

On the State of the American Health Care: A Discussion of the Health Care System and the Affordable Care Act

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This research intends to identify the priorities for healthcare reform thru understanding the current challenges of the health care sector in the United States. The study identifies cost, accessibility, and sustainability as the major concerns. Next, the paper proceeds to detail the highlights from the Affordable Care Act and assess its effectiveness in managing these priorities. The research then concludes with a discussion of the variables that would continue to shape the future of the American health care.

THE STATE OF HEALTH CARE

The current state of the American health care can be described in several terms. In terms of rising cost and spending, healthcare is adding pressure to the economy. In terms of the healthcare insurance system, it is becoming more complex and it increasingly shifts more and more burden to the individuals. Lastly, in terms of social insurances there are ballooning costs and inefficiencies. All of these conditions are adding tremendous fiscal pressure to the American economy, while simultaneously leaving upwards of 50 million citizens out in the cold, without health care coverage.

To begin with, healthcare in the United States is among the most expensive in the world. At double the OECD average, U.S. healthcare spending is approaching nearly one-fifth of GDP. Since the 1960s healthcare expenditures have more than tripled from 5 percent of GDP to 17 percent. Per capita healthcare spending is roughly 50 times what it was 50 years ago (\$149 in 1960 vs. \$8,402 in 2010). Despite all this investment in healthcare, quality of care fails to measure up to the cost. Not only is the spending ballooning, but so is per unit cost, especially in hospital care. The inflation rate over the past 50 years for the Consumer Price Index (CPI) has risen to 7 times what it was in the 1960s, while health care has increased to 20 times that of the same era, and physician's fees have grown to 17 times the rate 50 years ago. All of these pale in comparison to hospital fees which have skyrocketed to 60 times the rate in the 1960s (Phelps, 2013).

Overall the trend for the last 50 years has been a rapid increase in healthcare spending and costs. Increased spending and escalating costs of healthcare can be linked to a change in demographics due to an aging population and rising obesity, innovations in medical technology, and insurance-led consumption.

An aging population of the baby boomer generation is putting a strain on Medicare. More Americans are age 65 or older than ever before with 40.3 million individuals age 65+ in 2010, compared to 12 million in 1950. More baby boomers are moving into retirement everyday and adding to the millions enrolled in Medicare. In 2010, 47 million Americans were enrolled in Medicare. By 2020 that number is expected to rise to 61 million. In average, individuals age 75 and over incur 5 times the healthcare expenditures that individuals age 22-45 do.

Rising obesity also contributes to costly health problems. As a nation, obesity among American adults has risen from 15 percent of the population in 1960 to 38 percent in 2010. Obesity among children has also grown from 4 percent in the mid-60s to 17 percent in 2010. Growing obesity contributes to health problems both directly and indirectly. Its direct costs include hospital care, physician services, and medications. Some indirect costs of obesity are loss of output due to lost productivity, and lower moral among others.

Innovations in medical technology contribute to anywhere between 27 and 65 percent of growth in healthcare spending since 1960. Innovation and cost are intricately linked (Smith, Newhouse and Freeland, 2009). Although medical technology increases cost in the short-term, it provides better quality of care in the long-term. It is important to note that innovations often lead to less invasive procedures, reducing the possibility of complications down the road. For example, angioplasty is considered to be a superior alternative to open heart surgery. As a result of better technology, however, demand for quality care will increase. Availability of insurance would fuel more demand, creating moral hazard. With the implementation of the Affordable Care Act more patients could have access to the latest medical technology, which would increase spending in the short term, but also may lead to more innovations.

The role of insurance and its contribution to higher and costlier healthcare spending and the challenges this growing burden place on individuals and the persistently uninsured cannot be overlooked. Different kinds of insurance are currently available to individuals based on the type of provider, private (employer-sponsored), or public (government) entity. Private insurers provide individual or group sponsored plans. Group insurance in particular takes advantage of economies of scale in the form of loading fees and coordinating care. Risk pooling also reduces cost by pooling together young, healthy employees with health risk employees. Therefore, private insurers are able to offer lower premiums due to the low risk involved with insuring the young, healthy employees. In this situation adverse selection is not an issue. On the other hand, non-group insurance carries higher risk and administrative cost, which leads to higher premiums.

