatives had the chance to shape the bill. Additionally, The "Trim-Com" led by Representatives Waxman, Rangell, and Miller had three senior Democrats to overseeing reform.

Speaker Pelosi's greatest challenge came from concerns over abortion. Opposition from Democratic Representative Bart Stupak created the need for a deal to be made regarding abortion. Speaker Pelosi was able to convince members of her Caucus, especially the woman of the Democratic caucus, to accept a limitation on funding for

abortions under the health care law. With the successful resolution of this crisis the House passed the first version of health care reform in November of 2009. This passage set the stage for the battle in the Senate

GOP Opposition

The real battle for passing health care reform occurred in the Senate. First, the opposition to the passage of the health care reform by the Republican Party made health reform very difficult. In the House, Nancy Pelosi had enough of a majority that Republicans did not need to be made part of the process. However, for Senate Minority Leader Mitch McConnell a solidified Republican opposition had a chance to derail health reform. If one Democratic Senator abandoned the party, Democrats would not have enough votes to defeat a filibuster. Minority Leader McConnell repeatedly opposed the efforts. For example: "The notion that we would even consider spending trillions of dollars we don't have in a way that majority of Americans don't even want is proof that this health care bill is completely and totally out of touch with the American people."[187] Senate Minority Leader McConnell put his efforts into keeping any of the 40 Republican Senators from voting for health care reform.

Bringing the entire Democratic caucus in the Senate together to pass health care was no easy feat. Congressmen are of course inclined to focus on their own reelection. Without reelection Congressmen lose their jobs and are unable to achieve any of their other priorities. The Democratic caucus in 2008 was very diverse in their political make-up. The supermajority created in the election of 2006 and 2008 was made up from districts that were not considered safe seats for Democrats. For example, Forty-nine Democrats were elected from districts that voted for Republican Presidential candidate

John McCain in 2008. Senators Blanche Lincoln and Mark Pryor from Arkansas, Senator Mary Landrieu from Louisiana, and Senator Ben Nelson from Nebraska all had reservations about passing health care reform. The conservative bent of their states meant that their constituents were unlikely to support health care reform at all. Their states had also voted for John McCain in the previous election.

In order to make moderate Democrats feel more secure about supporting health care reform, Democratic leadership attempted to create bipartisan support for health care reform. Democratic leadership felt that a bi-partisan bill would give the Democrats from moderate districts the political cover they needed to feel more confident about their re-elections. Senator Max Baucus from Montana sought to use his influence on the Finance Committee to bring Republicans Senators Grassley, Enzi, and Snowe into the health reform process. Democrats also felt that Senator Kennedy's friendship and previous collaboration with Senator Hatch would make him want to be part of health care reform. In order to try to create support for the bill Senator Chris Dodd allowed for Republicans to offer amendments title by title while the bill was in the Health, Education, Labor, and Pensions (HELP) Committee. In total there were 160 Republicans amendments accepted by Democrats. However even after all those efforts the bill left the HELP committee on 13-10 partisan vote.

President Obama also tried to woo Republican votes for health care reform. Senator Snowe from Maine received a lot of individual attention from the President. However, she too refused to support a bill. For all the Republicans targeted, a Democratic bill sprinkled with Republican amendments was not enough to gain Republican votes. After all of the efforts by Democratic leadership Republicans still refused to be part of

the process of health care reform, instead preferring to oppose any bill. The few Republicans who may have voted for the bill felt that they were not involved enough in the crafting of the bill to support health reform.

Senate Majority Leaders Harry Reid had only one option, securing the support of the entire Democratic caucus for health reform, once attempts to create a bi-partisan bill had failed. "Reid adopted precisely the transactional, 'keep-the-chains-moving' leadership posture that matched both the institution he leads and his limited personal investment in the issue of health care prior to 2009."[188] Because Republicans refused to vote for any form of health reform, Reid was forced to do whatever it took keep Democrats on board. "Reid's efforts sometimes revealed an unseemly, if time-honored, side of congressional business as he struck bargains with senators who traded their votes for aid to their states."[189] For Senator Ben Nelson from Nebraska, more Medicare payments and abortion restrictions were included. Senator Mary Landrieu from Louisiana secured $300 million in extra Medicaid funding.[190] Harry Reid also watered down the bill to appeal to moderate Democratic Senators. One of the most contentious parts of the bill was the public option. First, Senator Reid promoted the idea of allowing an opt-out clause from the public option for states. However, the Joseph Lieberman became the final member of the Democratic caucus need to break a filibuster. When Lieberman made his vote dependent on the elimination of the public option Senator Reid abandoned principle for practicality and removed the public option from the bill.

All of these efforts to persuade the Democratic caucus to support health care reform paid off. The Senate passed their version of health care reform on Christmas Eve. Plans were made to negotiate the differences between the House and Senate version of

health reform after New Years. However, the Democrat's victory was short lived. Health care reform was close to being finished until the Massachusetts specials election occurred. The loss was particularly jarring because the election had been to fill Ted Kennedy old Senate seat after he had passed away. The election of Senator Scott Brown put the Democratic caucus into a panic. Before the election of Scott Brown there were no Republican members of Congress from Massachusetts. Many Democrats began considering a smaller bill or abandoning the effort entirely. Republicans touted the election as a clear sign that Americans did not favor health reform. This election could have very easily de-railed health reform except for the fact that President Obama and Nancy Pelosi doubled down on finishing the job

Despite this setback, the election of Scott Brown provided a clear road forward for the Democratic leadership. "The Massachusetts outcome absolutely ensured that health reform would get not Republican support in Congress."[191] This made the path forward for health reform fairly clear. With only 59 votes, it became clear that parliamentary tactics were the best road forwards for Majority Leader Reid used the reconciliation process, a parliamentary tactic, to make sure a bill finally passed. Under the reconciliation process, "only the fiscal aspects—money matters having to do with taxes and subsidies—could be changed in the sidecar bill."[192] All of the administrative structure from the Senate bill had to remain the same.

But before the reconciliation process could be used, the House of Representatives had to pass the Senate's version of health care reform. This was extremely unpopular for House Democrats. Many fiscally conservative blue dog democrats were concerned about having to again vote for a health reform bill that was unpopular in their district. However,

Speaker Pelosi was determined to see health reform to the finish line. When Brown's election sent the rest of Washington into a panic, Speaker Pelosi appealed for calm. She refused to compromise on a smaller bill and felt that "all the talk of an 'eensy weensy bill,' as she called it, was undermining her efforts."[193] After Scott Brown's election, "Pelosi figured that Massachusetts left her with a core of only about 180 Democrats sure to vote with her."[194] Speaker Pelosi meticulously rebuilt the coalition in order that the House could pass the Senate version of health care reform through the reconciliation process.

