

Jonathan Kolstad on Lessons from Massachusetts

Knowledge@Wharton: Much of the debate on the Affordable Care Act has centered on the individual mandate, the provision that requires all adults to buy health insurance either through their employers or by buying it themselves. What are your views of this provision?

Jonathan Kolstad: I think the individual mandate is ultimately one of the key features of this approach to health reform, which is in the Accountable Care Act nationally and then was [implemented] in Massachusetts previously. In some ways, it's what makes it a kind of middle-of-the-road type of policy approach. It's not at the extreme of just having a single payer system and it's not at the extreme of saying that everyone's in it for themselves. Because ultimately the individual mandate recognizes the relationship between my decision to purchase health insurance -- or my decision not to purchase health insurance and then go to the hospital if I get sick -- and the implications for others.

The individual mandate is very similar to a tax in many ways, but basically the simple idea is that, at the end of the day, if you don't have health insurance, you pay a penalty. You can think of it in some ways as a nudge toward getting health insurance. Depending on what the Supreme Court does, [under the individual mandate] if I don't have health insurance that's still my choice, but I will pay a penalty [that is] potentially and arguably commensurate with some of the cost I'm imposing on others. But ultimately I don't have to [buy health insurance.] It's not a mandate in the sense that everyone will be forced to do this.

A very similar thing occurred in Massachusetts, and in fact you did see a big effect among the people who were uninsured. About half of the newly insured were gaining coverage through their employers. So one argument is that what the individual mandate really does is augment some underlying value for health insurance. Maybe people valued it a fair amount, just not quite enough to take it up. [They thought,] "For every dollar of health insurance I get, 90 cents of it is worth it to me. That's not enough to make that trade off." But then you add on the individual mandate and it kind of puts you over the hump, as it were.

I think it's a new policy tool broadly in the health reform and the health insurance debate, but it's been tried in Massachusetts and it's obviously a fairly critical keystone to the national reform. The other big pieces [of the reform] on the insurance side are the substantial subsidies that exist, both for expansions in traditional Medicaid for people under 133% of the poverty line and then subsidies for insurance gained through the various state health insurance exchanges that will go up to 400% of the poverty line. So lots of people will have potential access to some form of subsidy. Those are the two pillars that really are intended to augment the expansion in health insurance.

Knowledge@Wharton: If the Court strikes down the individual mandate, or even the entire law, what would that mean for health care going forward?

Kolstad: I think absolutely this is a critical question and obviously one of the fundamental questions. From a legal perspective, the [question the] Supreme Court is facing is: Can the rest of the statute stand without the individual mandate in it? At a very simple level, the individual mandate is very important for facilitating pooling in the insurance market. One of the other key pieces of the ACA is the basic prohibition on pricing based on pre-existing conditions or not offering coverage. And that, of course, is a very popular and potentially very valuable tool. It effectively prevents people from facing the risk of becoming reclassified.

Right now, it may be that if I get very sick, I can still get health insurance. But if my premiums go up substantially, then I would like to insure against that. And so if you basically pool everyone, you've improved welfare by overcoming that problem. The issue is that if you don't have any way to actually get everyone into the pool and you can't price based on pre-existing conditions or price based on health risk, then in fact only the sickest people will decide to come into the insurance market. And that can potentially lead to rising premiums and, in the extreme, the individual insurance market unraveling.

Now there is some evidence of that at different state levels. You have seen, for example, in Massachusetts that when they implemented the individual mandate, you did get healthier people into the pool. In fact, at base line they had basically guaranteed issue and community ratings that ostensibly looked like the other pieces of the ACA without the mandate. And they did see [that] the newly insured were significantly healthier than the previously insured. So there's some evidence that there would be difficulties in operating the insurance market in the absence of the individual mandate but with the existing provisions that limit the ability of insurers to price an underlying risk.

The other important piece that I did bring up is the subsidies. It might well be that with various substantial subsidies, you are able to expand insurance coverage substantially and potentially these issues with [getting rid of the individual mandate] will not be as problematic if, for example, a subsidy gets relatively health folks into the pools and into the markets. It also depends on how the insurance exchanges are set up. That's one key feature of the ACA, but each state is setting up its own health insurance exchange and how that functions and how that works is going to be really critical to what insurance is available, who signs up, who enrolls - - even conditional on the over-arching structure which is in the ACA now and will be determined to some degree by the Supreme Court's decision.

So on the insurance side, [the individual mandate] is very fundamental, though, arguably those other provisions can stand in the absence of it. There are also key features ... that arguably are very critical going forward in thinking about new

models to address the cost of care, the appropriateness of care and the effectiveness of care, but are largely unrelated to the expansions in insurance coverage that are the keystone of this reform.

In the U.S. we have roughly 50 million uninsured. That's kind of a first-order issue to deal with. But we all know that the growth trajectory of health care costs relative to GDP is also a big issue. One argument has been to change the incentives to try to deal with that, and there are a number of provisions, demonstration projects and new approaches in the ACA that I think would be important to try. And it would be a setback to our understanding of the policy options to deal with health care costs if everything was thrown out and we weren't able to implement things like accountable care organizations or other forms of bundled payment that might potentially incentivize higher quality or lower costs or both by physicians.

Knowledge@Wharton: Given that almost everyone agrees that health care in this country is too expensive and getting more so every year -- plus it doesn't cover, as you said, 50 million people -- what would be one thing that we could do to tackle rising health care costs?

