

A study of the issues relating to the patient protection and affordable care act ...

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The Patient Protection and Affordable Care Act has been a hotly debated topic ever since President Obama introduced it in the election of 2008. Conservatives detest the bill, and liberals praise it. Despite any opposing efforts, Obamacare was signed into law in March of 2010. Six years later, Obamacare has had a substantial impact on the healthcare provider and insurance market. The PPACA has in fact caused the number of uninsured individuals to drop, however many of its goals have not been achieved. Obamacare has caused insurance premiums to rise substantially, as well as incentivized and encouraged conglomeration of insurance and healthcare providers across the US. Even the former Secretary of Health and Human Services, Kathleen Sebelius, has admitted that many aspects of the PPACA advocating for coordinated care are in “ constant tension” with antitrust laws. This begs the question, should the healthcare market be largely exempt from federal and state antitrust laws? Do the benefits gained from coordinated care and conglomeration outweigh the costs due to lack of competition? Arguably not. Allowing and promoting the monopolization of the healthcare market is extremely detrimental to consumers, as affordability and quality of healthcare will both decrease. Furthermore, Obamacare provides a legislative womb that fosters the concentration of the healthcare market, which will further diminish consumer welfare.

Pre-Obamacare

Prior to Obamacare, Medicare reimbursements were heavily skewed in favor of large, general hospitals, as opposed to smaller, specialized care facilities; prior to 2003, Medicare did not compensate Ambulatory Surgery Centers (small, specialized care facilities generally owned by physicians) for many of

the surgeries performed on Medicare patients. After the Medicare Modernization Act of 2003, Medicare began to reimburse ASC's for a wider range of surgeries; however, the same procedures were reimbursed at rates 16% higher at general hospitals than ASC's. This incentivized channeling surgeries to larger, general hospitals, and further boosted their revenues and market power. Thus, the Medicare policies in place in the 2000's were already shifting the climate of the healthcare market toward oligopoly.

Aims & Policies of Obamacare

The Affordable Care Act strives to decrease the level of uncompensated care in America, as well as provide affordable healthcare to all those in need. The PPACA at its core requires the American people to purchase comprehensive insurance, or pay a fee that, on average, will cover the cost to society for the uninsured person's uncompensated care. This incentivizes purchasing healthcare, which would result in a smaller number of unpaid ER visits. Furthermore, the Affordable Care Act forces insurers to sell standardized benefit packages in an effort to increase equality and affordability among subprime insurance candidates. For example, a 47 year-old, male candidate with a pre-existing heart condition must be given the same insurance package as a 47 year-old, male candidate with no pre-existing conditions. Obamacare also puts forth a new medical loss ratio (MLR) requirement. Health insurance companies must spend at least 80% of their revenue due to premiums on "activities that improve healthcare quality," or procedure coverage. This is in an effort to prevent insurers from hoarding too much profit from premiums, and refusing to payout for procedures.

The Patient Protection and Affordable Care Act also facilitates the elimination of small healthcare providers and incentivizes consolidation into large healthcare conglomerates. The aim of the PPACA in its fostering of hospital integration is to more efficiently run operations by eliminating unnecessary overhead, as well as cross-subsidize uncompensated care through increased revenues. Obamacare uses Medicare payment policies to limit patient options and drive medical professionals into a smaller number of integrated multi-faceted hospital systems. As ASC's began to capture market share and become more prevalent, Obamacare adjusted Medicare's payout rates to be far more in favor of larger hospitals. This adjustment was made in order to protect the market power of the larger hospital systems in place. In 2013, Medicare reimbursed general hospitals at rates 78% higher than smaller, specialized facilities for the same procedures. For example, Medicare today pays \$643 for a colonoscopy performed in a general hospital's outpatient facilities, whereas only \$362 for the same procedure at an ambulatory surgery center. Hospital financing is heavily reliant on these subsidies from Medicare and Medicaid; in 2011, 61% of hospital income originated from Medicare and Medicaid subsidy programs. The PPACA aims to expand the reach of these programs, thus solidifying and increasing the revenue streams of these large hospitals. Under Obamacare, people at or under 138% of the federal poverty level will qualify for Medicaid. With larger revenue streams, benefits from an economy of scale, and a higher amount of disproportionately large subsidies from government programs, the market share of general hospitals will continue to rise. Along with this bundle of policies that undermine the competitive checks present in a free market, the

