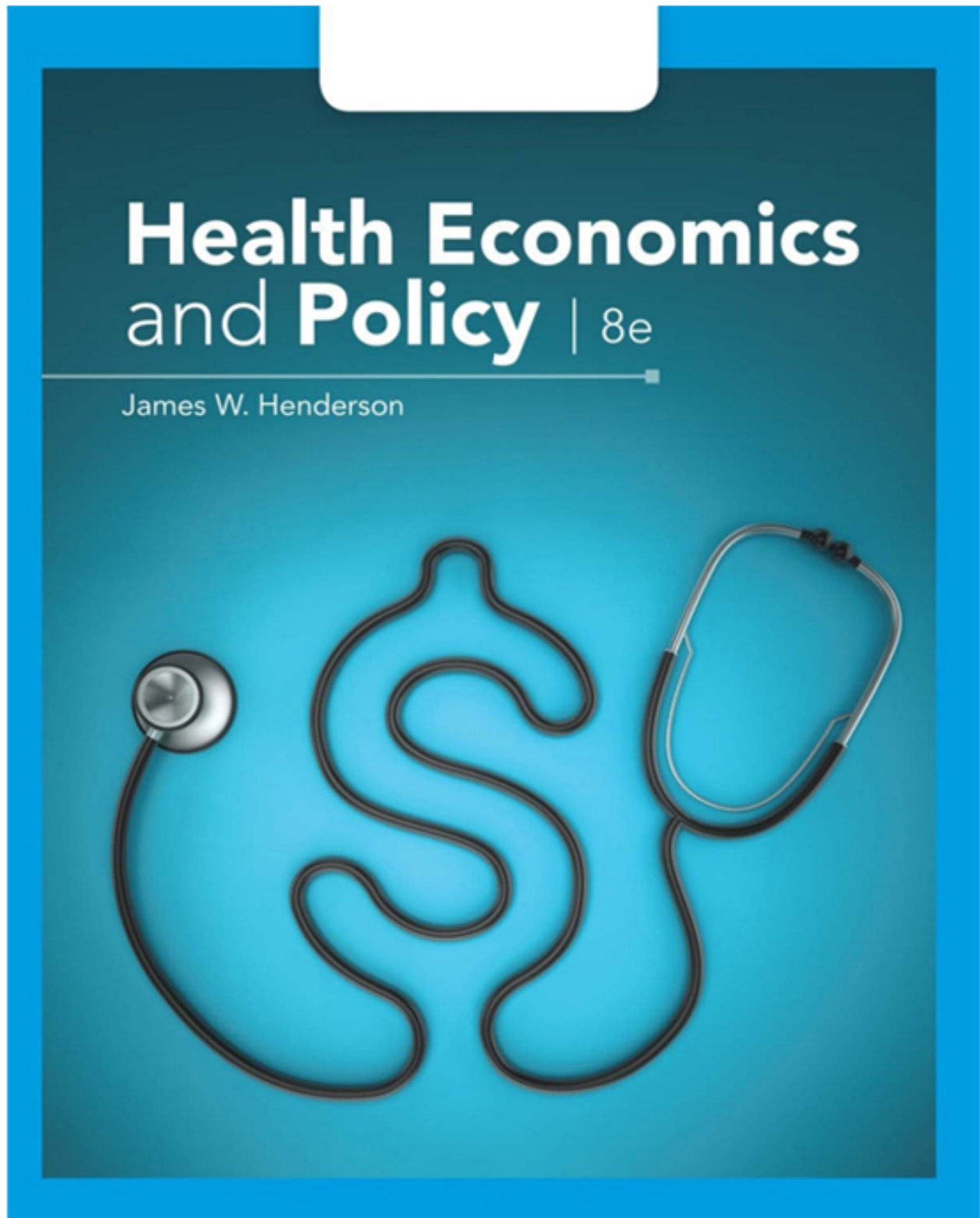


Note Book

summarize main ideas



CHAPTER 1

U.S. Medical Care: A System at the Crossroads

ISSUES IN MEDICAL CARE DELIVERY

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010

- The Affordable Care Act (ACA) has been controversial, and its popularity has not improved over time.
- The ACA has addressed many of the concerns of Americans, such as covering the uninsured and allowing those with preexisting conditions to purchase insurance at standard premiums.
- However, the ACA has also had unintended consequences, such as higher premiums for the young and healthy.
- The future of the ACA is uncertain, but there is still a need for change in the US health care system.
- Americans still worry about three broad issues: quality, access, and affordability.
- The chapter will examine the historical development of the medical care delivery system in the United States, the current framework established by the ACA, and the unintended consequences of its implementation.