Kolstad: An important thing to remember is that we get a lot for what we spend. We live longer and healthier lives today than we did in the 1960s and we spend more on health care. And, on average, we may be very willing to have made that trade off. Now that doesn't mean that health care costs are not eating up a larger and larger share of GDP. In fact, we can observe there are very wasteful things. The question is can we have our cake and eat it too? That is, can we cut back the wasteful stuff without really undermining those incentives that ultimately we all value for ourselves, for our families, that you can go into the hospital and get treated effectively for things that you couldn't have been treated for even ten years ago now. Most of what are driving cost growth is those new technologies, those new treatments. And one important feature there is potentially aligning the incentives of providers to provide high-quality, low-cost care and not to be rewarded for providing just the most intensive care, but arguably the care that provides gains in health while not incentivizing additional technologies or additional intensive procedures. There are features in the ACA that are intended to at least address this in some degree within Medicare, which is thinking about bundling payment or accountable care organizations, which I think are at least steps in the right direction

But the key feature that I think is unique and potentially positions us well, is that today, as opposed to say when managed care was first really on the rise in the early 1990s, we have substantial expansions in health care information technology and the ability to actually measure quality and quality of care and a lot of different conditions ... much more effectively than we have been able to in the past. If you combined potentially strong incentives to lower cost with very strong incentives to provide high-quality care, the confluence of those two things is potentially a

powerful mechanism to really align incentives to approximate what we would think the market would offer.

If I buy something at the store -- say I buy breakfast cereal -- we're not concerned about me making the wrong decision, or my decision not reflecting some optimum. Whereas in health care, the information problems -- namely, that I don't know what I need and I'm relying on a physician to both inform me, as well as sell me those goods and services -- is problematic. And then [physicians are] being paid by a third party. There is an argument that with information technology and with new incentive models, we might be able to actually begin to approximate the appropriate incentives and try to cut out those marginal services that are of low value. I think in general -- the Hospital University of Pennsylvania is right there and I like the fact that I can go to HUP if I get very sick. And I think most Americans do on average. So trying to align those incentives while keeping intact what we have that's functioning quite well -- I think those mechanisms and the combination of IT and incentives might be able to accomplish that.

Knowledge@Wharton: You've studied extensively the impacts of health care reform in Massachusetts. Are there any lessons learned there that you think should be considered at the federal level?

Kolstad: Absolutely. I think there are a number of interesting lessons in Massachusetts, and some of them are ongoing. In many ways, [the reforms in] Massachusetts were ... largely about insurance. Some of the ACA is largely about insurance. Massachusetts is now beginning to think about some ways to potentially tackle the cost growth [it experienced as a result of the reforms.] And the fact that Massachusetts has had cost growth and in fact has had cost growth that has exceeded other states before their reform and after their reform -- I think there will be interesting lessons coming out of Massachusetts there. But certainly from the perspective of the individual mandate, the employer mandate and subsidized care, the mechanisms in Massachusetts mimic very closely the key structures of the ACA, depending on what the Supreme Court does. And I think there are a couple important lessons.

First, there is a fair amount of evidence from Massachusetts that basically the provision of insurance to the new -- basically 6% of the population gained health insurance as a result of the reform. And there was evidence that basically they were using the emergency room less, both for outpatient visits and visits that eventually resulted in inpatient admission. There was also some evidence that they were getting access to outpatient care that could prevent hospitalizations. That evidence is a little more mixed, but there is certainly some initial evidence for that. And so I think there are some early signs that, given our system, providing access to insurance can actually make a more efficient delivery of health care and potentially lower costs, but certainly [lead to] improved health, which is of great value. So that's I think an optimistic lesson from Massachusetts.

The other big lesson relates to the function of the insurance market. As I was saying earlier, we've done some work and there is some evidence that when you implement the individual mandate on top of an insurance market that had community rating and guaranteed issue, you did find that the new enrollees were differentially healthier, at least based on hospital costs, than the prior enrollees. That is suggestive of some degree of adverse selection in the absence of an individual mandate... Now of course, Massachusetts' overall insurance market was functioning reasonably well [before the reforms]. But their individual market was very, very expensive prior to the individual mandate and was not functioning very effectively. So I think the individual mandate could be quite key if you really think we're going to rely on exchanges and acquisition of individual health insurance to facilitate expansions in coverage.

Now the other lesson from Massachusetts is that when they did implement the reform, about half of the newly insured gained coverage through their employers. That is not as consistent with a lot of the projections for national reform. But I think that some of those projections are missing this underlying feature that I was talking about earlier, which is that people value health insurance. Even if you don't take it up, you don't think of it as something that's totally worthless and so when you implement an individual mandate, in some ways that just augments the underlying valuation.

And if your employer is providing you a benefit that you see is well matched to you and something you value, then the combination of your value for health insurance and the individual mandate can actually be a powerful incentive to get people to take up their existing employer-sponsored health insurance. And that seems to have happened in Massachusetts. In some recent work we've done, we've found that the newly insured in Massachusetts were willing to accept wage reductions on an average of \$6,000 a year to gain employer-sponsored health insurance. And that [matches] almost exactly with the cost to their employer of providing that insurance. So implicitly that suggests that the combination of the underlying value [people subscribe to health insurance] and the individual mandate induces an evaluation that led them to basically value the health insurance benefits they received almost fully.

And that made [the individual mandate] an incredibly efficient mechanism to expand health insurance because effectively [the reform was] able to piggy back on the existing infrastructure, expand coverage to that additional population and distort the labor market very, very minimally. And so I think there are some lessons that suggest that this can be a very efficient tool. There are obviously legal questions that are critical in determining [what] the Supreme Court is focused on. But from an economic perspective and a policy perspective, I think it would be a major setback if we lose this tool as a mechanism for public policy, as well as kind of undermining what is a big step forward in terms of health policy. We've been trying for a hundred years to have some sort of comprehensive form of coverage.



And I think we are relatively close at this point. And there is some evidence from Massachusetts that this could be an effective, middle-of-the-road way to do it.