President Obama was key to helping rebuild the House coalition needed to pass health care reform. With Democrats scared by the loss of Ted Kennedy's old Senate seat, President Obama took a more direct role to rally the party. Several town hall style meetings, one with House Republicans and one with both parties refocused the debate and allowed the President to defend the merits of health reform. According to John Podesta, president of the Center for American Progress, "Everybody just decided, 'OK, let's see what happens a month from now [at the summit].' It stopped people from jumping ship."[195] By taking the lead, the President gave his party time to regroup. Furthermore it showed his commitment to the bill still existed. President Obama was willing to step in when it seemed Congress was unable to move forward.

Heading in to the final weeks of health reform, President Obama and Nancy Pelosi were able to persuade enough Democrats in the House to support the Senate's version of health care. President Obama used an executive order to again resolve a potential crisis over health care.

Finally on March 21, 2010 the ACA was passed by a vote of 219-212 in the House and the President signed the bill into law on March 23. At every stage of the process to pass the ACA the leaders of the Democratic Party were integral to seeing that the bill passed. President was critical to both making health care reform a priority and ensuring that bill passed after Scott Brown was elected. Speaker Pelosi's ability to quickly pass an initial version of the ACA got the ball rolling for reform. Additionally, her ability to persuade her caucus to vote for the bill was critical to keeping reform alive. Finally, Majority Leader Reid facing both reluctant Senators and the guarantee of a filibuster kept health reform alive by providing Senator's with provisions to benefit their state's interests. Through their efforts, Obama, Pelosi, and Reid were able to take advantage of a unique opportunity to pass health care reform.

Conclusion

Health care reform was finally possible after a Democratic supermajority and a looming crisis for the health care market. The Obama administration took the opportunity to fundamentally overhaul the health care system. However, health care reform likely passed because it at some level lined up with the incentives of the participants in the health care market. The final success of the ACA will largely be based upon whether it can improve the quality of the health care system while making the health care system more sustainable financially. The ability of the ACA to reform incentives away from escalating costs will be integral to evaluating the ACA's success.

Chapter 5: Cost Control in the Affordable Care Act

The passage of the Patient Protection and Affordable Care Act (ACA) has ushered in a new era for the U.S. health care system. Nearly every major sector in the U.S. health care system has been fundamentally changed. Major reforms include an individual mandate for health insurance, insurance practice reform, expansion of Medicaid and Medicare, and insurance exchanges among many other reforms. Critically, the ACA instigates changes to the health care system in order to make it more affordable for individuals, the government and businesses.

In order for the ACA to create a more sustainable health care system, reforms will have to account for the financial consequences that the U.S. faces from the cost of health care. The U.S. government faces soaring debt from its commitment to finance the health care system. During the passage of the ACA, President Obama consistently fought to make sure that bending health care's cost curve was a central part of the bill. One of President Obama's only stipulations for health care reform was that the bill had to reduce the federal deficit. This was necessary both politically to get enough votes for the bill to pass and was necessary to President Obama to govern responsibly. A federal government that was saddled with enormous debt form the cost of financing health care system would not leave it sustainable into the future. Individuals could no longer afford the cost that health care system had placed on them. The combination of exploding insurance premium costs and insurance industry that restricted costs left individual Americans responsible for more health care costs then they could afford. Finally, businesses struggle to turn a profit when they are saddled with the costs of insurance premiums. The high

costs of health care made it so that staying profitable was difficult, especially during the financial recession.

Integral to making the health care system more affordable across the board, the ACA will have to make changes to the incentives of the participant's in the health care market. As long as participants in the health care market are able to benefit from high health care prices the ACA will be unlikely to make a large impact. The ACA's ability to incentivize lower costs will be one of the most important parts of the bill's success. In order to address these incentives, the ACA focuses on payment systems and delivery systems such as Accountable Care Organizations. Backing up all these reforms are changes to the structure of the health care market. However, all these reforms represent a long-term approach to health reform. In order to bridge the gap until implementation, the ACA begins with immediate changes that will save billions.

Short-Term Savings

The financial crisis that the U.S. is currently facing mandated that there be immediate savings created in the health care system. Savings based on reforming the incentives of participants in the health care system could take a significant amount of time to be implemented and even accepted. Therefore, the ACA begins by making short-term savings to reduce the financial burden of health care on the federal budget. The ACA has been predicted by the Congressional Budget Office (CBO) to reduce the size of the federal deficit by $210 billion from 2012-2021, as the ACA will create $813 billion in additional revenues or reduced spending along with $604 billion in new outlays.[196]

Beyond 2021, the CBO expects for the trend to continue but they have not released a report beyond 10 years.

Medicare is the target of a significant number of these short-term cuts. Medicare is a target for many of the reforms because of its' massive expense to the federal government. With Medicare already responsible for about $500 billion or 13% of the federal budget, bringing the costs of Medicare under control help make sure that health care is affordable for the federal government. Furthermore, because Medicare is a government program, spending can be reduced quicker than in the private sector. The multiple reforms to Medicare are expected to create $400 billion in cuts to total Medicare outlays from 2010-2019 according to the Congressional Budget Office.[197] The majority of Medicare savings comes from $230 billion in reductions of the payment rates that providers receive for providing services in the fee-for-service system.[198] Physicians under a fee-for-service model control the amount of treatment that patients receive and therefore the amount of money they receive from each patient. Reducing the payments for services provided under Medicare reduces the amount of charges that Medicare physicians can create for the government in the short-term. The reduction in payment for services provided greatly restricts the amount of Medicare spending going to physicians.

Next, private insurance companies that receive funding for providing Medicare services will see their rates brought into line with the payment rates of Medicare. This will save another $50 billion. "Prior to enactment of the Affordable Care Act, Medicare Advantage plans were paid about 14 percent more per patient than it would cost the program had the patient remained in traditional Medicare."[199] Medicare Advantage was

intended to control the costs of Medicare. Bringing these payments closer to the rates paid under normal Medicare plans will create significant savings.

