Health-care Reform: An Economic Brief

The Patient Protection and Affordable Care Act (PPACA) and the Reconciliation Act were signed into law in March of 2010. Together, these make major revisions to health care and the health insurance system in the United States. They are commonly referred to as “health-care reform”.

Leading up to their passage, there was a lack of bipartisan support and much rancor over what would be contained in the bill and what would not. Much of the opposition was based on perhaps the uncertainty of the final bill. As with any legislation, the PPAC is fairly complex and unfortunately may not have cleared up much of the anxiety and uncertainty surrounding health care reform. However, one can condense much of the opposition to two main components of this legislation: mandated health insurance and the cost this legislation would impose on the federal government. The former has been the basis for much of the legal action pursued by various states’ Attorneys General against the federal government. The recently elected majority in the House of Representatives has vowed to repeal health care reform. So this would be a good time to briefly analyze this legislation.

Mandated Insurance Coverage

Health-care expenditure in the United States (U.S.) is approximately 17 percent of the Gross Domestic Product (GDP), the highest in any developed country. In addition to the high expense of health-care, approximately 15 percent of the population has no health coverage. These facts, more than any others, were the impetus for health-care reform. So will this be accomplished by the current legislation? To get to that, one must first consider why any meaningful health-care reform would have to mandate insurance for all1. In a seminal paper2, Nobel laureate economist George Akerlof applies the used car market to analyze the role played by uncertainty in the market mechanism. We will apply a similar argument to the market for health insurance.

Uncertainty of future health expenditure forces individuals to purchase health insurance. If there is a catastrophic event resulting in large health-care expenditure at some point in the future, the individual with health insurance coverage can rest assured that their expenditure would be limited to their premium and perhaps a deductible and/or co-pay. This reduces the

1 The constitutionality of mandated insurance is left to the courts and is beyond the scope of this article. Rather we pursue an economic analysis here.
uncertainty facing that individual, thus reducing their risk. So how do insurance companies price the premiums? The general rule of thumb is that they want to spend less in payouts than the amount they collect in premiums. The average amount paid out is depended on the average health of those the insurance companies cover. The healthier the average insured person, the lower the average payout. If a person feels that they are healthier than the average insured person (i.e., they feel the premium is too high), they will opt out of insurance and become part of the uninsured. As they drop out of the market for health insurance, the average level of health among the insured rises.

As a result, the expected payoff for the insurance company rises as well, thus forcing them to raise the premiums. This causes the next individual, who considers himself healthier than the average insured to opt out as well, since the premiums are higher than what he would expect to pay in future health care costs. Again, the average level of health rises, resulting in higher premiums. This cycle continues until those who are insured are the very sick, and are paying extremely high premiums. This is Akerloff’s market for ‘lemons’ (i.e., the only cars left in the used car market are of lower quality). The reason for all of this is the uncertainty of individual health. Insurance companies get around some of the uncertainty by requiring physical examinations, limiting and even denying coverage among other things. By mandating everyone to get health insurance, the average health level increases, thus resulting in lower premiums, thus making it affordable as well. Hence, any legislation that addresses health-care reform in the U.S. will need to include such a provision.

**Controlling Costs**

Total health-care expenditure as a percent of the GDP has increased from 3.5 percent in 1929 to the current 17.6 percent in 2010. Most of this increase is fueled by increased hospital costs, while physician and pharmaceutical costs have actually fallen (Getzen, 2010). How people pay for health-care has also changed over the last eight decades. Nearly 48 percent of health-care expenditure in the U.S. is by the government, while employers’ share is approximately 34 percent, a dramatic turnaround from the 1930s when three-quarters of payments were made from individual pockets. So how does the new legislation propose to control these rising costs? The following discusses the impact of the legislation on total health-care expenditure in the U.S.

1. **Individuals with pre-existing conditions. Expected effect: increase cost.**
   - Typically those who cost the most for insurance companies and hence usually denied coverage, or offered at extremely high premiums, will be covered under a federally funded program until 2014.
   - Insurance companies can no longer use this as a reason for denying coverage.

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3 While exact numbers do not exist, it is believed that a substantial percentage of the presently uninsured is made up of such individuals.

4 In the last decade, average family premiums for employer-sponsored healthcare have increased approximately 131%, almost 5 times the rate of inflation during the same period (KFF, 2009).
2. Adult children under the age of 26 can be covered under their parents’ insurance. *Expected Effect: decrease cost.*
   • These are typically the healthy adults who would have dropped out of coverage in the past. By keeping them within the insured, the average health level increases, thus theoretically lowering premiums.

3. Subsidized premium for those unable to afford them. *Expected Effect: increase cost.*
   • Offered through Health Insurance Exchanges (HIE), government funded. This brings in those who may be healthier than average (thus lowering cost) or less healthy than the average insured (thus increasing cost).

4. Uninsured individuals *Expected Effect: increase cost*
   • Some of these individuals will be covered under Medicaid (eligibility changes), while others will be covered by HIEs, reducing the uninsured population by half.
   • Those uninsured after 2014 will pay a penalty (up to $2000 for a family of four)
   • Increase in Medicare Tax

5. Insured individuals. *Expected Effect: increase cost*
   • No lifetime limits on coverage
   • Those with premium health insurance coverage will be taxed
   • Increase in the Medicare Tax

   • Those with more than 50 employees must offer affordable coverage or be penalized $2000 per employee (2014)
   • Small employers (less than 50 employees) not obligated to offer coverage, but will receive tax credits if offered

7. Health care providers. *Expected Effect: decrease cost*
   • Increased Medicare and Medicaid payments to primary care providers
   • Incentives to increase the number of primary care practitioners

8. Insurance companies. *Expected Effect: decrease cost*
   • More oversight of insurance companies and premiums
   • Increased competition as a result of HIEs

   • Federal funding for digitizing medical records

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5 Only one-third of all physicians practice primary care in the US; whereas fully two-thirds do the same in other developed countries, which spend a much lower percentage of their GDP on total health care expenditure.

6 Presently, most states only have two health insurance providers; some states have only one provider (Fumas and Buckwalter-Poza, 2009).
The above points are impacts on total health-care expenditure in the U.S. What about the impact on federal government spending? Here, according to the non-partisan Congressional Budget Office, the legislation is expected to save the federal government a total of $143 billion over the next decade. Where are these savings coming from? Most of the savings are expected to come from reduced Medicare/Medicaid spending, increased taxes on high personal income and premium health coverage plans.

While the new health-care reform legislation does address some of the issues it has set out, it may not do enough, or it may be far-reaching. Only time will tell whether this legislation will stay as is or will be changed or repealed. But, from an economic perspective, some of these changes are necessary if the U.S. wants to make health-care affordable and universal, goals best left to the people to decide.

Sources: