Health Care Reform — Public Policy and Political Economy

Public policy refers to a course of action or a set of actions taken by government as it relates to a particular issue. Political economy, a combination of politics and economics, explains the public policy actions taken by government and explains the consequences of these actions. Does the Patient Protection and Affordable Care Act, a public policy signed into law in March 2010, provide for a fairer health care system with positive economic and medical consequences to society?

Conclusions of "victory" and "failure" of this legislation already claimed by proponents and critics are very premature, as no one will know the outcome for many years to come. The passing of this legislation is only the beginning to fix an unsustainable and dysfunctional health care system. Today, health care expenditures account for approximately 16 percent of the nation's gross domestic product (GDP), projected to increase to nearly 20 percent of GDP by 2017. Medicare accounts for 20 percent of all federal budget outlays, only behind that of Social Security and defense. Many have criticized the system as one with limited access to care, inequitable healthcare, a rising number of uninsured, volume-driven, non-quality based, and fraught with waste.

The new law claims to have a cost of $940 billion over a 10-year period, with a positive impact of $143 billion on the deficit over that same period, and an additional positive impact of $1.2 trillion on the deficits over the successive 10-year period. Funding to keep the cost below $1 trillion comes from many sources: an excise tax on high value insurance plans; a 3.8 percent tax on unearned income for high-wage earners; a half-billion reduction in the Medicare growth rate; a tax on medical device makers; an increase in Medicare payroll taxes; a reduction in reimbursement on Medicare Advantage programs; and fees paid by private insurance companies.

Hospitals, in an agreement with lawmakers, pledged to do their part by accepting $155 billion in lowered federal insurance reimbursement, over a 10-year period, toward the cost of insuring Americans without coverage. Similarly, drug manufacturers will contribute $84 million, and insurers will ante up another $70 billion to help defray the cost of the legislation.

Reformers plan to rein in costs by rewarding physicians and hospitals based on health outcomes, such as chronic disease management and health outcomes, and away from the volume of services they provide. Several pilot projects, called demonstration projects, will be launched within Medicare and if successful, could be initiated by private insurers as well. One such measure is a statistics-driven research method called the comparativeness effective method. The measure is designed to show which device, treatment or drug works best and brings scientific rigor to medical decision making. This could have an enormous impact on the delivery of future health care. Other notable demonstration projects include set fees for a single episode of care, and value-based hospital payments.

From a coverage perspective, an additional 32 million Americans gain access to a health care system via insurance exchanges or Medicaid. Approximately 94 percent of the population will have insurance coverage, up from 83 percent today.

Potential winners due to this legislation include insurers, hospitals, information technology companies, and drug makers. Insurers stand to gain 20 million new customers with a tax deferral on fees until 2014; the threat of a "public option" is no more; and there is no longer the requirement to monitor rate hikes. Drug makers have more people insured to pay for their products, and they get a 12-year protection against generic-like competition for biotech drugs, an important and profitable segment. Hospitals will have more patients whose insurance will help pay their bills. The additional load of patients may not help physicians as much as they may help validate the ability of mid-level providers, such as physician assistants and nurse practitioners, to treat patients with minor health issues. The need for electronic records and data will help fuel information technology companies that support those services. In addition, the demand for care may lead to the opening of more sites of service constructed by health care REITs.

While some concede there is much to like about the new reform law, uncertainty remains among many as the 2400-page legislative document is translated into many thousands of pages of rules and guidance. Physicians are concerned about being overwhelmed by the additional demand especially in the midst of shortages. Providers will be keeping a close watch on reimbursement. Some states are filing suit about the right to force people to get coverage. Companies are taking non-cash charges to account for changes brought about by the new law. Moreover, a third of the nation's states are in bad economic shape and do not have the ability to add the cost of reform to their already poor financial health.

We will have to wait many years before we can assess whether the benefits and costs projected today have truly been realized. However, based on prior health care legislative history of this magnitude, one can assuredly state that health care costs will be much higher than that projected today, which should lead to higher "taxes" to cover such expenditures.

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