The ACA also seeks to create savings through providing more efficient services. "The Center for Medicare and Medicaid Services has set a goal to reduce preventable hospital-acquired conditions by 40 percent, preventing 1.8 million injuries and averting 60,000 deaths of hospital inpatients over the next three years."[200] These savings will come through The CMS is also implementing the goal of reducing unnecessary re-hospitalization by 1.6 million. The Obama administration and CMS expect that achieving these targets will save $10 billion for Medicare and $35 billion in total throughout the health care system.

Efforts to reduce unnecessary funding are also being taken through efforts to end Medicare fraud and waste. Each year, Medicare is falsely billed billions in extra costs. Medicare is charged for many services that were never provided to patients. Under fee-for service formatting, each service provided for a patient adds to the payment physician's receives from Medicare. Anti-fraud measures are expected to save $7 billion over 10 years. Administrative simplification through reduced paperwork and uniform electronic records are expected to free up $20 billion over 10 years.[201] Uniformity in the health care will help streamline care and reduce the amount of time and money that health car providers have to use to complete paperwork.

Taxes

The federal government will also see its health care bill lessened through increased revenues. The ACA adds several new taxes to keep Medicare financially solvent. The CBO expects that by 2019, $200 billion in revenue will be generated from a

tax on Medicare Hospital Insurance. Currently, Part A of Medicare that covers hospital insurance for the elderly is funded by a 2.9% payroll tax. Beginning in 2013, Individuals making more than $200,000 and families earning over $250,000 a year will pay an additional 0.9% tax. Medicare Part A will have additional funding through a 3.8% tax on investment income such as interest and dividends for high-income families. Medicare will also charge its own beneficiaries more for coverage. One reason Medicare was created was to help keep the elderly out of poverty. For wealthy elderly Americans Medicare can be additional income. Therefore, high-income Medicare beneficiaries will also a permanent raise in their Medicare premiums, earning Medicare approximately $40 billion by 2019.[202]

Beyond these major changes to Medicare financing, there are also smaller taxes on health insurers, brand-name prescription drug and medical device makers, large employers that do not offer health insurance, individuals who do not purchase health insurance, and other businesses such as indoor tanning. All of these taxes expand the revenue financing the Medicare system. This additional tax revenue is meant to offset the increased number of Medicare beneficiaries.

The combination of payment cuts and new revenues make the Medicare system more sustainable. The $400 billion in savings by 2019 pushes back the date that the Medicare Part A trust fund will expire from 2017 to 2029. The Medicare trust fund helps provide funding for Medicare when revenues are not enough to cover the benefits seniors' need. If the trust fund were to run out, it would require even more deficit spending by the federal government as the government is required by law to cover Medicare spending.

While these changes in Medicare strengthen its' financial solvency, they are relatively small and do not slow the overall growth of the health care cost curve. The savings were still integral to getting the bill for health reform small enough so that it could be passed and these cuts will be integral for buying time for more changes to be made. The incentives that create high health care costs still exist even after these taxes and cuts. Funding cuts and taxes by themselves only delay the date at which the system would be unaffordable.

Bending the Health Care Cost Curve

In order to create long-term stability in the health care system, the ACA creates several programs to create a system that is sustainable into the future. Health care costs must be stopped from growing at the seemingly exponential rate they have over the past century. The ACA's reforms to the health care market seek to reform both the structure of the market and the incentives of market participants in order to find long-term health care savings. "The ACA does not establish a rigid bureaucratic structure to be changed only episodically through arduous legislative action. Rather, it establishes structures that can develop and institute policies that respond in real time to changes in the system in order to improve quality and restrain unnecessary cost growth."[203] As of now, most of these structures are still pilot programs. The ability for these pilot programs to reform the financial incentives of the participants of health care market will be critical to the success of the ACA.

The center of health care reform will take place in several panels created by the ACA. These panels will innovate both the organization and delivery of health care in

order to create savings. “The ACA established two independent and independently funded boards to control costs. The Independent Payment Advisory Board’s (IPAB) task is to implement target growth rates for Medicare, while the PCORI task is to evaluate and apply effectiveness research.”[204] The ACA also creates the Center for Medicare and Medicaid Innovation (CMMI) which will “test innovative payment and delivery system models that show important promise for maintaining or improving the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), while slowing the rate of growth in program costs.”[205] These programs seek the holy grail of health care policy—reducing costs while increasing access and quality of care.

Independent Payment Advisory Board

The program created by the ACA with the most potential to have an enormous impact on the growth of health care costs is the Independent Payment Advisory Board (IPAB). “The board was a top priority for Mr. Obama during the long legislative battle. He faced down Democratic leaders, who opposed delegating powers to an unelected board for the government’s popular health insurance programs.”[206] The IPAB is comprised of an independent panel of medical experts who have the power to make changes to Medicare’s payment system. The President, with the advice and consent of the Senate, appoints the 15 members of the IPAB to six-year terms. The board also has a 10-person consumer advisory board. The consumer board has no binding power over the IPAB.

The IPAB is charged with the task of keeping Medicare’s growth rate stable. Each year a target growth rate is based on the measure of inflation. After 2020, the growth rate

will be based on per capita growth in the economy-- the GDP plus one percentage point.[207] Starting in 2014, if Medicare's growth is expected to exceed the target growth rate, Medicare spending must be decreased by either 1.5% or by the projected excess of the growth rate over the target rate, whichever is lower.[208] "For implementation years starting with 2020, the target will be the growth rate of the per capita gross domestic product (GDP) plus 1 percentage point, again averaged over 5 years."[209] The IPAB must at least bring spending in line with this 1 percentage growth rate. The IPAB may also make recommendations for slowing health care growth to less than GDP to 1 percentage point. In fact, the IPAB is required to make advisory recommendations on slowing national health spending other than federal health programs.

Within this framework, the CBO has estimated that the IPAB will achieve $15.5 billion worth of savings from 2015-2019.[210] In order to do so "the IPAB will rely heavily on cuts in provider payment rates, changes in conditions of provider participation, and potentially new payment models."[211] With the restrictions on what the IPAB is allowed to address, the targets in the near future are likely to be very focused. Programs such as Medicare Advantage, Medicare Part D prescription drug program, skilled nursing facility, home health, dialysis, ambulance and ambulatory surgical center services, and durable medical equipment (DME) are all likely to see reforms.[212] These groups are likely to see payment rates reduced, as the original language of the ACA did not cut these parts of Medicare.