Private insurance through employers peaked in 2000 with 68% of individuals enrolled in employer-sponsored health insurance, but has since fallen to 50 percent in 2012 (Kaiser/HRET, 2013). Facing declining coverage and rising premiums, most insurers took to not covering pre-existing conditions as part of pre-existing condition clauses. One of the major accomplishments of the ACA was to address pre-existing conditions and fallen coverage. An affordability crisis now occurs as health care costs continue to rise. Insurance has become even less affordable for small employers due to a lack of economies of scale. The decline of employment-based coverage systems has put more pressure on public systems to fill in the gap. Medicaid and rising unemployment due to recession have put even more burden on public insurance. To address this issue the ACA looks to expand coverage to at least 60 percent of the currently uninsured.

Looking past affordability a more pressing issue lies in access to healthcare, which uninsured and underinsured individuals must face. Currently there are 53 million uninsured individuals in the United States. This situation stems from the slow economic growth between 2001 and 2010, which resulted in increased poverty rates and number of uninsured. The uninsured individuals consume \$86 billion worth of healthcare annually, of which \$56 billion is uncompensated, and for which the government must be responsible. Underinsured individuals account for 25 million Americans, many belong to the middle income class, and this group has steadily increased. All these factors worsened during the economic recession. The ACA intends to internalize the costs of uninsured and underinsured individuals by expanding coverage or collecting penalties. By 2020 roughly half of these respective groups would be covered, leaving 30 million uninsured.

All these problems add to the urgency of healthcare overhaul. The goals for the health care reforms should focus on four priorities: procedures for cost containment, provision of a safety net, choices for patients and providers, and an ease in administration (Folland, 2013). The following section is dedicated to analyze the effectiveness of the ACA in addressing these priorities.

ENTERING THE AFFORDABLE CARE ACT

Signed into law on March 23, 2010, the Patient Protection and Affordable Care Act, later on augmented and renamed as the Affordable Care Act (ACA), eliminated underwriting policies that exclude pre-existing conditions, created an individual mandate, and expanded Medicaid. Individuals can now purchase health insurance at Health Insurance Exchange (HIX), which subsidizes those with income up to 400% of the federal poverty line (FPL). The ACA also established “pay or play” for employers of 50 or more employees, which states that employers can either pay \$2000 per each employee not covered in an employer sponsored insurance plan, or play meaning offer coverage. Employers of 200 or more employees are required to take the play option. Finally the ACA establishes Small Business Health Options Program (SHOP) for small businesses (less than 100 employees) to purchase coverage.

One of the most critical challenges to the viability of the Medicare program and the public insurance system in general is its fiscal sustainability. Medicare is funded through the Medicare payroll tax (38 percent) and general revenue gathered through the federal payroll (42 percent). In 2000 Medicare had 40 million beneficiaries and 160 million workers supporting those beneficiaries, a ratio of 4 workers per beneficiary. Today there are just 2.9 workers per beneficiary. By 2030 it is estimated that Medicare will have 80 million beneficiaries and 184 million workers to support them, a ratio of 2.3 workers to every beneficiary. There will be more beneficiaries, but fewer payers. Will this rising trend be fiscally feasible? The program was stable when there were more than three workers per beneficiary.

Medicare covers 95 percent of the aged population and those with disabilities, a total of close to 50 million enrollees. The four parts of Medicare cover hospital insurance, supplementary medical insurance, the medical advantage program and prescription drug insurance. Options not covered include long-term nursing care, custodial care, dentures and dental care, glasses, and hearing aids. The ACA attempts to address these issues. In addition, the “donut hole” in Medicare part D leaves a gap for those with medium-level (ranging from \$2,840-\$6,000) prescription expenses. Starting year 2010, the ACA has begun to close this coverage gap via addition benefits and a 50 percent brand drug discount, and by 2020 enrollees will be entitled to a 75 percent discount.