Historical Developments in Medical Care Delivery and Payments

- The germ theory of disease expanded use of medical technology, and increased urbanization have shaped the modern medical care delivery system.
- The germ theory of disease revolutionized the treatment of patients, leading to more elaborate testing and diagnostic services, as well as the centralization of medical care.
- New hospital technology, especially advances in surgical and diagnostic imaging, provided physicians with the tools to revolutionize medical intervention.
- Urbanization also played an important role in the centralization of medical facilities, as people could no longer count on treatment at home.

Emergence of the Modern Medical Care System

- The modern medical care system began to emerge in the twentieth century, with a focus on scientific medicine, physician licensing, and hospital accreditation.
- The Great Depression and World War II had a significant impact on the medical care system, leading to the introduction of private health insurance and the growth of the federal government's role in healthcare.
- The 1950s and 1960s saw rapid growth in medical spending, driven by technological advancements, the expansion of government programs such as Medicare and Medicaid, and cost shifting by providers.
- The 1970s saw a shift away from regulation and planning and towards a greater reliance on market forces in healthcare.
- The 1980s saw the introduction of alternative payment schemes and delivery systems, such as prospective payment, capitation, and managed care.

Here is a more concise summary of the main ideas:

The US healthcare system began to emerge in the twentieth century, with a focus on scientific medicine, physician licensing, and hospital accreditation. The Great Depression and World War II had a significant impact on the system, leading to the introduction of private health insurance and the growth of the federal government's role in healthcare. The 1950s and 1960s saw rapid growth in medical spending, driven by technological advancements, the expansion of government programs, and cost shifting by providers. The 1970s saw a shift away from regulation and planning and towards a greater reliance on market forces. The 1980s saw the introduction of alternative payment schemes and delivery systems, such as prospective payment, capitation, and managed care.

Recent Changes in Medical Care Delivery

- Managed care became the prevailing form of insurance in the US market during the 1990s.
- Managed care changed the incentive structure within the industry, forcing providers to consider costs more carefully.
- Horizontal integration, characterized by hospital mergers and consolidations, transformed the industry into one characterized by multihospital systems.

- Downsizing in the name of efficiency had many concerned about the quality of care and the provision of care to the indigent population.
- A system dominated by solo practitioners witnessed a shift to group practice that began in the 1990s.
- More recent merger activity is best classified as vertical integration, characterized by clinically integrated systems where a patient may access the entire spectrum of care.
- Medical care delivery has become more coordinated as systems define and narrow their provider networks.
- The implementation of the ACA encourages the consolidation of services within the framework now called accountable care.
- The focus on population health has the potential to change the way we think about medical care delivery.

Here is a more concise summary of the main ideas:

The US healthcare system has undergone significant changes in recent decades, with the shift to managed care, the consolidation of hospitals and physician practices, and the increasing focus on population health. These changes have been driven by several factors, including the need to control costs and improve the quality and efficiency of care.

Recent Changes in the Payment Structure

- Spending growth moderated in the 1990s, due in part to the expansion of managed care.
- The federal government became more involved in health care policy, enacting legislation such as HIPAA and CHIP.
- Managed care became more prevalent in the 1990s, with indemnity plans falling below 10% of the market by the end of the decade.
- Third-party payers, such as government and private insurers, became the primary source of payment for medical care.
- Moral hazard, the tendency to consume more goods and services when the cost is subsidized, has led to higher costs for services covered by insurance.
- The cost-plus approach to hospital pricing was replaced by prospective payment in 1983, shifting the financial risk of treating patients from the payer to the provider.
- The government's share of medical care spending has increased from 25% in 1960 to 50% today, with the federal share more than tripling from 10% to 40%.

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Recent Developments in System Design

- Policy dimensions: The ACA advocated for the fully integrated delivery system as the answer for improving health care quality and reducing spending at the same time. This approach is now known as the accountable care organization (ACO).
- Conceptual approach: There are three primary goals for health care delivery: access, quality, and cost. During the 1990s, policymakers viewed these goals as competing trade-offs. However, a growing number of policymakers now believe that all three goals can be achieved simultaneously, a paradigm known as the "triple aim."
- Iron triangle: William Kissick (1994) viewed access, quality, and cost as competing goals. He argued that policymakers must make difficult decisions about how to allocate scarce resources.
- Triple aim: In 2010, Berwick, Nolan, and Whittington articulated the vision of the triple aim, which is to improve the experience of care, population health, and per capita health care spending simultaneously. They argued that this vision is attainable under the direction of an integrator, such as an ACO.