The IPAB's most effective tool is its' ability to change physician incentives. First, the IPAB has the power to make alternative payment systems more attractive by being able to make change Medicare provider's payment rates. Reducing the cost of health care

services to the government significantly limits the financial impact of the fee-for-service system. For example, the IPAB has the ability to set Medicare Advantage spending at or below spending the fee-for-service levels in traditional Medicare.[213] Savings will occur regardless of the amount of services provided. Even if doctors overprescribe, the savings are likely to still exist as over prescription occurs even now. Anti-fraud measures help back up the system by providing a buffer to over-prescription of Medicare. The manipulation of provider rates will be a key tool for ensuring that Medicare's cost growth stays manageable. Changing payment rates could especially make a difference in Medicare Part D. The IPAB could take action such as mandating rebates from prescription drug manufacturers for overcharging prices. This would incentivize drug providers to control their costs.

Expanding on the ability to changes physician incentives is the IPAB's ability to address payment systems for physicians. Programs such as Medicare Advantage and Part D are within the IPAB's jurisdiction and the IPAB has the ability to change physician incentives in these programs by altering the traditional fee-for-service program. By switching away from a fee-for-service system, the IPAB can ensure that physicians no longer financially benefit from practices that drive up health care costs for everyone else. Here the IPAB can mandate payment programs in Medicare that incentivize savings.

The IPAB is also unique in the fact that it has the ability to by-pass the incentives of Congressmen. The IPAB's recommendations that are required by law are put on the 'fast-track' through Congress. Recommendations by the IPAB must be introduced and assigned to a committee the day they are submitted to Congress. Committees have just two and one-half months to make their amendments to the IPAB's proposals. The House

and Senate cannot consider amendments that would change the proposals unless they are able to create the same amount of savings. This restriction can be waived with approval by three-fifths of the Senate.

Limiting Congress' role in the equation is a significant factor in the likely success of the IPAB. Perhaps most important to the success of the IPAB is the fact that the filibuster cannot be used to stall implementation. Debate on the bill is limited and amendments to the bill must be related to cost-reductions. Then, if Congress fails to pass the recommendations by August 15, the department of Health and Human Services is required to implement the IPAB's proposals.[214]

Next, by making the cuts to Medicare automatic if cost growth is too high, the IPAB remove the influence of Congressmen's incentive to get re-elected. Congress has routinely shied away from the task of reducing health care costs. For example, the sustained growth rate cuts for Medicare provider payments have been postponed every year. Congressmen are unwilling to make cuts to Medicare because they are unpopular in their home districts. Physicians in their districts depend on Medicare payments for income and Medicare patients are afraid of that they will bear the negative repercussion of cuts. The IPAB takes some of the political risk out of cuts to health care spending by making them automatic. Congressmen cannot be specifically blamed for cuts. Furthermore, the IPAB's recommendations are automatic unless Congress passes an alternative bill. In a divided government, Democrats and Republicans both controlling at least the Presidency or a branch of Congress, it can be extremely difficult to pass anything. The IPAB will ensure that cost control remains a priority regardless of politicians' motivations.

The IPAB does have limitations built into its' structure. First, the quality of care received from Medicare must remain the same. The IPAB is prohibited from recommending policies that "(1) ration health care; (2) raise revenues or increase Medicare beneficiary premiums or cost sharing; or (3) otherwise restrict benefits or modify eligibility criteria."[215] Without being able to restrict benefits, the IPAB will have to primarily focus on providers to achieve cuts. In years when the projected Medicare growth rate falls below the target growth rate or the medical care category of the CPI falls below the CPI, no proposal may be made.[216] Next, the IPAB can only address the growth in health care spending created by providers. The patient demand side cannot be addressed at all. Patients are more likely to be deliberate with the care they receive if they are paying for it or cannot afford it. This prevents alterations from being made to patient demand.

Furthermore, through 2019 the mandatory proposals cannot include recommendations that reduce payment rates for provides and suppliers below the 'level of automatic annual productivity adjustment' created by the ACA. Therefore, payments for hospital services, inpatient rehabilitation and psychiatric facilities, long-term care hospitals, and hospices cannot be touched by the IPAB until 2020.[217] These exclusions mean that Medicare Advantage, Medicare Part D, skilled nursing facilities, home health, dialysis, ambulance and ambulatory surgical center services, and durable medical equipment will see the majority of cuts to begin.

While the IPAB is a force for limiting health care costs, it can only do so as long as the growth of Medicare costs is extremely high. The IPAB's recommendations are only mandatory if cost growth exceeds 1% more than GDP growth. Keeping the growth

of health care costs at an average rate of 1% instead of 2.4% growth will provide a more sustainable growth. The CBO has projected that Medicare growth will be within the rates mandated by the ACA by 2020 if the entire law is implemented. While this hope is optimistic given the history of health care cost growth, it means that the IPAB will likely be focused on creating short-term solutions. Because the IPAB is not expected to be need by 2020, there is hope that the process will not have to be significantly expanded. Fortunately, the IPAB does not work alone to achieve savings.

Center for Medicare and Medicaid Innovation

The problem of health care cost does not just exist when health care costs grow slower than 1% more than GDP. In fact this rate itself is likely already too high considering how health care already encompasses one-sixth of the economy. In order to create continuous cost containment strategies for Medicare and Medicaid, the ACA will experiment with cost control measures within Medicare. The Center for Medicare and Medicaid Innovation (CMMI) is charged with the task of developing, testing, and evaluating policies to improve the quality of care for Medicare beneficiaries and reduce costs.[218]

The CCMI has the ability to experiment directly with the incentives of participants in the system in order to find cost saving programs. Some of the CMMI's first pilot programs include provider payment reform, collaborative care, efforts to increase efficiency of outpatient services, risk-based comprehensive payment, salary based payment, community based health teams, aligning cancer care with payment incentives, patient centered medical homes, and state experimentation with payment

reform. All of these pilot programs seek to create savings in the health care system through systems of payment or system of delivery.

Many of these reforms are centered on physician behaviors and trying to find an alternative to the fee-for-service system. One of CMMI's pilot programs is a patient care model that works to use bundled payments instead of fee-for-service billing.[219] "Bundled payments and global payments encourage providers to take clinical responsibility for their patients across a continuum of care, yet they also introduce a corresponding financial risk."[220] Under bundled payments, physicians are given a set amount of payment with every patient they receive. This means that physician's are incentivized to control costs. If a patient receives a lot of treatments, then the physician will begin to lose money when treating them. There is evidence that this system could work. One voluntary program in place since 2009 is seeing approximately 10% savings due to bundled payment systems.[221] While these savings are preliminary, the fact that they address physicians incentives makes this program promising.

