

U.S. Health Care Reform: A Primer and an Assessment

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Abstract

A comprehensive health care reform bill was passed by the U.S. Congress and signed into law by President Obama on March 23, 2010. In this brief paper, we attempt to convey the existing structure of the U.S. health care system, to identify its major weaknesses, to describe the primary new features introduced by the act, and to offer our overall appraisal of the reform.

Today's pre-reform U.S. health care system produces a huge volume of services—as of 2007, expenditures had reached \$2.2 trillion or 16.2 percent of the nation's GDP. These services are often distributed inefficiently and inequitably, and both per capita costs and total cost relative to GDP exceed those of other developed nations.

The health care reform includes expansion of the Medicaid program (in 2014) to cover everyone with income below 133 percent of the federal poverty line; and those with low to moderate incomes will receive subsidies to achieve increased coverage and access. By 2014, private insurers will no longer be able to exclude any person with a preexisting condition from coverage or charge them more for coverage. Tax credits starting at 35 percent and going up to 50 percent will be given to small firms. The U.S. private health insurance market will be fundamentally changed by the introduction of a set of organized *Health Insurance Exchanges*, which will be established in each state (or in groupings of states), and will require insurers to offer four standard packages of benefits.

The 2010 legislation sets several constraints designed to reduce inefficiencies in the operation of the system; reduce complexity in health care choices; and expand and restructure existing public programs. The changes introduced by the reform are enormous. Health care coverage will be provided to an additional 32 million Americans, reducing the uninsured population from about 12 percent to 6 percent of the population. Of course, problems will remain, and uncertainties in implementation are pervasive. Nevertheless, gains in the form of movement toward near universal coverage, a lower rate of increase in health care costs, and a realignment of incentives for cost-effective decisions by providers, insurers, and consumers are major gains attributable to the reform.

Keywords: health care reform; Preferred Provider Organizations (PPOs); Health Maintenance Organizations (HMOs); health care access; health insurance

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I. INTRODUCTION

After efforts by five presidents and numerous Senators and Congressional Representatives, a comprehensive health care reform bill was passed by the U.S. Congress and signed into law by President Obama. The Patient Protection and Affordable Care Act of 2010 became law on 23 March 2010.¹ The bill is long—1,200 pages—complex, and comprehensive; there is no major part of the existing health care system that is not changed, and providers, consumers, and taxpayers will all be affected.

In this brief paper, we attempt to convey the existing structure of the U.S. health care system, to identify its major weaknesses, to describe the primary new features introduced by the act, and to offer our overall appraisal of the reforms.

II. THE EXISTING U.S. HEALTH CARE SYSTEM

Today's pre-reform U.S. health care system is a unique and awkward combination of arrangements. Taken together, the system produces a huge volume of services—as of 2008, expenditures had reached \$2.3 trillion or 16.2 percent of the nation's GDP; about \$7,700 per capita (Hartman et al. 2010). These services are often distributed inefficiently and inequitably, and both per capita costs and total cost relative to GDP exceed those of other developed nations.²

¹The Act passed the Senate on December 24, 2009, and the House on March 21, 2010; a reconciliation bill was passed by the Senate shortly thereafter and signed by the president on March 30, 2010. The reconciliation bill is known as the Health Care and Education Reconciliation Act of 2010. In the discussion below we refer to the law as having been established by both of these bills. The five presidents refer to those in office following the establishment in 1965–1966 of Medicaid and Medicare who attempted reform: Presidents Nixon, Carter, Clinton, Bush, and Obama. An interesting interactive timeline of the 100-year history of U.S. efforts to secure universal health care is available at http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html.

²For example, as a percentage of GDP, Canada, Germany, France, and the Scandinavian countries spend about 9 percent to 11 percent on health care; the figure is about 8 percent for the United Kingdom. See http://en.wikipedia.org/wiki/Health_care_system#Cross-country_comparisons.

Most non-elderly Americans,³ 162 million persons (53.2 percent of the total population), obtain health insurance through their own or a family member's employer. Under this arrangement, they then purchase health care largely from private providers (doctors, clinics, hospitals), under constraints imposed by their health care plan. Some of these insurance plans are tied to various groupings of providers, known as Preferred Provider Organizations (PPOs) or Health Maintenance Organizations (HMOs). Those covered under the latter usually need to choose among providers that are members of a group organized by the plan; those under the former face financial incentives to choose member providers.⁴

American families without a regular full-time worker (e.g., many single parents, elderly, and disabled persons) are not offered employer-based insurance. Many employees of small firms also are not offered employer-based coverage and have to purchase insurance themselves, usually at much higher prices than offered by employer-based insurance. Low-income families without job-related insurance rely largely on a federally sponsored (but state-based) insurance program, *Medicaid*.⁵ Each state has a somewhat different set of eligibility requirements and coverage arrangements under Medicaid, even though all states operate within federal government guidelines. Generally, benefits under the Medicaid program are quite comprehensive and generous, though compensation to providers is not. As a result, providers in some markets limit access as they decline to serve Medicaid-covered patients. In 2010, over 60 million Americans (one in four children) received insurance under this program. In 2008, \$340 billion was spent on the health care of Medicaid beneficiaries; the program accounts for nearly 16 percent of all personal health care spending and almost 45 percent of spending on nursing home care. Were it not for the Medicaid program, many of these families would be without health insurance.

³Americans 65 years of age and older have coverage through Medicare, a government-run program described below.

⁴<http://www.kaiserhealthnews.org/Stories/2009/September/28/NPR-employer-explainer.aspx>

⁵For more information on the Medicaid program, see <http://www.kff.org/medicaid/upload/7235-04.pdf>.

Families headed by a person aged 65 or older receive health care coverage from yet another public program, the *Medicare* program.⁶ The program covers much but not all of the expenses of inpatient hospital, and nearly all former workers older than 65 years have this coverage. Medicare also covers physician services and outpatient visits, but this insurance requires a monthly premium and relatively high cost sharing. If people covered by Medicare join a managed care health plan that participates in the program, they can obtain additional health care services that are not covered by “traditional” Medicare.⁷ Finally, Medicare has a voluntary subsidized prescription drug benefit that has been available since 2006; it also requires a premium and patient cost sharing. This year, Medicare expenditures are expected to total \$504 billion—15 percent of the federal budget. The program is funded by a combination of general revenues (40 percent), payroll taxes (38 percent), beneficiary premiums (12 percent), and other sources. Many people with Medicare purchase supplementary insurance to cover the patient cost sharing required by the program; most low-income elderly are covered by a combination of Medicare and Medicaid.

Children who are in low- to moderate-income families who are not eligible for Medicaid may be covered by the newest public program, the Children’s Health Insurance Program (CHIP). This program is another joint state-federal program with income eligibility guidelines that differ by state. The federal government pays a higher share of the costs of this program than for Medicaid in an attempt to encourage more generous eligibility standards, though federal allocations are capped annually. States also can obtain waivers to cover parents under CHIP; however, states do not receive the higher federal matching support for parents. In 2009, 7.7 million people were enrolled in CHIP.

Finally, there are Americans who have no health insurance at all—almost 18 percent of those under age 65 in 2008. The reasons for this are complex. Part of the explanation is that many families without a full-time worker at a large firm are not offered an employer-based policy. Self-employed people, including farmers, and anyone who is not offered employer-based coverage typically have to pay

⁶For more information on the Medicare program, see <http://www.kff.org/medicare/upload/1066-12.pdf>.

⁷About 25 percent of Medicare enrollees are now enrolled in a managed care Medicare plan.

much more for insurance if they buy it on their own compared to the per person price for employer-group insurance. In addition, the Medicaid program is “categorical,” meaning that many low-income people do not meet the categories eligible for benefits. People without health insurance use community health centers where available (and pay on a sliding scale) or go to hospital emergency rooms when they have a medical emergency—a costly option. Often regular health care services, including preventive care, are simply foregone.

III. EIGHT PROBLEMS WITH THE PRE-REFORM U.S. SYSTEM—AMONG MANY

A. The Uninsured Population

The large number of Americans without health care coverage—over 15 percent of the population—is an internationally embarrassing offshoot of the complex and costly nature of the American employer-based health insurance arrangement. That many of these citizens have low incomes only heightens these inequities.

B. Constrained Access to Health Care

Many Americans forego health care, especially preventive care, because they either lack health insurance altogether or their insurance requires that they pay high cost-sharing rates relative to their incomes. The foregoing of care often results in the diagnosis of certain conditions at later and more costly stages of disease. The result is a likely increase in national health costs, but also long-term health declines and shorter life expectancy, as well as personal stress and even bankruptcies due to the inability to pay medical bills.

