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Working Paper Series
La Follette School Working Paper No. 2010-013
http://www.lafollette.wisc.edu/publications/workingpapers

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August 2010

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I. Introduction

After efforts by five presidents, a comprehensive health care reform bill was passed by the US 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 US 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.

II. The Existing US Health Care System

Today's pre-reform US health care system is a unique and awkward combination of arrangements. Taken together, the system produces a huge volume of services—as of 2007, expenditures had reached USD 2.2 trillion or 16.2 percent of the nation's GDP; about USD 6,200

[1] The Act passed the Senate on 24 December 2009 and the House on 21 March 2010; a reconciliation bill was passed by the Senate shortly thereafter and signed by the president on 30 March 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 US efforts to secure universal health care is available at http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html.

per capita is spent on personal health care (NCHS 2009).[2] 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.[3]

Most Americans, 162 million, 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 the 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 these groups; 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. 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, 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 and that results in limited access in certain markets where providers decline to serve Medicaid-covered patients. In 2010, over 60 million Americans (one

[2] Personal health care makes up about 84 percent of all health expenditures and excludes investment and administrative costs. See http://www.cdc.gov/nchs/data/hus/hus09_InBrief.pdf.
[3] For example, as a percentage of GDP, Canada, Germany, France, and the Scandinavian countries spend about 9 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.
[4] http://www.kaiserhealthnews.org/Stories/2009/September/28/NPR-employer-explainer.aspx
[5] For more information on the Medicaid program, see http://www.kff.org/medicaid/upload/7235-04.pdf.

in four children) received coverage under this program. In 2008, USD 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 coverage.

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 inpatient hospital and skilled nursing home stays, and nearly all former workers older than 65 years have this coverage. The program also covers physician services and outpatient visits, but this coverage also requires a monthly premium and relatively high cost sharing. There is provision for older citizens to secure additional benefits if they join an HMO organization. Finally, there is a voluntary subsidized prescription drug benefit that is available, again with a premium and cost sharing. This year, Medicare benefit outlays are expected to total USD 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 also purchase supplementary insurance to cover deductibles and co-payments; 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 guidelines that differ by state. The federal share for this program is more generous than for Medicaid in an attempt to encourage more

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

generous eligibility standards, though federal allocations are capped annually. There are also waivers that allow states to cover parents although these do not receive the higher federal matching support. In fiscal year 2009, 7.7 million people were enrolled in CHIP.

Finally, there is the remaining group of Americans who have no health insurance coverage—over 15 percent of the population in 2008. The reasons for this are complex. Part of the explanation is that many families without a full-time worker are not offered an employer-based policy. Another reason is that many small firms (including farms) do not offer their employees such coverage. In addition, the Medicaid program is "categorical," such that many low-income people are ineligible for benefits. People who are not offered coverage, or who find the cost of the plans that are offered too expensive, either are forced to rely on the individual private health insurance market, use community health centers where available (and pay on a sliding scale), or forego health care insurance altogether. Ultimately, these uninsured do receive health care services if they experience severe problems, and these services are often provided by emergency rooms in hospitals—a costly option. Many regular health care services, including preventive care, are simply foregone.

III. Eight Problems with the Existing US 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 most of these citizens have low incomes and transitory ties to the formal labor market only heightens these inequities.

B. Constrained Access to Health Care

In part because of the lack of health care coverage, but also because of high cost-sharing arrangements, many Americans forego health care, especially preventive care, often resulting in later diagnosis of certain conditions. The result is a likely increase in national health costs, but also long-term health declines, personal stress and bankruptcies due to the inability to pay medical bills.

C. Private Insurance Market Problems

The US 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 alternative options to offer employees are local and thin—shopping opportunities are often limited. As a result, purchasers in such markets often find it difficult to find policies that are "affordable," especially for small groups or individuals. Moreover, the menu of plans offered to employees is often very complex, and choices seem largely unrelated to relative costs and gains. Administrative costs are high on policies offered; over 10 percent of the premium, not including the costs employers bear—including legions of consultants and benefit managers—in purchasing and managing their health insurance budgets;

these costs make coverage exceedingly expensive to small firms. Because the US income tax does not tax employer-based benefits (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 laid at its doorstep. 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. And since premiums are experience weighted, it also encourages them to avoid hiring people who they suspect may have high health costs (including those of other family members); this is especially true for smaller firms. Because those workers who may suspect high future health care costs are afraid to leave jobs with such coverage, economists have worried about the resulting decrease in labor market mobility, or "job lock" (see Glied 2005).

D. Health Care Costs

In part because of the uninsured problem and the constrained access to health care, the total and per capita cost of the US 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 US health care system are the arrangements for its financing. In order to assist families to purchase private health coverage offered by employers, US federal tax policy allows the payment of health insurance premia to be made with 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," they are exempt from both income and payroll taxes. The large subsidy was designed to raise the overall willingness of firms to provide insurance coverage; however, it favors the highest earners, who pay the highest marginal tax rates. 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, US 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 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. In many cases, a five-year period must elapse before private insurance is available, and in some cases no coverage at all is offered. And, once a condition is diagnosed, some companies refuse to continue coverage.

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.

IV. US 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).[7] 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.

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

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 below 400 percent of the FPL; indeed, a family of four with income below USD 88,000 (2010 dollars) can receive a subsidy. Moreover, health insurance premiums are capped for these families, again on a sliding-scale basis.[8] Out-of-pocket payments are also capped for families with income below 400 percent of FPL. Again, 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 without alternative coverage up to age 26. 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

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

maximums on coverage, and are no longer permitted to deny coverage based on an individual having a new health shock. As of 2014, private insurance exchanges will be established to enable jobless and unemployed workers, and lower income workers in high-cost 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.[9]

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 uninsured rate should decline dramatically, and with it the challenge of unpaid bills and bankruptcies.

B. Reorganization of the Health Care System

[9] Larger firms will face a fee per full-time employee (after an exemption for the first 30 employees) of USD 2,000 if they do not offer coverage, and families who choose to go without coverage will face a penalty of USD 95 or 1 percent of taxable income in 2014, rising to USD 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 objectionsare exempt.

Health Insurance Exchanges

As noted above, the US private health insurance market will be fundamentally changed by the introduction of a set of organized *Health Insurance Exchanges.*[10] 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).[11] 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.

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.

[10] The 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.

[11] The 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.

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 Heatlh Centers as well as new c*ommunity-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 and are funded by public sector grants, fee for service and "pay-as-you-can" (sliding fees) but serve everyone regardless of ability to pay. About two thirds of their patients are covered by Medicaid or Medicare. Under reform 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 a number of initiatives. A number of pilot projects focus on ways to improve efficiency and reduce costs, including 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.[12]

The 2010 legislation notes the many inefficiencies of the existing fee-for-service provision model that characterizes the existing US 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.

[12] Due 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.

In the bill, financial incentive is given to 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. The concept here is an "HMO-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.[13] The vision is that these arrangements will lead to coordination among providers resulting in fewer duplicate tests and services, and increasingly cost-effective treatment. Clearly, the outcome of this experiment 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

[13] "Savings" are defined as the difference between actual expenditures and projected expenditures under group-specific current reimbursement arrangements.

growth in coverage and increases in access included in the legislation, this level of "savings" is impressive. Unfortunately, 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 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, Medicaid, Medicare, and Children's Health Insurance.

Consider, first, the Medicare program. 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 early retirees, who have a high rate of being uninsured after leaving work and prior to entering Medicare. Many of them have lost insurance coverage as firms have recognized their relatively high costs and eliminated them from coverage. The reform plan 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 is also 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 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) has also been modified to expand eligibility and 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

reform also establishes more uniform eligibility levels across states. In addition, the legislation increases outreach and enrollment grants to increase participation in the program.

The reform legislation pays special attention to a particularly disadvantaged group, American Indians. The Indian Health Service has been constrained over time, but the reform provides additional benefits and a simpler enrollment arrangement. 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.

Financing Health Care Reform

The legislation imposes a variety of taxes and fees designed to offset the public share of 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 USD 27 billion from 2014 to 2019. Beginning in 2018, a 40 percent excise tax will be imposed on "Cadillac" (high-benefit/high-cost) insurance plans, which is expected to raise about USD 15 billion per year. High earners will also face an increase in the payroll tax beginning in 2012; this tax, directed to supporting the Medicare program, is expected to raise USD 210 billion from 2012 to 2019. Finally, an excise tax of 2.9 percent will be imposed on medical device manufacturers, expected to raise USD 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.[14]

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 USD 160 billion from 2010 to 2019, an estimate that is very controversial. And, as noted above, insurance companies will have to have rate increases reviewed by the appropriate level of government, and Medicare payments to high-cost plans will be reduced. These changes are expected to result in cost savings of more USD 200 billion from 2010 to 2019.

V. Will the Reform Work; Will Problems Remain?

The changes introduced by the US 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 bill, measures are introduced to increase access, reduce inequities, control costs, increase quality, and realign incentives.

[14]This "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.

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.[15] Sixteen percent of the newly insured have incomes below 133 percent of the FPL; they will now be covered by Medicaid. Access to 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 is the 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

[15] The 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.

primary providers in certain areas. 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.

One the most troubling aspects of the effort was the inability of the administration and Congress to reign in the huge and inequitable tax subsidy associated with the exclusion of health care insurance costs from the definition of taxable compensation; doing so would have reduced both expenditures and inequity.

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