EEA Presidential Address: The Past, Present and Future of Health Care Reform

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The starting point for my speech is the explosive growth in the field of health economics. In 1990, the *American Economic Review* published just two articles in health economics; now it publishes about five per year. In the *American Economic Journal: Economic Policy* and *American Economic Journal: Applied Economics*, major new general-interest journals in health economics, about one in eight articles published in 2017 was in health economics. And what has made health economics so fascinating is that its impact was felt not just in the scholarly world but also in the policy world as well, most notably through the Affordable Care Act (ACA) in 2010.

One of the most frustrating aspects of being a health economist is that expectations for health care suffer from extreme black and white thinking. Is the ACA a failure or a success? Are health care costs under control or not under control? Is health care reform over or still going? The answer to all of these is yes! When you have a sector that is 18% of the US economy, there are never simple yes and no answers.

And in particular, one of the most frustrating aspects of working on health care reform is the idea that we have ever "done" health care reform. Health care reform is not a single battle; it is an ongoing war that will never be fully resolved. So when thinking about health care reform, it is important to understand where we have been, where we are, and where we need to go next – and that's what I'll try to cover in this lecture.

Where we have been

Cast your mind back to the long ago days of 2010 and ask how different it was from today. At that point, we had a system that largely worked for the 60% of the population with employer-sponsored insurance (ESI), or the 20% of the population that had government insurance. But for the 15% of the population that was uninsured, and the remainder who had to rely on the non-group insurance market, the system was broken. In that market, insurance companies were free to discriminate in many ways. In particular, individuals who were sick could be denied or charged much higher prices – and they typically were. This didn't just apply to illness but other characteristics such as gender.

And such insurance was expensive with costs growing rapidly – in the recent past premiums in the non-group market were rising by more than 10%/year. That wasn't that much more than the growing costs of ESI, which during the previous decade had averaged about 7%/year – well above inflation and economic growth. And even those who could get and afford insurance weren't really sure what they were getting. Many plans had annual or lifetime limits that made them effectively indemnity plans – leaving consumers holding the bag.

Then came the ACA, and, although I am biased, the results were impressive. First, the number of uninsured was reduced by about 40% within two years of implementation in 2014. Second, the nongroup insurance market was repaired so that insurers could no longer discriminate along dimensions such as gender or illness. Third, competition on the newly established insurance exchanges (marketplaces where consumers could shop across non-group insurance plans) and other factors led to very slow growth of premiums. Over the first three years of the exchanges, premium growth averaged 7%/year; since 2018, the benchmark premium is completely flat.

Meanwhile, employer insurance costs and overall medical spending have grown at historically low rates, leading to relief for the economy through lower pressure on compensation costs and a reduction in the long-run fiscal deficit faced by the US due to slower spending on health entitlement programs.

After efforts to weaken the ACA during the Trump administration, President Biden greatly strengthened the program. In particular, insurance premiums on the exchange were capped at 8% of income for all—so we can literally say that no American has to pay more than 8% of their income for insurance premiums. Partly as a result, the uninsurance rate has fallen to below 9%.

Ongoing Issues

But things are not all rosy!

First, health insurance affordability remains a problem. In 2022, average annual premiums were $7,911 for single individuals, and $22,463 for families. The good news is that premiums have risen by only 43% over past ten years, or less than 4%/year. The bad news is that this still a lot of money.

And the bigger issue is rising out-of-pocket costs. Health insurance deductibles are up 95%, and there has been a large shift to "narrow network" plans, particularly for those on the exchange. Narrow network plans, which limit the choice of enrollees across health care providers, pose an interesting tradeoff. On the one hand, they can save money – with no evidence to date of adverse impacts on health. On the other hand, the operate as a tool of selection for insurers to try to chase away the sickest patients by excluding the providers that serve those patients from their networks.

Meanwhile, there are reasons to worry that the trend towards reduced uninsurance may be reaching its limit and reversing. The first reason is the "unwinding" of Medicaid entitlements that were put in place during the pandemic. Medicaid is a means-tested program targeted to the lowest income, but people's income changes over time. As a result, we have reassessments periodically – every six months or year – and kick off those who are no longer eligible. The problem is that we end up kicking off many eligible as well – individuals who face language barriers or other reasons are not responding to the reassessment notice. This is a challenging problem to resolve, but at a minimum we should be smoothing the pathway for these individuals to the state exchanges, for example by contacting those losing Medicaid and helping them through the exchange enrollment process.

Additionally, the subsidies put in place by the Biden administration sunset in two years. If they are not renewed, that could move another large set of individuals into uninsurance.

Where we are going – and what needs to happen

Single-payer health care – a universal government-run insurance plan - is not walking through the door. Independent of whether or not a single payer system is a good idea, it is simply not politically feasible in the near term. This is for three reasons. First, replacing our primarily employer-sponsored insurance system to single payer requires replacing an implicit tax – the shifting of the costs of employer-sponsored insurance to wages – with an explicit tax – the tax to finance single payer. Second, this would require the vast majority of Americans to give up insurance that they are used to for an unknown new – and, in the minds of many Americans philosophically opposed to expanded government, inherently flawed – government system. Third, the private health insurance industry makes more than $1 trillion per year, and it will lobby hard against its elimination.

As a result, progress on covering the remaining uninsured in the U.S. will require additional incremental steps within the existing system. One example of such a step would be automatic enrollment of individuals insurance. States or the federal government could set up a system where anyone who – based on their taxable income – qualifies for free insurance are automatically enrolled in insurance. This would bring millions of uninsured individuals into insurance coverage. A bigger challenge is the fact that a large minority of the remaining uninsured in the U.S. are undocumented immigrants, who do not qualify for benefits under either Medicaid or the ACA.