C. Private Insurance Market Problems

The U.S. health insurance market is a private market—largely due to job-based health insurance—in which health insurance policies are bought and sold. As such, it is essential that many

buyers and sellers participate in the market, and that both groups have full information. Unfortunately, many of the markets in which employers shop for insurance options to offer their employees are local and thin, with limited opportunities. Purchasers in such markets often find it difficult to find policies that are “affordable;” this is especially true for small firms. Individuals who seek policies that they pay for themselves have an even more difficult time finding affordable insurance. Moreover, the menu of plans offered to individuals is often very complex, and choices seem largely unrelated to relative costs and gains. The proportion of premium revenues that is not paid out for actual medical expenses is high: well over 10 percent of the premium for small firms and more than 25 percent for individual policies. Insurers argue that there is far greater risk in insuring people in small firms or who want coverage as individuals than in large employer-groups, and hence that they need to have higher premiums to cover such risks.⁸ Finally, because the U.S. income tax does not tax employer-based insurance as income, higher income employees seek comprehensive packages with a wide spectrum of choices, avoiding packages with more limited choice and greater use of cost controls. This pattern perpetuates inefficiencies in the health insurance and health service arrangements.

This private insurance market arrangement also has other problems. While it offers flexibility, responsiveness, and options among which to shop, the arrangement encourages firms to shift low-wage workers out of the pool of insurance-eligible employees by contracting out or hiring temporary workers (see Swartz 2006). And since premiums often are experience rated, it also encourages them to avoid hiring people who they suspect may have high health costs; this is especially true for smaller firms. Because workers who may suspect high future health care costs are afraid to leave jobs with insurance benefits, economists have worried about the resulting decrease in labor market mobility, or “job lock” (see Glied, 2005).

⁸The explanation for the higher risk is that adverse selection is more present among small firms and individuals who want insurance.

D. Health Care Costs

To many, the primary problem with the U.S. health care system is its overall cost—over 16 percent of GDP. With the share of the population over age 65 projected to grow rapidly in future years, many fear that this percentage can only rise. Part of the explanation for the high cost is simply the higher income and hence higher demand for services in the United States, but part of it is likely due to higher unit costs for services, and higher administrative costs tied to the complex structure and greater use of high-tech services including specialist care. Getting paid to deliver services (fee-for-service) and ownership of outpatient facilities by doctors may also contribute to this problem. It is not due to greater use of hospitals or lengths of hospital stay.

E. Regressive and Inefficient Financing Arrangements

Contributing to the high cost of the U.S. health care system are the arrangements for its financing. In order to assist families to purchase private health coverage offered by employers, U.S. federal tax policy allows individuals to pay for health insurance premia using pre-tax dollars. This provision results in a very regressive financing arrangement, with the largest “tax-expenditures” (i.e., subsidies) going to the highest-earning households, who face high marginal tax rates. Moreover, because federal and state tax policies do not treat the employer costs as “compensation,” households are exempt from both income and payroll taxes on this component of compensation. Although the large subsidy was designed to raise the overall willingness of firms to provide insurance coverage, it is a seriously regressive arrangement. Moreover, because the subsidy is not constrained, plans that offer choice among providers with little or no cost sharing (hence, encouraging excessive health care utilization) tend to be favored, at least by higher income employees and their families.

F. Coverage beyond Traditionally Insurable Components

Largely as an offshoot of the regressive financing arrangement, U.S. health coverage has expanded to include items traditionally not insured, such as dental care (including braces) and eye care (including glasses). This expansion means that those with higher incomes receive the greatest public subsidies for services that are largely discretionary, predictable, or inefficient.

G. The Problem of “Preexisting Conditions”

Because of the nature of the employer-provided health insurance arrangement, the available insurance options tend to be limited and very expensive for people with preexisting conditions. An employee with a preexisting condition at the time of application can be denied coverage for that condition for 12 to 18 months (although prior continuous coverage can reduce this waiting period). But in the individual market in nearly all states (45), private insurance may not be available (or available only at very high premiums) for those with preexisting conditions (including those with a genetic marker). And, in all markets, the lifetime limits of a policy may lead to a total loss of benefits for individuals with expensive conditions. Once a condition is diagnosed, some companies refuse to continue coverage or retroactively discontinue the policy.⁹

H. Underserved Areas

Finally, across the nation, there are numerous “underserved areas” where access to care is limited. In most cases this is tied to low reimbursement by Medicaid, payment uncertainty if uninsured, or inflexible licensing laws preventing the use of para-professionals in practicing medicine; usually these are low-income and rural areas.

