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OP-ED

The Affordable Care Act—A New Way Forward

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On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA). The law is a step in the right direction, doing exactly what its name states: making health care more affordable for all Americans. Health care expenditures in the United States reached \$2.6 trillion in 2010, comprising 17.6 percent of gross domestic product [1]. Increases in health care expenditures are the driving force behind rising health insurance premiums, such that the average cost of insuring a family of four is now \$13,770. As insurance has become increasingly unaffordable, more Americans have been forced to go without it.

The ACA helps to make health care more affordable in two ways: by providing insurance coverage for approximately 50 million people who are currently uninsured and by striving to control health care costs by changing how medical services are paid for. First, the law offers health insurance to some subgroups of the currently uninsured, so that they can obtain care with a copayment or coinsurance rate, rather than paying the full price of a physician visit, hospital stay, or prescription drug. For example, the ACA has already enabled parents to add their dependents up to age 26 to their own plans. In 2014, health insurance companies will no longer be able to deny customers coverage due to preexisting conditions. Also in 2014, families with incomes at 133 to 144 percent of the federal poverty level will be able to purchase a health insurance plan with benefits specified by the federal government at a cost no more than 3 to 4 percent of their income, or slightly under \$2,000. Similar subsidies will be available on a sliding scale for families with incomes up to 400 percent of the poverty level. The federal government will provide the funds needed to low-income families to enable them to purchase health insurance at these specified costs.

The public disagrees on the merits of using more taxpayer money to reduce the number of uninsured persons. One of the most compelling arguments provided by economic research is that the expansion of the Medicaid program in the 1980s and 1990s led to an 8.5 percent reduction in infant mortality and a 5 percent reduction in child mortality [2, 3]. A recent Institute of Medicine report estimates that the monetized lifetime value of the improved health that would be gained by covering the uninsured (so that they obtain needed care) exceeds the costs of paying for this additional insurance [4].

The second way that the ACA makes health care more affordable is its concerted effort to control rising health care costs while ensuring high-quality care for those who already have health insurance coverage. These features of the ACA have

received less public attention because most people (and the media) do not fully understand our complex health care system. The majority of both public and private health insurance reimbursement mechanisms reward physicians for providing greater *quantities* of services, rather than providing higher-*quality* services. Health care professionals are richly rewarded for performing more open heart surgeries and angioplasties, while they receive little or no financial compensation for time expended educating patients to practice the healthy habits that would reduce the need for costly, aggressive medical treatments.

There are numerous examples of how the current financial incentives lead to high expenditures with questionable value. Between 1997 and 2005 the real cost of treating patients with spine problems in the United States rose from \$4,695 to \$6,096 per patient. Yet after the additional \$85.9 billion was spent, data from surveys of patients who had received treatment revealed that self-reported mental health, physical functioning, work or school limitations, and social limitations were all worse than they had been prior to treatment [5]. Research indicates that only 44.5 percent of Medicare patients underwent stress tests prior to elective percutaneous coronary intervention (PCI), even though clinical guidelines call for such noninvasive testing to confirm the need for treatment [6]. Medicare pays for more than 800,000 PCIs per year, at a cost of \$10,000 to \$15,000 per case.

The ACA changes per-treatment reimbursement to a system that rewards high-quality care using several strategies. Medicare will soon begin to reward hospitals and physicians for establishing accountable care organizations. An ACO is a group of providers that works together to coordinate care for the patients they serve under Medicare. The Center for Medicare and Medicaid Services (CMS) will track the quality of the group's care and share savings with the ACO if its patient costs are lower than those in a yet-to-be-determined benchmark. ACOs will encourage coordinated care that is likely to improve patient outcomes and simultaneously reduce costs.

The ACA also calls for Medicare to move toward “bundled” payments for procedures such as open-heart surgery or hip replacement. Medicare currently makes separate payments to different health care professionals for services delivered during a single course of treatment, leaving individual physicians and hospitals little incentive to coordinate care. Under the ACA, CMS would move toward paying a single bundled payment to a team of caregivers for an episode of care, so that they will have an incentive to coordinate care and lower costs resulting from complications and delays, in order to earn greater net compensation.