The CMMI is also experimenting with ways to create savings through the way the patients are treated. Seamless coordinated care models work to enable doctors in different settings to work together on providing services for Medicare, Medicaid, and CHIP.[222] These innovations will enable the care to be more streamlined when multiple physicians are needed. Examples of the focus of the program include deploying advanced primary care and health home models to support Affordable Care Organizations (more on this later).

Perhaps the most important power belonging to the CMMI is the ability for the Secretary of Health and Human Services to expand successful pilot programs without

additional approval from Congress.[223] These programs can be expanded to cover the entire Medicare, Medicaid, and CHIP populations.[224] This can be a process to create enormous savings in the future. Many of the pilot programs being tested by the CMMI deal directly with the incentives of the system. The CMMI can also be used to make other ACA programs more effective. "The innovation center should coordinate with the new Independent Payment Advisory Board to promulgate successful models as the standard of payment under Medicare. The goal should be to influence other public programs and private payers to adopt these methods as well."[225] The opportunity for these pilot programs to be expanded and copied in other areas of the ACA make a strong possibility that ACA will be able to reform provider incentives.

Patient Centered Outcomes Research Institute

Another program created to discover programs to reduce health care cost growth is the Patient Centered Outcomes Research Institute (PCORI). "The Patient-Centered Outcomes Research Institute was established by the ACA to promote comparative effectiveness research (CER) to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence."[226] CER is "the generation and synthesis of evidence that compares the benefits and harms of alternative methods to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care."[227] The research is meant to find both medically effective and cost effective treatments. The PCORI will produce CER for organizations like the IPAB to use to make better decisions.

The ACA establishes a number of projects that will begin CER research to find cost controlling practices.[228] Projects focusing on using CER are likely to be effective for cost controlling practices. There is evidence that CER can make a difference for health care costs. The Agency for Healthcare Research and Quality has invested in programs focusing on patient-centered health, prevention and management, health information technology, and patient safety.[229] Medicaid already uses CER to identify savings.[230] In Oregon, CER was used to prioritize the most needed health treatments. This saved Oregon money by analyzing which programs provide the most efficient service. Internationally, more evidence exist that CER can provide cost-reducing programs. Canada uses CER to review the effectiveness of new drugs and determine whether or not to pay for the drug for enrollees.

Similarly to the IPAB, the PCORI also has limitation to what it can do. "Medicare coverage decisions cannot be made in a manner that "treats extending the life of an elderly, disabled, or terminally ill individual as of lower value" than an individual "who is younger, non-disabled, or not terminally ill."[231] While this alleviates some of the concerns over 'death panels', is does not make it easier to find the value of treatment. No life can be considered more valuable to save than another. The high amount of care provided at the end of life is evaluated no different than medical treatment on a teenager. Still, this does not eliminate the usefulness of CER as it can still be used to show the value of treatments throughout a person's life.

The PCORI will certainly allow for stakeholders to make better-informed decisions. The objective source from researchers will help provide the information needed to create the best and most effective route to treatment. While the research may

help, the challenge is making sure that the evidence will be used throughout the system. The CBO has projected that CER will "gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States by an estimated $8 billion from 2010 to 2019."[232]

The burden will be on physicians to incorporate the new research into their practices. "To affect medical treatment and reduce health care spending, the results of comparative effectiveness analysis would ultimately have to change the behavior of doctors and patients."[233] The existing fee-for-service regulations and desire to provide excellent treatment mean that physicians are still incentivized to use more expensive treatments.[234] The real challenge is in finding ways to ensure that health care providers make use of CER in their decision making process. Physicians are unlikely to adopt the new practices on their own because they become set in their ways.[235] However, if CER practices are combined with payment reform, they are more likely to be used. CER has the ability to magnify the ability for physicians to reduce the cost of treating patients.[236] CER also has a massive amount of potential because the Secretary of HHS again has the ability to expand finding from the PCORI to all of Medicare, Medicaid, and CHIP. When effective practices and programs are found, the Secretary can mandate their use. This creates the potential for a massive increase in the savings that the PCORI can create.

Ultimately for the IPAB, the CMMI, and the PCORI, savings cannot be immediately quantified. However, all three of these programs set the framework more future expansions to be made to practices that reduce costs. Both the CMMI and the PCORI have the ability to be expanded by the Secretary of Health and Human Services

throughout the government insurance system. The IPAB already has the power to reduce the rate of Medicare spending growth now and can potentially do so every year. These programs all have the potential to keep health care costs from growing as fast as they otherwise would.

Accountable Care Organizations

The delivery of health care is another area identified that can be reformed along with payment reform for cost control. Specifically, health care providers are targeted through Accountable Care Organizations (ACOs). ACOs are "a set of providers, including primary care physicians, specialists, or hospitals, that bear responsibility for the cost and quality of care delivered to a subset of traditional Medicare program beneficiaries."[237] In order to achieve the cost saving, ACOs use a combination of saving from a streamlined health care system and a hybrid payment structure of bundled payments and fee-for-service payments.[238] The CBO has projected that ACO will reduce Medicare spending by nearly $5 billion over the next ten years.

The models for ACOs in health care reform use three main strategies. First, patients in integrated care management programs will be able to engage patients quickly. For example, patients with several conditions will be able to receive their needed treatments at just one medical home rather than among several. Second, providers will seek to identify and head off potentially preventable events. This will help remove preventable admissions, readmission, complication, and unnecessary emergency room visits. Third, ACOs will seek to reconfigure health care delivery to reduce costs, waste, and harm to patients.[239] All of these strategies focused on creating a more efficient health care system.

In order to promote these cost saving reforms, ACOs are given several financial tools incentivize cost saving physician behavior. The Center for Medicare Service (CMS) is transitioning towards bundled payments instead of fee-for-service payments for physicians.[240] Under the bundled payment, profits are dependent on keeping costs below the total amount of payment received. This is likely to widespread very soon as 70% of hospital leaders believe that their institution will be part of an ACO in the next 5 years.[241] In addition to the bundled payment system, ACOs use financial incentives that reward providers for keeping patients healthy. This incentivizes physicians to cooperate on patient care. Using electronic health records and collaborative care can improve treatment efficiency and create better treatment at a lower cost.[242]

While past efforts to create health care savings through delivery have failed, ACOs have several unique factors that are likely to make them more successful. To start, new technologies exist to track patients and identify where waste is occurring. This allows for informed decisions to be made. Next, physicians are not as likely to be solely entrepreneurial as they used to be. They are much more likely to be part of a medical group that will be aware of the benefits of saving money under the ACO model. These organizations will provide pressure on physicians to keep costs low so that they can receive the financial incentives. With an organization pushed for savings, finding ways to prevent overtreatment will more likely be a priority.