⁹See Waxman H and Barton J. (2009).

IV. U.S. HEALTH CARE REFORM, 2010

The health care reform proposal of President Obama—and the signed legislation that resulted from it—is complex, misunderstood, and controversial. It addresses many of the problems of the existing system, sometimes in ways that seem indirect and opaque. Many of its provisions came about through the long and tedious process of partisan Congressional debate and compromise, and the long arms and deep pockets of vested health provider, insurance, and consumer advocates. Given this, it is surprisingly comprehensive and directed at reducing existing inequities. Here, we outline the main provisions of the legislation, and relate them to the problems they are asserted to solve.

A. Expansion of Access to Health Care and Health Insurance

The primary focus of the reform is to increase health insurance coverage and increase access to health care for citizens and legal immigrants. This is accomplished by several changes.

Medicaid Expansion

The Medicaid program will be expanded (in 2014) to cover everyone with income below 133 percent of the federal poverty line (FPL).¹⁰ Hence, state differences in eligibility levels will be eliminated as will the lack of coverage for individuals and couples without children. This expansion provides a true safety net for those with very low incomes, who gain generous coverage without required premium payments.

Income-Conditioned Subsidies

Those with low to moderate incomes will receive subsidies to achieve increased coverage and access. A variety of sliding-scale subsidies will be made available for persons whose income is at or

¹⁰The 2009 federal poverty line (also called poverty guidelines) in the 48 contiguous states and the District of Columbia for an individual is \$10,830, and for a four-person family, \$22,050. <http://aspe.hhs.gov/poverty/09poverty.shtml>. Accessed 28-7-2010.

below 400 percent of the FPL; indeed, a family of four with income below \$88,000 (2010 dollars) can receive a subsidy. Moreover, health insurance premiums are capped for these families, again on a sliding-scale basis.¹¹ Out-of-pocket payments are also capped for families with income below 400 percent of FPL. All of these changes will be implemented in 2014.

Coverage of Those with Preexisting Conditions

Within six months of the passage of the law, insurers are prohibited from excluding children up to age 19 with preexisting conditions from coverage, and states are required to set up insurance pools to offer coverage to these individuals (or to rely on a federal program for “high-risk” persons). By 2014, private insurers will no longer be able to exclude any person with a preexisting condition from coverage or charge them more for coverage.

Expansion of Private Job-Based Insurance Coverage

Starting immediately, private job-based insurance is required to include coverage for dependent children under the age of 26 who do not have alternative coverage. Tax credits starting at 35 percent and going up to 50 percent will be given to small firms in order to encourage the offering of insurance to their employees. Starting immediately, private firms are prohibited from setting lifetime maximums on coverage, and are no longer permitted to deny coverage based on an individual having a new health shock. As of 2014, insurance exchanges will be established to enable individuals and small firms to purchase insurance at reasonable rates (see below).

Finally, firms will be encouraged to offer coverage by the imposition of a sizable annual fee per full-time employee not offered coverage, and most families above a specified income level will be penalized if they are without health insurance.¹²

¹¹The cap is 3 percent for those at 133 percent of FPL, and rises to 9.5 percent for those at 400 percent of FPL.

¹²Larger firms will face a fee per full-time employee (after an exemption for the first 30 employees) of \$2,000 if they do not offer coverage, and families who choose to go without coverage will face a penalty of \$95 or 1

Overall then, by 2014, low-income individuals regardless of family status or location will be covered by Medicaid with at least a uniform and generous minimum set of benefits; persons and families with incomes up to 400 percent of the FPL will be subsidized on a sliding scale basis in order to encourage them to purchase coverage via caps on insurance premiums and co-pays. Employees in small firms are more likely to be offered coverage and low- to moderate-income workers in larger firms will be protected from ever-increasing premiums as well. Persons with preexisting conditions will be able to obtain coverage at rates only adjusted for age, and no one will face a dollar limit on coverage. The number of uninsured people should decline dramatically, and with it the challenge of unpaid bills and bankruptcies.