The ACA also establishes an Independent Payment Advisory Board (IPAB) charged with developing detailed proposals to reduce the per-capita rate of growth in Medicare spending. The IPAB has been referred to as a “MedPAC on steroids.” MedPAC, the Medicare Payment Advisory Commission, has been advising Congress for years on strategies for improving the structure of Medicare, but it only plays an advisory role. MedPAC issued a report in June 2010 identifying several highly

promising strategies for controlling health care costs, such as coordinating reimbursement for dually eligible Medicare and Medicaid enrollees and adopting novel quality- and cost-improvement strategies that have been used in the private sector. Expanded authority through the IPAB would enable these strategies to be implemented more quickly and comprehensively, again helping to slow cost growth. All of these efforts will slow the rate of increase in health care spending.

Where Does the ACA Need Mending?

The law needs stronger language to empower CMS to refuse coverage for new technologies that are more expensive and yield no demonstrable benefit to patients. The current language in Title XVIII of the Social Security Act states that “no payment may be made [by the Medicare program] for any expenses incurred for items and services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury” [7]. This language is too weak, allowing marketers of costly new drugs and devices to obtain Medicare coverage for their products even if existing products are equally effective and cheaper. The recommendation to refuse payment for technologies that are both costly and ineffective seems straightforward, but efforts to include cost effectiveness as a criterion for coverage in the ACA led to panicked (and misinformed) outcry about “health care rationing” from the public.

The ACA failed to address the need for price transparency for patients. Physicians and hospitals are not required to post the prices they charge for office visits or elective procedures, making it extremely time consuming and difficult for patients to compare the potential costs of seeking care from different physicians or hospitals. I work in the city of Houston, where local television news reporters have shown me substantial price variations for diagnostic procedures, delivery of a newborn baby, and elective procedures. Having to post the price of services could encourage providers to be more competitive on price, which would aid in lowering costs. Some commentators are skeptical that price transparency will lower prices, because insured patients only pay coinsurance, which is usually a fraction of total costs [8]. However, even insured patients are likely to be sensitive to price variations when they must pay coinsurance rates that are a percentage of total prices. Moreover, insurers would be able to offer lower copayments for physicians and hospitals that charge lower prices and have demonstrated high quality of patient outcomes.

The third area of the ACA that needs mending is the tax on “Cadillac” health insurance. The ACA imposes an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage beginning in 2018. Insurance policies with premiums at this level truly are “Cadillac” policies. The average costs of individual and family coverage in 2010 were \$5,049 and \$13,770 respectively, so that the overwhelming majority of workers will avoid paying taxes on health insurance for years to come.

I would prefer instead that the tax be expanded to “Chevrolet” health insurance. Currently, employees pay no income, Social Security, or Medicare payroll taxes on the value of health insurance that they obtain through their employers. This causes a

distorted preference for workers to receive additional compensation in the form of health insurance rather than (taxable) wages, which, in turn, leads them to choose much more expensive health insurance plans than they would otherwise. As a result, workers consume some care that likely has relatively little value. This phenomenon, known as moral hazard, leads health insurance to be more expensive than it would be if workers used only care that is worth its full cost [9]. Expanding the number of health insurance policies subject to taxation will nudge workers to think more carefully about insurance premium levels when they are choosing their policies at renewal time. This added price-consciousness will encourage insurers to introduce less generous insurance products with correspondingly lower premiums, which should lower health care costs in the long run [9].

Conclusion

Over the past year and a half, I have struggled to explain many important aspects of the ACA and the U.S. health care system to newspaper and television reporters. I quickly realized that even these well-informed individuals were facing significant difficulties understanding more than 1,000 pages of legislation and with an industry consisting of so many different health care providers and payors for services, with often contradictory priorities and incentives. It is even more unreasonable to expect the general public to understand what must be done to achieve high-quality, affordable health care. Efforts to mend the ACA must come from within the health care profession—from the physicians who have primary authority for prescribing and delivering treatment, as well as the best ability to identify cost-effective care. The federal government can do only so much to provide subsidies and regulations to increase access to health insurance. The future success of the ACA depends on doctors' willingness to take the lead in identifying high-quality, cost-effective health care.

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