ACOs will create savings through improvement in care. To start, ACOs are likely to help decrease preventable illness. By having ACOs focus on preventing readmission, heading of complications, and eliminating future emergency room visits, they will create significant savings. Physician incentives line up with the focus on preventable illness

because in the short term as it allows physicians to prescribe more treatment. The preventative treatment that ACOs emphasize is a guaranteed source of income for physicians.

ACOs are also expected to excel at chronic illness management. Chronic illnesses account for up to 75% of health care expenses.[243] By managing illnesses such as heart failure ($38 billion per year), diabetes ($116 billion), cancer through ACOs, significant saving can be achieved. Keeping the patient in one treatment network will allow for better-coordinated care and a continuity of care that can more quickly manage this condition. For physicians in these networks, they would likely see more financial benefits. With all the treatment occurring in one location, all the fees from services will go directly to physicians in the ACO network. More profits will be available because patient treatment occurs in one place.

Finally, ACOs have the ability to address the inefficiencies in the health care market. ACOs keep patients within one medical network so that their treatment occurs in the same place. The network collaborates to treat an individual patient in all settings including doctor visits, hospitals, and long-term care facilities.[244] The continuity of treatment for patients eliminates unnecessary testing.[245] Other ways to better coordinate health care include using the phone or email for follow-ups or making sure patients are properly discharged. However, these inefficiencies have not been previously addressed because they drive up profits. In order for these savings to occur, physicians will have to be incentivized to pursue them.

All of these reforms are backed up through ACO payment reform. The motivation for profits fuels the switch to ACOs in the short term. "ACOs would receive part of any

savings generated from care coordination as long as benchmarks for the quality of care are also maintained."[246] In March of 2011, the CMS released guidelines for the initial participants in the ACO organizations. These pioneer health care providers will gradually shift to system that less fee-for-service and less capitation. The final stage would have fee-for-service reimbursement at 50% with capitation (a fixed amount of money per payment whether or not they seek treatment) payments as well. The provider would then receive up to 70% of savings.[247]

By making savings contribute directly to physician's paychecks, creating health care savings is directly incentivized. The move towards a bundled payment system would mean that physicians have a set amount of payment for patients that they treat. Revenue will be dependent on saving money.[248] This would invariably change the business model for many health care providers. "ACOs would have to control traditional Medicare spending by providing financial rewards for good performance based on comprehensive monitoring of quality and spending. Any Medicare savings that emerge would be shared with the providers."[249] The saving that could emerge from an ACO plan will be a major step in controlling health care costs.

Reduced Hospital Payments

As hospitals are the largest setting for health care's enormous costs, they also see specific changes from the Affordable Care Act. The ACA attempts to make a significant dent in their spending through financial rewards and punishments. "Starting in 2012, Medicare payments will be reduced for hospitals with high levels of preventable readmissions."[250] These payment reductions incentivize hospitals to provide comprehensive treatment the first time they see a patient and give them preventative

treatments so that they are not readmitted. In 2015 hospitals will be docked money if rates of hospital-acquired infections are too high. Here again, hospitals are incentivized to avoid punishment.

The reforms for hospitals still can be financially beneficial for them. In the short-term, these measures line up with hospital's normal financial incentives. Hospitals are expected to provide as much care relevant care as they can to ensure that the patients is healthy. This creates a short-term windfall for hospitals. The savings come in the long-term reduction in readmissions. If patients are cured the first time, they will not receive costly redundant treatments.

Medicare is also trying to induce hospital savings through payment reform. "Also in 2012, Medicare will establish a value-based purchasing program in which hospitals will be paid more based on performance measures."[251] Bundled payments are being used to force hospitals to achieve savings in order to reduce expenses. "A hospital would be paid a set amount for a period of care beginning three days before hospitalization and ending 30 days after discharge, giving the hospital an incentive to coordinate care in cost-effective ways."[252] Patients readmitted would be the hospital's responsibility without the opportunity for more profits.

The common factor for all of these programs is their ability to change the incentives of physicians. As controlling factors of costs in the health care system, incentivizing physicians to control cost would make an enormous in the financial challenges America faces because of health care. If any of these programs prove to be very successful, the ability to expand the results to the rest of Medicare makes the results even more power. There is hope that these changes to physician financing will catch on,

especially if physicians realize that Medicare has to be solvent in order to get paid. This effort by the ACA to find an alternative payment could prove to be an important first step for creating lasting health care costs.

Additionally all these organizations and programs have the ability to create real relief for government spending on Medicare. With all of these short and long-term cuts, the federal government spending on health care will certainly be reduced. This will help alleviate many of the problems the government faces on its spending. Debt will no longer grow at nearly the same rate if Medicare sees billions of dollars in reduced costs. Strengthening the Medicare trust fund means that far less general tax revenue will be needed to keep Medicare running.

Health Insurance Exchanges

Individual Americans are also in need of relief from high health care costs. Most especially, they need help affording the cost of the insurance premiums. The private health care market insures 158 million Americans and is responsible for much of the financial challenges non-elderly Americans face.[253] The structure of the insurance market that is so different than the free market insulates insurers from competition and allows for unnaturally high costs. Before the ACA, competition for insurance consumers is limited. Consumers are largely locked into one health care insurer as under the employer-based system of health care, employers are largely in charge of selecting the insurance provider that patients will receive. Instead of having tens of millions of individual Americans shopping for insurance, companies purchase the insurance for a large number of people, significantly reducing the number of purchasers in the insurance market.

The ACA injects competition into the private insurance market through health insurance exchanges. States are required to create a health insurance exchange both for individuals and for small businesses.[254] Each state has the option to merge these markets or to set them up separately. Health insurance exchanges are expected insure 9 million Americans in 2014. By 2019, 29 million Americans will be insured through exchanges.[255] The ACA requires all 50 states to create an online market place where consumers can shop for health insurance plans. There are several tiers of plans at different prices available through exchanges: bronze, silver, gold, and platinum. If a state fails to create their own insurance exchange, the federal government will do so for them. These exchanges are intended to "create a more organized and competitive market for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them."[256] These exchanges will be a convenient and simple way for individual Americans or businesses to shop for health insurance.

Insurance exchanges seek to use market factors to control health care costs. The creation of health insurance exchanges uses millions of new customers to incentivize reform in the health care market. Through health insurance exchanges the ACA strives to reform the health care market into one that acts more like a free market would. While the free market model cannot be completely applied to the health care market, instituting a quasi-market system can be appealing.

There are several ways health exchanges will incentivize insurance companies to control their costs. To start, insurance companies will be put into direct competition with each other through these exchanges. Each state will have a website with a list of

insurance companies and possible options for coverage. Consumers will be able to compare plans to each other on websites that are set up by the state's insurance exchange board. This 'menu' of insurance plans is a new option that consumers have not had in the past. The menu will give them easy access to comparative information that they have not had in the past. Insurance companies will have to keep their prices low if they want to attract the millions of new customers in the health insurance exchange.[257] This also makes it easier for employers to choose an insurance provider.

Exchanges can also bring down the cost of health care if states choose to be active purchasers in the health care system. States are required to create an independent agency to govern the health care exchange. States have to choice to actively choose which insurers are allowed to be a part of the insurance system. For states that choose this option, they can make the ability to join the exchange dependent on price and quality of coverage.[258] Some of the possible options for states when including health insurers include "selective contracting, negotiating on price and quality, requiring payment and delivery reforms as part of plan design, requiring additional certifications, providing consumer education materials, and further regulation of the market by standardizing health plan benefit packages."[259] While states are still in the planning stages of their exchanges, all of these options can bring about cost reduction.

While adverse selection has been a problem for insurance in the past, there are steps that can be taken to avoid this problem. First, subsidies are available to help bring in healthy groups such as low-income families.[260] Next, exchanges are expecting to receive a large number of young Americans. One-third of the uninsured population is under the age of 26. Their entrance into the insurance market through exchanges is likely to provide

a significant buffer to adverse selection. States also have policy options at their disposal. States can prohibit insurers from charging different prices inside and outside of the exchange, prohibit the creation of plans that only attract healthy customers, require insurers to include catastrophic coverage in their exchange package, and can provide financial incentives to keeping business within exchanges.[261]

Employers are likely to be driven to health insurance exchanges as well. Small businesses can use the exchanges in 2014 and larger employers will be allowed to if states want to expand the exchanges in 2017.[1] This means that millions who already receive insurance will be part of the exchanges. Both prices and administrative ease will drive employers to the exchanges. Furthermore, the option of shopping in exchanges allows employers to give their employees more control and more responsibility in shopping for their health plan. With plans comparable in one location, businesses will take advantage of the convenience of exchanges or allow their employees to do so. Many of the same advantages that individuals will receive from exchanges will also be available for these businesses.

Health insurance exchanges also allow consumers to take more active role in the cost control process. Before, consumers were generally subjected to the rates that employers had negotiated with insurance companies. If consumers were on their own, rates were likely to be even higher. Exchanges help consumers control their spending on health care by giving them easily accessible information about health insurance costs. Each plan is required to show the cost of the plan and what is covered. This allows

consumers to pick the plan with the most comprehensive coverage at the cheapest cost. Furthermore, it allows consumers to easily switch plans if they are not satisfied with their current coverage. Insurance companies will have to adapt their prices to account for consumers new access to knowledge about their product. The individuals using exchanges will have more control over the health spending. Subsidies provided for some groups will make it even easier to afford higher levels of coverage. This comparison of plans will allow consumers to pay exactly as much as they need. Exchanges simplify the process of purchasing health care and will see sizeable populations.

The open enrollment system will mean that insurance companies will have to directly competing against each other. Direct competition would drive prices lower once they have to compete on price. In a system in which the lowest bidder wins, only the insurance companies with the lowest prices will be part of the system. Either way, insurance companies are competing with each other more than they currently do.

Cadillac Tax

The ACA also slightly addresses the consumer side of the health care costs. Beginning in 2018, plans that charge more than $27,500 for families and $10,200 for individuals will have a tax of 40%. This price limit for these 'Cadillac' insurance plans rises with the rate of inflation. The purpose of the tax is twofold, to discourage consumers from purchasing expensive plans and to put a limit on what insurance companies are able to charge for coverage.

The large tax on the Cadillac insurance plans effectively puts a cap on the insurance market. A 40% increase in cost makes luxury health insurance benefits far less

attractive. When consumers purchase these luxury plans, they expect the very best coverage. This gives health care providers free reign to charge as much as they can to these patients. The excise tax effectively prevents luxury plans that are targets for over prescription from being purchased. This tax effectively forces insurers to limit the cost of their premiums. For insurers, expensive plans were a way to both attract wealthy customers to purchase their plans and a way to mitigate the risk of chronically sick patients. By creating a limit to the amount that can be charged to consumers, the 'Cadillac' tax prevents insurance companies from continually raising premiums.

Primary Care

Another tactic used by the ACA is to control health care costs is to prevent as many medical emergencies from occurring as possible. In order to do so, the ACA greatly expands Americans access to primary care, the initial and basic level of health care treatment that is provided to patients.[262] Primary care is generally non-specialized treatment. The ACA makes all preventative services received from primary care physicians in Medicare, Medicaid, and private plans free; co-pays are no longer needed. In addition to primary care being free, the ACA "provides a total of $26.4 billion over ten years to support [primary care]."[263] This money will be used to expand access to preventative services.

Increasing access to primary care will provide financial relief for individual Americans. With preventative care now free, Americans will have access to these primary care services whenever they desire them. In the short term, this significantly decreases individuals spending on health care, as price is no longer a barrier for preventative services. Furthermore, if individuals are able to catch large health problems

before they become emergencies, this will save them money in terms of insurance premiums and time lost to sickness. The incentives easily line up for individuals to embrace these new technologies. Free health care is an easy sell to anyone.

The Obama administration hopes that preventative treatments will make a larger impact on spending in the health care system. The logic is that this new access to treatment will decrease the amount of preventable diseases that occur. "In 2000, 5 million hospital admissions, costing a total of $26.5 billion, might have been prevented with better primary care."[264] The hope is that Americans use of preventative services will make a serious dent in that number and prevent more intense episodes of care from occurring later.