Medicaid is a federal entitlement that pays for those with low-incomes and now covers more than 60 million people. Included in this group are low-income women and children, families, unpaid Medicare for low-income elderly, low-income disabled, and nursing home care for the elderly. States define their own eligibility requirements and scope of services, set rates, and administer their own programs. Costs are shared between federal and state governments with the federal sharing between 50 and 80 percent. Enrollment is distributed as 50 percent disabled, 22 percent elderly, and 20 percent children. The major criticism on Medicaid is quality and access of care. One reason is that Medicaid rates for physicians are 65 percent of the Medicare rate for comparable treatments, which lead to reduction of treatment time (length of visit) with doctors. Medicaid also offers notoriously low reimbursement to hospitals, and less than 40 percent of doctors accept Medicaid patients. As a result, patients face more access problems than those of Medicare. With the implementation of the ACA, this access shortage is to become more pronounced.

The ACA has expanded Medicaid coverage to all individuals, not just women and children, with income at 133 percent of the FPL starting in 2014 and adding drug and mental health services later. The ACA also intends to improve the coordination between Medicare and Medicaid through creating agencies such as Coordinated Health Care Offices (CHCO) and Children’s Health Insurance Program (CHIP). By 2020 Medicaid is expected to exceed Medicare.

Other than the runaway cost of healthcare expenses, the other critical piece of the healthcare reform is its funding. The ACA raises revenues mainly through taxes. A 3.8 percent tax (hospital insurance) from investment income for those earning over \$200,000 in gross income is estimated to generate \$318 billion, making it the largest contributor of the ACA. A tax penalty paid by those individuals, employees, and employers who do not purchase coverage generates between \$55 and \$106 billion over the course of a decade and totals \$161 billion. An excise tax on Cadillac insurance plans generates \$111 billion, fees from health insurance providers will bring in \$102 billion, and some smaller contributors are tanning

salons, medical device makers, and pharmaceuticals companies. Expected savings from the positive results of insurance expansion from reductions in uncompensated care consumed by uninsured will total \$216 billion. However, the cost of the ACA is believed to exceed \$1 trillion from 2013 to 2022, which would surpass the revenues collected.

DISCUSSION

Cost of health care in the short-term will continue its expansion as coverage, demographics, and technology costs continue to rise, while IT, medical research and breakthrough and alternative treatment options such as medical tourism may help to slow down growth in the long-term. The immediate short-term impact on the labor market and employment brings to the forefront urgent concerns about the shortage of healthcare providers, especially the specialists to which there are limited substitutes.

It has already been established that the ACA expands Medicaid and institutes an individual mandate. Employers will face the “pay or play” scenarios in which, depending on the number of individuals they employ, employers will need to pay penalty fees or offer coverage. Most of the debate over the ACA has focused on the individual mandates and its effect on the businesses or employers. Regardless, it is important to note that the cost eventually falls on the employees and the taxpayers. As for overall employment, the ACA is not expected to have significant impact on the medium and large employers; most (91%-99%) have already offered coverage. For the small businesses, it is a different story.

Two new Medicare taxes will reduce earnings for small business owners, especially the 75 percent of employers who report business income on their personal tax returns. The 0.9 percent payroll surtax hits wages and salary income over \$200,000 for single filings, or \$250,000 for joint filings. The 3.8 percent investment income tax pulls from any rents, dividends, interest, royalties, or capital gains. Together these taxes total an average of \$600 or more per person. Although small business owners are exempt from the ACA, tax incentives show potential to save money if coverage is offered. This is especially true for very small businesses. The maximum benefit employers may receive is a 50 percent tax credit (35 percent for nonprofit) for employer contribution toward workers’ health insurance. Despite tax incentives we could see a decrease in employment due to higher costs, stemming from costs of documentation and proliferation of paperwork. These costs also imply businesses have an incentive to stay away from small vendors that lack economies of scale.