PPACA further requires that payments to smaller surgical facilities like ASC's should be incrementally reduced as to keep up with annual improvements in "medical productivity." The combined effect of these policy changes has successfully caused the growth of independent care facilities to stagnate, and hospital mergers to flourish: ASC growth has gone from 5% in the mid-2000's down to 2% since the turn of the decade. Along with this, hospital M&A has been on the rise since 2003, going from around 40 mergers to 100 in 2012. Hence, the healthcare provider market is condensing with time.

Diminished Care Quality & Rising Premiums

Obamacare, along with the nature of the healthcare insurance market, provides an economically suboptimal environment for consumers. The terms of the Affordable Care Act allow and force insurance companies to raise prices. Since Obamacare enforces a fine for uninsured Americans, insurance companies are empowered to inflate prices. These companies will experience an influx of demand, and raise premiums to adjust. Additionally, the PPACA requires that insurers sell standardized benefit packages, restricting them from properly adjusting premiums to reflect the customer's healthcare risk. This cost of risk is distributed to all customers, and insurance premiums have, on average risen. Not only has this caused insurance premiums to rise, but it also further creates a prime environment for insurer consolidation. Since insurers cannot create insurance packages adequately adjusted to the insured's risk, they will be forced to narrow profit margins and raise prices. A larger insurer would be able to continue its operations under these conditions, benefiting from scale, whereas a smaller insurer would be unable to meet its opportunity cost. Moreover, insurers are subject

to a new medical loss ratio requirement. This MLR requirement could only be sustained with large scale (sufficient to survive under thin profit margins), and will impede market entrants as well as promote acquisitions of smaller healthcare insurers by larger ones. Since rookie firms are almost always relatively small, they will not be able to survive in these market conditions. Consequently, they will either shut down operations, or merge with a larger firm. This conglomeration of insurance has been starkly observed: the average market share for the top three health insurers by state was 86% in 2013, up from 83% in 2010. Some states such as Alabama, Georgia, Iowa, Kentucky, New Hampshire, New Jersey, Maine, Rhode Island, Vermont, and Washington attribute upwards of 95% of their healthcare insurance to the top three providers in the state. This market power further inflates insurance premiums that are already being driven up by hospital consolidation across the US.

This hospital consolidation, encouraged by Obamacare to streamline healthcare and decrease costs, has not been successful in fixing the problems it is meant to. Indeed, early mergers in the hospital market did reduce average costs by 7%. However, beyond moderate scale, hospitals tend to flex market power and increase prices, and do not increase efficiencies proportionally. This has been observed time and time again—healthcare costs tend to increase at least 20% following mergers in condensed markets, lending to the hikes in insurance premiums. Price bargaining power of hospitals is directly dependent on the ability of insurers to exclude them from coverage—if a hospital raises its costs too much, the insurer will remove the hospital from its benefit packages. However, if a

hospital becomes a substantial market power within a geographic area, it will become increasingly difficult for insurers to exclude that hospital, as patients will have no option but to use the consolidated hospital's facilities. Thus, drastic price increases in both procedure costs and insurance premiums have been observed with growing hospital mergers. The amount of inefficiency and outrageous pricing is heinous; an Oklahoma nonprofit hospital system billed its patients \$77 for a gauze pad and \$200 dollars for a toothbrush. Furthermore, it has been observed that patients are more likely to die when being treated by hospital systems in non-competitive atmospheres, shining light on the amount of inefficiency market power allows. This could perhaps be justified if hospitals were indeed cross subsidizing uncompensated care within their facilities. Yet, this is unfeasible. Cross subsidization within hospital systems is impractical due to the lack of transparency of its operations. There is no way to measure how a hospital is subsidizing its uncompensated care—resulting in a lack of accountability. Without accountability, there is no incentive for these firms to direct their increased revenues toward uncompensated care, so they instead exercise their monopoly power and raise prices—all while consuming private benefits of control. Even if a hospital monopoly were to have pure-hearted intentions, it would be difficult to efficiently cross-subsidize uncompensated care. Since internal systems do not rely on prices and exchange to allocate resources, they must rely on persuasion and bylaw manipulation. Doctors will declare all of their requests ' necessary' in order to stockpile resources, and thus will result in inefficient distribution of materials.