Here is a more concise summary of the main ideas:

The ACA advocated for the ACO as the answer for improving health care quality and reducing spending at the same time. Policymakers now view access, quality, and cost as complementary goals, rather than competing trade-offs, a paradigm known as the "triple aim." The triple aim is to improve the experience of care, population health, and per capita health care spending simultaneously.

The Current Framework

- The Affordable Care Act (ACA) was passed in 2010.
- The ACA was intended to expand health insurance coverage to millions of uninsured Americans.

- The ACA was passed with a narrow majority in the Senate, and only after Democrats realized that their only option was to pass the Senate version of the bill or get nothing at all.
- The ACA left many operational details to be determined by the secretary of Health and Human Services, who published over 15,000 pages of regulations in the Federal Register.

In summary, the ACA was a complex and ambitious piece of legislation that was passed with a narrow majority in Congress. The law left many operational details to be determined by the secretary of Health and Human Services, who has published over 15,000 pages of regulations in the Federal Register.

History of the 2010 Legislation

- Barack Obama chose to follow the process of health care reform from afar and let Congress do the heavy lifting.
- The Democrats enjoyed clear majorities in both houses of Congress, but close senatorial races in several states delayed the confirmation of the full Senate until July 2009.
- A series of recounts in Minnesota finally gave the Democrats their 60th senator and more importantly a filibuster-proof majority, which opened the pathway to reform.
- The death of Edward Kennedy of Massachusetts meant that the majority was no longer filibuster proof.
- The Massachusetts state legislature rewrote the law to allow the governor to appoint a successor until a special election could choose a permanent successor, giving the Senate at least four months to get a reform bill approved.
- The House of Representatives passed its bill in November, but the Senate did not pass a bill until Christmas Eve.
- After the holiday break, the Massachusetts voters elected a Republican to fill the now vacant Senate seat, and the Democrats were now one vote short of the required number to ensure the passage of the final legislation.
- The only way to overcome this dilemma was for the House to discard its version of the bill and approve the Senate version passed the previous year.
- This resulted in a document with glaring problems that energized its opposition.

In summary, the process of passing the Affordable Care Act (ACA) was complex and challenging, and the final legislation was passed with a narrow majority in Congress. This resulted in a document with some problems that have energized its opposition.

The Key Elements of the ACA

- The ACA is a complex law that has extended federal control over the health insurance market, expanded Medicaid eligibility, and created health insurance exchanges.
- The ACA has also mandated that individuals purchase health insurance and required employers to provide health insurance to their employees.
- The ACA has reduced Medicare spending to fund coverage for non-Medicare recipients and raised new federal taxes.

Here is a more concise summary of the main ideas:

The ACA is a complex law that has expanded health insurance coverage and reformed the health insurance market. The law has mandated that individuals purchase health insurance and required employers to provide health insurance to their employees. The ACA has also reduced Medicare spending to fund coverage for non-Medicare recipients and raised new federal taxes.

Here is a more detailed summary of the key provisions of the ACA:

- Expanded insurance regulation: The ACA has extended federal control over the health insurance market by setting standards for qualified health plans. These standards include guaranteed issue, guaranteed renewability, no benefit exclusions due to preexisting conditions, and limits on deductibles and out-of-pocket spending.
- Expanded insurance coverage: The ACA has expanded health insurance coverage through two primary mechanisms: Medicaid expansion and the creation of health insurance exchanges. Medicaid expansion has made Medicaid available to all individuals with incomes up to 138% of the federal poverty level. Health insurance exchanges are online marketplaces where individuals can purchase subsidized health insurance plans.
- Personal responsibility mandate: The ACA requires that all individuals purchase health insurance or pay a penalty. This mandate is intended to ensure that

everyone has access to health insurance and to reduce the number of uninsured Americans.

- **Employer mandate:** The ACA requires employers with more than 50 full-time employees to provide health insurance to their employees or pay a penalty. This mandate is intended to ensure that most Americans have access to employer-sponsored health insurance.
- **Changes to Medicare:** The ACA has reduced Medicare spending to fund coverage for non-Medicare recipients. The law has also expanded Medicare benefits and increased the Medicare payroll tax for high-income taxpayers.
- **New federal taxes:** The ACA has raised new federal taxes to fund the law's provisions. These taxes include a tax on private insurance plans, a Medicare surtax on high-income taxpayers, and an excise tax on high-cost health plans.

The ACA has been a controversial law since its passage. However, the law has had a significant impact on the health insurance market and has expanded health insurance coverage to millions of Americans.