B. Reorganization of the Health Care System

Health Insurance Exchanges

As noted above, the U.S. private health insurance market will be fundamentally changed by the introduction of a set of organized *Health Insurance Exchanges*.¹³ These exchanges will be established in each state (or in groupings of states), and will require insurers to offer four standard packages of benefits (three of varying coverage levels, and a basic plan for younger citizens and those with limited resources).¹⁴ Premiums for these plans will differ only by age. The establishment of these exchanges offering well-specified packages is expected to reduce complexity, making “shopping” among plans easier. The additional transparency of the products together with the size of the “markets” is expected to generate competition among insurers and act to control costs and price.

percent of taxable income in 2014, rising to \$695 or 2.5 percent of taxable income by 2016. Those who pay no federal income tax as well American Indians, undocumented immigrants, and those with religious objections are exempt.

¹³The inclusion of the exchanges in the legislation—and the limited access to their services—was a compromise between those who favored a full “public insurance option” and those who wanted no public sector intervention to increase competition among insurers.

¹⁴The benefit packages will be standardized and all qualified health plans are required to provide a set of preventive benefits including immunizations and other preventive health services with no cost sharing permitted.

Targeted Health Care Workforce Expansion

The health care reform recognizes the problem of underserved areas, and provides increased support for training additional health care providers, including those providing pediatric services and physicians who are willing to work in underserved areas. In addition, funding to reduce the student loan debt of medical students willing to serve in underserved areas is to be doubled.

More generally, the reform seeks to increase the supply of primary care providers, a group that is in short supply nationally, and for whom earnings are much lower than those of other physicians. For example, both Medicaid and Medicare will pay bonuses for services provided by primary care physicians. While this provision may increase costs in the short run, the goal is to increase the proportion of recent and future medical school graduates who become primary care providers by increasing the return to these doctors.

Creating New Institutions to Serve Low-Income Groups

The reform plan will increase funding for Community Health Centers as well as new community-based collaborative care networks, which are consortia of providers operating under a joint governance structure and providing comprehensive health care services to low-income populations. Such networks extend the traditional medical care model by performing health outreach (using neighborhood health workers), providing transportation to reach the network, and offering “telehealth” and after-hours services. The goal is to encourage innovation in order to improve access to care among this underserved population. Existing Community Health Centers are located in underserved areas, serve about 20 million people, and are funded by public sector grants, fee for service and “pay-as-you-can” (sliding fees) serve everyone regardless of ability to pay. About two thirds of their patients are covered by Medicaid or Medicare. Under the new reforms, they are expected to expand to serve 20 million more patients with an additional 15,000 in staff.

Fostering More Efficient Service Delivery and Controlling Costs

Although much of the emphasis in the reform bill is on increasing access and coverage, the high and rapidly growing cost of health care is also addressed in the legislation. The issue of efficiency is the focus of several initiatives. A number of pilot projects focus on ways to improve efficiency and reduce costs. These projects will be overseen by a new national Center for Medicare and Medicaid Innovation that will test a variety of approaches to reward providers for quality and improvements in efficiency (rather than the volume of services). There will be a new and well-funded federal independent advisory board to identify cost savings in the Medicare program, without increasing cost-sharing, using rationing, changing eligibility, or raising taxes. And, a new “Patient-Centered Outcomes Research Institute” will be established to identify comparative effectiveness research priorities and conduct, commission, and make public research to improve health care decision making.¹⁵

The 2010 legislation notes the many inefficiencies of the existing fee-for-service provision model that characterizes the existing U.S. health care system, and sets several constraints designed to change the operation of the system. In order to reduce administrative costs, insurers covering large firms that spend less than 85 percent of their premiums on health care are required to offer rebates to enrollees (80 percent for insurers covering small firms). Health insurers will be required to follow administrative simplification standards involving electronic exchange of health information to both reduce paperwork and administrative costs as well as reduce duplicative services. All insurance rate increases must be submitted to public boards for approval; companies must justify their requests and provide information on nonmedical expenditures.