However the cost-effectiveness of preventative services can vary greatly. A review of preventative services from the New-England Journal of Medicine found that the efficiency of treatment gathered by emphasizing preventative treatment was not much higher than treating conditions after they occurred.[265] Factors determining whether preventative measures represent good value depend on the population targeted; high-risk populations offer more opportunities for savings. For services such as screenings, the more screenings given the less valuable they become. For example, colonoscopy screenings for men age 60-64 is a cost-saving preventative treatment but screening all 65 year olds for diabetes adds to health care spending.[266]

The fact of the matter is that there is not enormous savings to be immediately found through treatment. Targeted areas for savings can be found but there is no guarantee that the findings will be widespread. Furthermore, the terrible reality of health care is that the older someone is, the more expensive they likely are to be treated. More

preventative care will certainly better and extend lives, which is excellent for the quality of the health care system. Unfortunately expecting primary care to reduce costs is trying to have you cake and eat it to. Primary care may delay expensive treatments but it does not end them.

Conclusion

All of these programs seek to make an impact on the incentives of the health care market in some way. Most importantly multiple programs target physicians incentives. If a way can be found to incentivize physicians to control their own health care costs, there is a significant chance that health care cost growth can be slowed. Once these incentives reform are combined with market and reforms and empowering consumers, obtaining a cheaper health care system is very realistic. The wide range of efforts at health care could prove to combine to create large savings.

If the costs are going to be curbed far into the future the efforts of the IPAB, CMMI, and PCORI all must be embraced. Their missions to cut spending and create reforms such as payment reform and increased efficiency could all go a long way to reigning in cost. Reducing the amount of fee-for-service physicians could enormously limit over treatment. The ACA has created the beginnings of the institutions necessary to controlling costs. If there is going to be a continued savings in the future, the power of the Secretary of the HHS to expand services throughout government insurance programs must be embraced.

Chapter 6: Conclusion

The Affordable Care Act is an important step in the right direction for controlling health care costs. The explosion in healthcare costs has been a serious problem for the government for decades and grown to be more problematic for Americans seeking coverage and employers every year. With one-sixth of U.S. spending tied to up in only consuming health care, something had to be done. Fortunately, the ACA will at least begin the process for alleviating these problems.

The most important factor to take away from this thesis is that the ACA created a new era in the health care market, health care incentives, and health care politics. The passage of the ACA represents an important change in the cycle of government's treatment of health care. While the ACA attempts to change the incentives of the health care market's participants and to also fundamentally changes the structure health care market. Previous health care reform efforts by the government have either significantly expanded coverage or taken half-measures at controlling health care costs. Instead the ACA brings a much more focused effort to controlling health care costs. The incentives of the major participants are directly focused on. Physicians, providers, insurers, and consumers will all see new changes focused on incentivizing or empowering them to pursue lower health care costs. Perhaps most importantly, physicians may soon be compensated in an entirely different way if the IPAB, the CMMI, and the PCORI can identify viable alternatives to the fee-for-service system. This is fundamental change that has to occur if the ACA is going to be successful because physicians control the amount of care provided to patients. If physicians can still feel secure in their financial standing without providing extra care, it will go a long way for the health care system.

All of these incentives reforms are backed up by efforts to create a new health care market. Health insurance exchanges inject a whole new level of competition that has not existed in the health care market for a while. This changes the incentives of insurance companies and consumers. Health insurance exchanges will line up the health care market so that it will be self-policing in terms of price will make significant changes to the health care system. This forces insurance companies to compete on terms on price, something they have hardly at to do at all. Exchanges also give consumers a chance at becoming a force to drive down prices. They will have both more options and a better knowledge of insurance coverage. Once consumers have a more equal playing field when purchasing health insurance the health care market will look much more like a free market.

These along with many other reforms will bring some needed relief to the dangers of enormously high health care costs. The government will find relief from its spending on Medicare with the immediate cuts made and the potential for even greater cuts later. The billions in savings created extend the life of Medicare. Perhaps more importantly, lowering the bill for Medicare will contribute significantly to efforts to lower the federal debt. If Medicare's costs can fall to the point where they longer create billions of dollars of debt every year, one of the largest sources of government spending will be sustainable.

Individuals Americans are the clear winner from the ACA. Individuals are given more guarantees in their access to insurance coverage such as the elimination of pre-existing conditions and more access to coverage. On top of this, health insurance coverage will almost certainly be cheaper. Through reforms made primarily through insurance exchanges, individuals have the tools they need, knowledge and product

choice, to find the best price possible for them. Based on these changes, Americans are likely to see far less financial hardship from health care.

Finally, while benefits going towards businesses are not direct, the ACA could tangentially bring benefits to businesses. Cost saving measures occurring Medicare and Medicaid could spill over into the private insurance market. If the private market insurers have to compete with the government for more customers, businesses as the main provider of insurance will see those benefits. In the meantime, the more access to health insurance exchanges businesses are given, the more they will receive similar benefits as individuals. At the very least, a decreased government debt from health care costs will go a long way towards restoring business confidence and a healthy economy. The sizeable impact the health care has in the economy makes it likely that businesses will eventually see more specific benefits.

However, despite the monumental changes that the ACA makes to the health care system, it is not likely to be a permanent solution on its' own. The programs created by the ACA are largely pilot programs. There will have to be a buffer time to see which programs can make an impact. Critical for significant action being taken to control health care costs is a continued political will to see health care cost containment through until the end. It will be a slow process to find and implement the policies discovered. Removing Congress from much of the decision-making process will be critical for this. The IPAB can consistently work for Medicare cost control and drag Congress along in the process. The Secretary of Health and Human Services can expand findings from the CMMI and the PCORI throughout Medicare and Medicaid. However, if Congress were to

be an active part of the process for containing health care costs it would go a long way towards ensuring the ACA has the tools to control health care costs.

As hard as it was to pass the ACA, there will likely need to be more action to fully address the problems high health care costs create. The programs to create new payment systems will have to be expanded. Furthermore, the cuts made to Medicare spending are temporary in nature. There will have to be a significant amount of savings achieved from programs in order to make a trend out of health care savings. Otherwise, provider cuts are just one time events that will prevent health care costs from trending upwards.

As long as health care costs remain high, they remain a contentious political issue. The ACA has made it so that health care cost containment will remain a political priority in addition to expanding Medicare and Medicaid coverage. Continued study of the effects of the ACA will be important for the financial future of the U.S. budget, economy, and individual Americans. Furthermore, the effects of the ACA will continue have a significant impact on the political process and battles in Congress. While time will be the final indicator of the success, the ACA's focus on incentives coupled with both a short and long-term approach makes the ACA likely to be a significant first step in containing health care costs in the United States.

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