Major Accomplishments

- Proponents of the Affordable Care Act (ACA) point to the increased insurance coverage as the major accomplishment of the reform.
- Using survey data, Frean, Gruber, and Sommers (2016) estimate that the ACA extended insurance coverage to approximately 20 million Americans who were previously uninsured, reducing the percentage of the population uninsured from 16 to 9 percent.
- Estimates from administrative data provide additional insight into the coverage expansion.
- Table 1.3 summarizes these findings, showing that overall coverage of the population under the age of 65 increased from 233.9 to 249.7 million or 15.8 million after full implementation of the program.
- Over 80 percent of the expansion (or 13.7 million) was due to increased enrollment in Medicaid and CHIP.
- Coupled with the 7.5 million increases in individual coverage, the two major avenues for expanded coverage were responsible for 21.3 million insured.
- The 5.5 million declines in unsubsidized individual and employer-sponsored insurance lowered the overall coverage gains to 15.8 million.

In summary, the ACA has expanded health insurance coverage to millions of Americans, with much of the coverage expansion occurring through Medicaid and CHIP.

Unintended Consequences

Unexpected results of the ACA

- **Access problems:** The ACA has expanded insurance coverage, but it has not necessarily improved medical care access. Shortages of certain specialties, low reimbursement rates to physicians, and the fact that Medicaid patients are twice as likely to visit the emergency room as the uninsured, all contribute to access problems.
- **Affordability issues:** The ACA's coverage provision for adult children and the exclusion of preexisting conditions from the insurance underwriting process have worked against the creation of workable risk pools in the insurance exchanges. The penalty for refusing to purchase coverage was modest from the beginning and easy to game, and other insurance requirements allow risk rating by age, geographic region, tobacco use, and family size, which has resulted in higher premiums for the young and healthy who remain.
- **Increased consolidation among providers:** The ACA has encouraged the creation and use of ACOs, which has led to an increase in the size of the typical medical practice and more bargaining power with insurance companies, resulting in higher medical prices and insurance premiums.

Additional details

- The rollout of the insurance exchanges in 2013 fell far short of expectations, with problems with the website, information security, and 4.7 million insured Americans losing their plans. Insurers are continuing to exit the exchanges, and over 60 percent of counties across the country have only one or two insurer options. By 2017, the cost of coverage was over 100 percent higher than the actuarially fair premium for 19–34-year-olds.
- The co-op health plans established in the original legislation did not serve their intended purpose to provide a reliable alternative to the for-profit plans in the exchanges. Only five of the original 23 were still active by the end of 2016, and the other 18 failed and lost over \$2.5 billion in taxpayer funds.

- Horizontal integration among providers has resulted in an increase in the size of the typical medical practice, providing more bargaining power with insurance companies leading to higher medical prices and thus insurance premiums.

In summary, the ACA has had several unexpected results, including access problems, affordability issues, and increased consolidation among providers.

Changes in the System since Passage

- The Affordable Care Act (ACA) has been a controversial law since its passage in 2010.
- The Supreme Court has issued two rulings upholding the constitutionality of the ACA, but the law has also been challenged in Congress and through presidential orders.
- In 2012, the Supreme Court ruled that the individual mandate to purchase health insurance is constitutional as a tax, but also made the Medicaid expansion voluntary for states.
- President Obama vetoed a repeal bill in 2016, but repeal efforts came close to succeeding in 2017.
- President Trump has used presidential orders to make changes to the ACA, such as expanding Association Health Plans, reinstating short-term limited-duration insurance policies, and expanding access to health reimbursement accounts.
- President Trump has also expanded the use of Section 1332 innovation waivers, allowing states to experiment with ways to provide coverage for their Medicaid population. He has also targeted gaming of the system and expanded access to health savings accounts.

In summary, the ACA has been a controversial law that has been challenged in the courts, in Congress, and by presidential orders. However, the law remains in effect and has provided health insurance coverage to millions of Americans.

Ten Key Economic Concepts

1. Scarcity and choice: We must choose how to use our limited resources to satisfy our needs and wants.

2. Opportunity cost: The cost of a decision is the value of the next best alternative that is given up.
3. Marginal analysis: We should make decisions based on the incremental benefits and costs of each option.
4. Self-interest: People are motivated to pursue their own best interests.
5. Markets and pricing: Markets are the most efficient way to allocate scarce resources.
6. Supply and demand: Supply and demand determine the prices of goods and services.
7. Competition: Competition forces businesses to produce goods and services efficiently.
8. Efficiency: Efficiency measures how well resources are used to promote social welfare.
9. Market failure: Market failure occurs when the free market fails to promote the efficient use of resources.
10. Comparative advantage: People benefit from voluntary exchange when they specialize in producing goods and services that they have a comparative advantage in.

These ten key concepts are unifying themes throughout the book and provide a foundation for understanding economic theory.