The new law provides a financial incentive for the creation of “Accountable Care Organizations”—groups of doctors, hospitals, and other caregivers who will work together to improve the efficiency and quality of care and share in any savings. The ACO concept is largely based on an “HMO-

¹⁵Due to a variety of political pressures, the work of this institute is formally limited to comparative effectiveness rather than cost effectiveness or benefit-cost analysis.

type organization” providing care to older citizens enrolled in Medicare. Providers who join such organizations will receive “shared savings” from the efficiencies gained by providing coordinated care.¹⁶ The vision is that these arrangements will lead to coordination among providers resulting in fewer duplicate tests and services, and increasingly cost-effective treatment. Whether the ACOs will actually lead to higher quality of care at lower costs is not yet known, though existing efforts along this line seem promising.

The reform plan also provides incentives for health insurers to seek reduced costs by offering “closed provider panel” plans. In these arrangements, a limited set of providers enables insurers to more effectively bargain over the terms of reimbursement and thereby to obtain “discounted” prices. While those patients covered by such plans are able to seek services outside the panel, they will be required to share more of the costs. Such closed panel plans are likely to appeal to smaller firms that currently do not offer coverage but are required to do so under the reform. They may also appeal to many larger firms as a way to reduce costs of coverage. However, current covered employees may object to the need to change providers.

Combining these efforts and the numerous other cost reduction measures in the bill, it is estimated that national health care expenditures will grow 69 percent over the 2009 to 2019 period, compared to 89 percent were the reform not to be undertaken. Given the significant growth in coverage and increases in access included in the legislation, this level of “savings” is impressive. In spite of these gains, a greater proportion of GDP is expected to be spent on health care in 2019 than in 2009.

Reducing Complexity in Health Insurance Choices

The reform act recognizes the current frustration of both firms and workers regarding the complexity involved in both offering and accepting private, job-related insurance coverage. The federal government has set up a new health insurance Web site (HealthCare.gov) designed to assist families

¹⁶“Savings” are defined as the difference between actual expenditures and projected expenditures under group-specific current reimbursement arrangements.

choosing among health insurance options. The Web site will offer user-specific coverage, eligibility, and cost-sharing information on available private insurance plans and public programs (e.g., Medicaid, Medicare, CHIP), and on any existing high-risk insurance pools or new pools that will be created by the legislation. Eventually, it will also provide standardized quality information as well. For firms, the Web site will include information on tax credits and other subsidies included in the legislation. In addition, employers are required to disclose to each employee the value of the benefits paid on their behalf for health insurance on the annual income statements used for tax reporting.

Expanding and Restructuring Existing Public Programs

The 2010 legislation contains numerous changes to and expansions of the three large public programs, Medicare, Medicaid, and Children's Health Insurance.

Medicare is modified in many ways, most of which encourage cost reductions; capitated payments to the most-generous (and generally acknowledged) over-paid plans will be reduced, the awkward subsidy arrangements in the drug benefit plan modified, and provider payments both tightened and redesigned to increase access to care. Related to this program is the coverage problem faced by people who retire before the age of 65, the age when people are eligible for Medicare; many such people currently are uninsured because they cannot afford or cannot obtain coverage as individuals. Many others have lost retiree insurance coverage as firms have reacted to their relatively high costs and eliminated them from the employer-group insurance plan. The new law establishes a temporary reinsurance program to offset some of the high coverage costs faced by firms and constrains the premiums that are charged for coverage.

The Medicaid program for lower-income people also is modified by the reform legislation. Eligibility is made more uniform across the states, and a benefit floor is set both to increase equity and to encourage medical providers to offer care to this population. As noted above, Medicaid (and Medicare) will pay bonuses for primary care services provided by primary care physicians, and for service provision in underserved areas. Costs should be reduced by the expected reduction in costs paid to hospitals that

serve disproportionate numbers of low-income uninsured (known as the Disproportionate Share Program).

The state-based Children's Health Insurance Program (CHIP) also has been modified to expand eligibility and increase insurance coverage; an annual eligibility period enables any child in a family with income below 200 percent of the FPL at the time a child is enrolled to remain eligible for 12 months. The new law also establishes more uniform eligibility levels across states and increases outreach and enrollment grants to increase participation in the program.

The reform legislation pays special attention to a particularly disadvantaged group, American Indians. American Indian reservations are among the most underserved areas, and a number of financial inducements are offered to increase providers serving this population. With the goal of reducing long-term health disparities, the bill includes a wide variety of demonstration programs and mental and behavioral health programs for this population in addition to simplifying enrollment in the Indian Health Service and increasing benefits in this program.