Even before the establishment of the ACA, there was a shortage of primary care providers (PCPs) due to income disparity in comparison to other medical professions and unfavorable lifestyle for PCPs. Before the ACA there were 256 million insured in the U.S. and around 470,000 PCPs, a ratio of 541 people per PCP (AHRQ, 2011). This problem is expected to exacerbate with the implementation of the ACA: the number of insured is expected to be 291 million, leading to a ratio of 651 people per PCP. There is also a decline in individuals seeking medical school training, partly due to the high cost of education and lengthy training. For example, thoracic surgery residencies have been filled less than 50 percent since 2007. With reduced reimbursements, deteriorating working conditions and rising malpractice costs, physicians may find less incentive to stay in their profession.

Demand is expected to expand significantly as a result of changes in health care, and it will further exacerbate the shortage problem of PCPs and other health professionals. Medical tourism, which involves cross-national transfer of technology, expertise and services, has provided some short-term relief. Medical tourism is growing rapidly at 20% annually, and 25% of the physicians in the U.S. are from abroad. However, severe shortages and marked mal-distribution of health professionals is a global crisis not unique to the United States (Crisp and Chen, 2014). Each country will have to respond to its own challenges and global pressures eventually.

The nationwide health plan enrollment at HIX has been successful, with more than seven million individuals signed up for health insurance policies (Cheney, 2014). However, the demographic composition of the enrollees misses the federal target of 40-60; i.e., 40 percent of enrollees in the age cohort of 18 to 34. Instead, only about 28 percent of 2014 exchange enrollees belong to this age group.

The majority of the enrollees are older, and more than half are between 45 and 65 years old. This discrepancy serves as a cautionary note on the long-term fiscal sustainability of HIX.

CONCLUDING REMARKS

Revisiting the objectives of a health care overhaul, the ACA has succeeded in providing a safety net for individuals without coverage as the robust enrollment at HIX has indicated. However, the impact on the net uninsured rate is mixed (CPS, 2014), suggesting the positive effect of acquiring coverage through HIX may be offset by the loss of existing coverage for other individuals. According to the Center for Disease Control (CDC), the uninsured rate declined from 14.4% in 2013 to 13.1% as of March, 2014. Meanwhile, the U.S. Census Bureau's Current Population Survey, which uses a sample 2.5 times the size of CDC's survey, reported that the uninsured rate for U.S. adults has increased to 13.8% as of April, 2014, from 13.3% in 2013. Regardless of this data discrepancy, the challenge remains as to how to achieve the ACA's goal of reducing the uninsured rate to 11%.

The ACA also introduces and encourages cost-management practices and procedures of the health professionals under the guidance of IABP (Independent Advisory Board). However, the pending shortage of health professionals implies that cost containment will be limited, unless healthcare rationing is practiced. In terms of the third objective on administrative efficiency, the ACA has yet to make substantive progress to ease policy administration. The last objective for an effective health care overhaul is the availability of choices for patients and providers. The ACA has received a mixed review on this objective. Will the private insurance industry eventually collapse? Will there be more or less flexibility in treatment plans? Will patients have access to a variety of healthcare services? These are some of the concerns remained to be addressed.

A group of researchers conducted a twenty-five years of research on global health care systems (Balabanova, 2013). Their historical study examined the contribution of the health care system to improved health. The recently published paper identified several characteristics shared by successful health systems (See Table 1), notably the importance of building consensus at a societal level, allowing flexibility and autonomy, and soliciting support from the broader governance and socioeconomic context. The healthcare policy makers may want to take note of these findings.

TABLE 1
MAIN CHARACTERISTICS OF SUCCESSFUL HEALTH SYSTEMS

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| ▪ Have vision and long-term strategies |
| ▪ Take into account the constraints imposed by history and previous decisions |
| ▪ Build consensus in the society |
| ▪ Allow flexibility and autonomy in decision-making |
| ▪ Facilitate collaboration between public and private sectors |
| ▪ Receive support from the broader governance and socioeconomic context and are in harmony with the culture and population preferences |

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