Other Attempts to Fix the Problem of Uncompensated Care

Giving out subsidies for any uncompensated care that a hospital might have provided would be a straightforward way to mend this issue. Funding from the subsidies would be channeled from the fees collected from uninsured individuals. This has been attempted through disproportionate share hospital (DSH) programs. However, this nature of lump-sum payments is quite inefficient at solving the issue. In 2011, 80% of hospitals received DSH payments, and thus are heavily reliant on these programs. This reimbursement structure provides incentives for hospitals to inflate uncompensated care bills, however artificially. When Massachusetts enacted a statewide bill very similar to the Affordable Care Act in 2006, uncompensated care fell substantially, yet DSH claims remained at levels close to those prior to the bill's enactment. This shines light on the agency problems inherent in the hospital market—problems that would only become more apparent if conglomeration were allowed to continue. Thereby, the government enacted legislation that would more directly tame management—certificate of need laws.

Hospitals have been known to inflate costs and provide far more expensive (and unnecessary) services when third parties are required to reimburse for care. In order to alleviate this problem, Blue Cross Blue Shield, along with the public health system, began lobbying for “certificate of need” (CON) laws. CON allowed states to regulate hospitals' capital expenditures, service expansion, bed count, and more. CON laws require that hospitals demonstrate an unequivocal market need for expansion of any sort, as well as an inability of other providers to fill that need. Additionally, competitors

are empowered to rebut claims of need by other hospitals—the primary reason for CON's being overturned. CON laws induce artificial capacity constraints on hospitals, which is a major basis for hospitals' price bargaining power. Since resources are scarce, prices will rise—and do. Moreover, mortality rates at hospitals in states that have active CON laws are much higher than in states without stringent CON laws. Even the dialysis market has seen deterioration of quality in states with CON laws. However, in states that have repealed CON laws, the healthcare provider markets have seen no price increase—in fact large decreases have been observed. For example, in certain states that repealed CON laws, the cost of cardiac care dropped so substantially, that total spending on cardiac care fell even as volume skyrocketed.

How to Solve the Problem

In order to solve the problems of increasing healthcare costs and provider inefficiency, a number of things must be done. Firstly, the constraints on ambulatory surgery centers must be abolished. Medicare and Medicaid should reimburse ASC's and general hospitals at equal rates, as this would eliminate any incentives to create large hospital systems. It has been shown that ASC penetration causes hospital market shares to fall, along with costs—without detrimentally affecting care. Although it has been shown that ASC's are beneficial to the healthcare provider market, they are also exempt from Stark Laws. Stark Laws prevent physicians from providing referrals to other care centers in which they possess an ownership stake. This creates a conflict of interest, and could cause price inflation if referrals were concentrated to a small number of providers. Stark Laws should extend to

ASC's as to prevent any conflict of interest, while at the same time allowing them to flourish across the US. In addition, certificate of need laws should be repealed nationwide. It has been empirically shown that CON laws cause price inflation, inefficient allocation of resources, and market consolidation. The main problem with the current legislation in place is the peripheral nature of it; present laws attempt to mitigate the symptoms of hospital monopolies, instead of looking to the source. A problem caused by over-regulation cannot be fixed with further regulation.

There are far better and economically efficient ways of dealing with uncompensated care as well. Instead of relying on hospitals to generate higher revenues with monopoly prices and cross subsidize their own uncompensated care, the government could directly subsidize the people getting that care. That way, there is transparency and accountability, and the problem of uncompensated care will fade without destroying incentive structures. There are many legislative problems with the current healthcare system—a result of too much regulation. Federal and state health care reform should retain the essence of the Patient Protection and Affordable Care Act, but also recede the reach of the governmental arm only to where it is absolutely necessary.