Financing Health Care Reform

The legislation imposes a variety of taxes and fees designed to offset the public share of health care costs. These include a tax (fee) on pharmaceutical companies and those who import brand name drugs. The fee is based on market share, and is expected to raise \$27 billion from 2014 to 2019. Beginning in 2018, a 40 percent excise tax will be imposed on high-benefit/high-cost insurance plans this tax is expected to raise about \$15 billion per year. High income individuals and couples will also face an increase in the payroll tax beginning in 2012; this tax, directed to supporting the Medicare program, is expected to raise \$210 billion from 2012 to 2019. Finally, an excise tax of 2.9 percent will be imposed on medical device manufacturers; it is expected to raise \$20 billion over the 2012 to 2019 period. And as

noted above, an additional tax is imposed on those who pay federal income tax if they do not have health care coverage, designed to decrease the uninsured population.¹⁷

Modifying Provider and Insurer Incentives

Modifying incentives to providers is another vital component of the reform. For example, Medicare will reward hospitals that attain better patient outcomes (higher quality) and Medicare provider payments will also be designed to reward productivity; these incentives are projected to generate cost savings of \$160 billion from 2010 to 2019, an estimate that is very controversial. Finally, as noted above, insurance companies will have to have rate increases reviewed by the appropriate level of government, and Medicare payments to high-cost managed care plans will be reduced. These changes are expected to result in cost savings of more than \$200 billion from 2010 to 2019.¹⁸

V. WILL THE REFORM WORK? WILL PROBLEMS REMAIN?

The changes introduced by the U.S. health care reform of 2010 are enormous. While basic aspects of the existing system will be maintained—for example, the employer-provided insurance arrangement at the core of the system and the basic fee-for-service payment system—there is virtually no part of the nation’s health care system that will remain untouched. Throughout the new law, measures are introduced to increase access, reduce inequities, control costs, increase quality, and realign incentives.

Health care coverage will be provided to an additional 32 million Americans, reducing the uninsured population from about 15 percent to 6 percent of the population.¹⁹ Sixteen percent of the newly insured have incomes below 133 percent of the FPL; they will now be covered by Medicaid. Access to

¹⁷This “individual mandate” is a critical part of the plan, as the insurance exchanges to be established must both have a large pool of individuals and avoid the selection of the least healthy in order to be successful.

¹⁸The Congressional Budget Office expects the health system reform law to reduce the federal deficit by \$143 billion by 2019 and by about 0.5 percent of GDP in the following decade.

¹⁹The remaining uninsured will be primarily undocumented immigrants; they are not eligible for any benefits under the plan, nor are they able to use the exchanges. In addition, there will be some with moderate income who are not subject to a penalty for being uninsured, and who choose not to purchase coverage.

care of all of those covered by Medicaid should improve as provider payment rates in this program increase to those paid by Medicare. Persons with existing conditions will no longer be excluded by health insurers. For the first time, those with low to moderate incomes (up to four times the FPL) will receive subsidies to purchase coverage. In addition to these subsidies, there is a cap on co-payments for all these families (many of whom are already insured), greatly reducing potential out-of-pocket expenses and adding security. Small businesses are offered subsidies in the form of tax credits if they offer coverage, making it easier for them to hire workers. The expenditures on health care are expected to be reduced because of the reform and the federal deficit will not grow as these expansions of coverage, quality improvements, and financial protection are financed by payment and system reform and by new tax revenues.

Of course, problems will remain, and uncertainties in implementation are pervasive. The remaining 6 percent of the population without coverage is troubling. The high administrative costs of the system, due largely to the need for many providers and insurers and the bargained system of payment determination, will not be reduced easily. As the debate over the legislation revealed, some citizens who face a penalty as they exercise their right to remain without coverage are angry. Some inequalities in access will remain, and there will still be too few primary providers in certain areas. Employer-based health insurance will still be excluded from the definition of taxable compensation, continuing the huge and inequitable tax subsidy that contributes to high expenditures. Nevertheless, gains in the form of movement toward near universal coverage, a lower rate of increase in health care costs, and a realignment of incentives for cost-effective decisions by providers, insurers, and consumers are major gains attributable to the reform.

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