We should not be concerned only with the uninsured but also the underinsured, given the growth in cost sharing and narrow networks. Doing so requires tackling the hard issue of what is "affordable" health care spending. Many of those who consider themselves underinsured are able to pay out of pocket costs, but would prefer not to. It is important to distinguish these individuals from those who truly cannot afford these costs.

But this is all the easy stuff – this is about spending new money. The much harder piece is controlling health care costs – which involves reducing spending. Yet this is an essential issue for the future of the U.S. While long run estimates are challenging, estimates suggest that the long run fiscal deficit of the US government is about $65 billion – and almost 100% of that is health care spending.

In theory, the answer is easy: we need to regulate health care prices. As Kenneth Arrow pointed out in his seminal 1963 article that gave birth to the field of health economics, there is almost no area of the economy more rife with market failures, from incomplete information to imperfect competition to externalities. And basic economics tells us that when there are market failures the private market will not set prices optimally, leading to a potential role for government regulation. Indeed, every other developed country in the world has heeded that lesson and heavily regulates their health care prices. But the U.S. is the exception. While prices are regulated for some (e.g. doctors and hospitals serving publicly insured patients), they are freely determined in most. The results are striking: for example, a hip replacement is twice as much as that in the average developed country – and 7 times that of the lowest cost country.

The U.S. has taken an important step to address this through the Inflation Reduction Act, which empowers the government to negotiate prices very aggressively for a small but growing set of prescription drugs. Whether to be optimistic about the future depends on whether one thinks this is the first step or the last step. Remember, this is the easiest place to start – there are fairly transparent and painful prices that are separable from other aspects of treatment, with a clear bad guy in the wealthy pharmaceutical companies. But what happens when we start trying to regulate your friendly hometown doctor or hospital? The politics here will be much more challenging.

The key to effective government regulation, however, will be developing a proper and implementable framework for valuing the benefits of new drug treatments. Other countries have public institutions charged with carrying out this task, such as the euphemistically named NICE (National Institute for Comparative Effectiveness) in the UK. This is a challenging area and we need more research on how to best measure the effectiveness of medical treatments.

One common criticism of regulation is that it will deter innovation. This is a particular concern in the pharmaceutical sector, which is incredibly R&D intensive and has seen some of the most important innovation in recent U.S. history. But as my coauthor Simon Johnson and I point out in our book *Jump-Starting America*, a key determinant of innovation in the U.S. economy in the post-war period has been public R&D. If the U.S. government is starved for funds by rapidly rising drug prices, and public R&D falls as a result, total innovation is likely to fall. Proper regulation where some of the government savings are dedicated to public R&D in bio-pharma is likely to cause a net increase in pharmaceutical innovation in coming decades.

A key driver of health care costs are the costs of the labor force – and in particular very highly paid professionals. Therefore, a key barrier to controlling costs is that professional boundaries are keeping folks from practicing at the top of their skill level (by not allowing nurses to deliver certain medications, for example). It is critical that states loosen their restrictive scope of practice laws that interfere with this process.

At the same time, it is important to recognize that we need as well a large influx of unskilled workers in this sector – particularly with our rapidly aging society. In 2020, in only three of the 51 U.S. states (and District of Colombia) had more than one-fifth of the population above age 65. By 2050, the number of such states is projected to be 43! This growing elder population will need lots of unskilled help with managing their activities of daily living.

But the real cost for health care costs is coming, in the form of miraculously effective but incredibly expensive treatments such as cell and gene therapies. One example of such a therapy is Zolegensma, a treatment for the rare but horrific genetic illness Spinal Muscular Atrophy (SMA). This illness, which leads to certain young death among children, can be cured by this incredible new invention – at a cost of $2.1 million per person to treat. A high price tag to be sure - but at standard values of life, this is a good deal! Figuring out ways to price and to make these treatments affordable for individuals who, through pure genetic bad luck, have diseases such as SMA is a critical priority in the coming decades.

Conclusion: Make Yourself Useful!

In conclusion, the enormous growth of health economics research, and the resulting positive spillovers in the policy making process, illustrate the critical role that economists can play in shaping public policy. Yet our profession does not reward such engagement, focusing instead solely on published research, teaching and service to one's institution and the economics profession. These are all important and should be the focus of one's economics career, particularly at the early stages.

But they don't need to crowd out full engagement in the policy process. Engagement can take many forms, from public education through op-eds and media appearances, to more private direct engagement with public interest groups and legislators. In whatever form, it is important to remember three principles.

First, *enter with what you have but give them what they want*. Based on existing research findings, we may have a set of results and economic insights that we want to impress on policy makers. Your expertise in a particular area, and knowledge of these results, is what gets you into the room. But it often doesn't speak directly to what the policy maker wants to know, which may be related but not exactly on point with what the research says. It is important to hear out what the policy maker wants to know and to think about how to meet them where their interests are.

Second*, a good number is worth a thousand words*. Policy makers are interested in our insights, but what is often much more valuable are numbers of two types. The first is data points that help cogently illustrate the point in a clear way. The second is modeling of policy options – e.g. using existing knowledge to help the policy-maker understand how their policy might play out in practice. This often can involve applying existing estimates in a creative way.

Finally, *remember to speak non-economics*! We are professionally rewarded for using a set of jargon and technical terms that are impressive to our colleagues – but unintelligible to the general public. To be a convincing policy analyst or advocate, it is critical to translate these economics concepts to generally understandable terms that policy makers can comprehend and digest.