The Affordable Care Act: More Health Care Services at Lower Cost?

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“...you would think that would not be so controversial. (Laughter.) You would think people would say, okay, let’s go ahead and let’s do this so everybody has health insurance coverage. The result is more choice, more competition, real health care security.”

—President Obama concerning the Patient Protection and Affordable Care Act (ACA)

The Affordable Care Act

In 2010, the Patient Protection and Affordable Care Act (ACA) was passed by Congress and signed by President Obama with two main purposes:

• Provide health insurance to those not currently covered
• Decrease costs across the U.S. health care system

Figure 1 shows a measure of health care expenditures per person in the United States over the past two decades. In the context of the ACA, the goal of decreasing costs is synonymous with decreasing the expenditures paid by the average consumer for health care—or at least causing expenditures to increase more slowly.

Figure 1

Real Personal Consumption Expenditures on Health Care Services, Per-Person 2012 Dollars

NOTE: The figure does not include net health insurance/worker’s compensation, prescription or nonprescription drugs, medical equipment or supplies classified under nondurable/durable goods. Gray bar indicates recession as determined by the National Bureau of Economic Research (NBER).

Expenditures are paid by consumers to doctors, hospitals, and other health care providers in three ways: (i) directly to providers as out-of-pocket payments, (ii) through fees paid to private insurers that then pay providers, and (iii) through taxes paid for government insurance and spending programs such as Medicare and Medicaid that cover provider charges. Estimates for 2019 indicate that at least 44 percent of health insurance costs will be paid privately, either directly by consumers or via private insurance (Table 1).

Expenditures that flow from consumers to providers can be broken down into the following: the quantities and prices of health care goods and services (Expenditure = Quantity × Price), administrative costs of insurers and payment systems, and profits for private insurers. Any legislation that attempts to control total costs has to control quantities, prices, profits, or administrative costs—or some combination of each.

### Market Power and Competition

Discussions of rising health care costs often overlook the role that limited competition in health insurance markets may play. If numerous firms produce identical products, those firms will compete by keeping prices low. In such competitive markets, firms have little to no power to control their prices. If they charge higher prices than their competition, they may get no customers, while if they charge lower prices, they may lose money. At the other end of the spectrum are monopoly markets, where only one firm exists and can set pricing based on its individual costs—because there is no competition. Anyone who has ever seen a movie at their local cinema has viewed a type of monopoly first hand: The candy counter has the exclusive right to sell their goods in that market and can therefore sell at elevated prices. Even companies in markets with very few firms, called oligopolies, will have some power to control pricing. As a general rule of thumb, markets with one or few firms have more market power, which is the ability to control and elevate prices above competitive levels.

There are several ways to measure market power, such as the four-firm concentration ratio and the

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**Table 1**

<table>
<thead>
<tr>
<th>Source of payments</th>
<th>Percent of expenditures</th>
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<tbody>
<tr>
<td>Government payments and insurance</td>
<td>41</td>
</tr>
<tr>
<td>Private insurance</td>
<td>34</td>
</tr>
<tr>
<td>Out of pocket</td>
<td>10</td>
</tr>
<tr>
<td>Other health spending</td>
<td>15</td>
</tr>
</tbody>
</table>

Herfindahl-Hirschman Index (HHI). The HHI takes the percentage of the market that each firm possesses, squares each percentage, and then sums the squares. The maximum value of the HHI is 10,000, while the minimum is arbitrarily close to 0. For instance, if one firm has a monopoly in a market, that firm would have 100 percent of the market and the market’s HHI would be 10,000:

$$\text{HHI} = 100^2 = 10,000 \text{ (monopolist)}.$$

In contrast, a market with 1,000 firms each possessing 0.1 percent of the market would have an HHI of 10:

$$\text{HHI} = 0.1^2 + 0.1^2 + 0.1^2 + \ldots \text{ (Add } 0.1^2 \text{ 1,000 times total.)}$$

$$= 1000 \times 0.01 = 10.$$

In general, the higher the HHI, the more likely firms will have market power.

**Market Power in ACA Exchanges**

In economic theory, competitive markets can reduce costs to consumers by forcing insurance companies to keep prices at competitive levels and forfeit monopoly profits. With similar health insurance requirements and subsidies for low-income households, the Swiss health care system offers a model for comparison with the U.S. health care system. As of 2011, there were close to 100 insurers in Switzerland competing for consumer health care dollars, forcing firms to compete by setting prices to just cover costs. In the United States, markets are state specific and consumers may choose from plans available in the state in which they reside. In 2014, of the 50 states and the District of Columbia, 11 had only 1 or 2 insurers, 21 had 3 or 4, and only 19 states had 5 or more. As of July 2019, the number of states with only 1 or 2 insurers had increased from 11 to 20, indicating a growing divide between ACA exchanges and competitive markets. Measuring market concentration by HHI yields similar results (Table 3), with 43 percent of markets classified as super concentrated and 47 percent as highly concentrated. Therefore, the ACA has not yet been successful in creating highly competitive markets.

Additionally, researchers have found mounting evidence that the lack of competition in health care exchanges is directly related to premium increases. Jessica Van Parys

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**Table 2**

<table>
<thead>
<tr>
<th>Year</th>
<th>Health expenditures per person (2012 $)</th>
<th>Average yearly growth rate (%)</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>7,349</td>
<td>2.0</td>
<td>Health care policies before the ACA</td>
</tr>
<tr>
<td>2004</td>
<td>7,539</td>
<td></td>
<td>increased coverage with the ACA</td>
</tr>
<tr>
<td>2005</td>
<td>7,726</td>
<td></td>
<td>Full ACA with exchanges</td>
</tr>
<tr>
<td>2006</td>
<td>7,909</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>8,051</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>8,157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td>8,264</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>8,281</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>8,312</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>8,450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>8,521</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>8,786</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>9,161</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>9,398</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>9,540</td>
<td></td>
<td></td>
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</tbody>
</table>

claims that markets with only one or two insurers see an average increase in consumer premiums of 50 percent. Similarly, Richard Scheffler and Daniel Arnold claim that although monopolistic insurers can indeed use their market power to negotiate better prices from health care providers, insurers often keep any savings for themselves in order to increase profits, rather than pass the savings on to consumers.

Of course, more analysis would be required to determine if the lack of competition is contributing to the ACA not generating the cost savings it is hoped to achieve. There are many other factors to consider, such as expanded benefits and higher government subsidies, that could be keeping costs elevated.

Conclusion

In offering more expansive health care coverage to U.S. citizens under the Affordable Care Act, lawmakers are forced to face the question of whether such coverage is driving up costs. With low-income consumers receiving new subsidies to pay for health insurance, and with insurers having to cover new patients with preexisting conditions that often require expensive treatment, one should expect that more services would lead to higher costs. Economic theory suggests that increasing the level of competition in the insurance market could decrease monopolistic practices and reduce costs to consumers. Based on market concentration data, the United States seems to have a long way to go to substantially increase competition among insurers.

Notes

4 While a theatre’s movie tickets and candy combined could face competition from other theatres in town, the candy counter has a monopoly within its own theatre.
5 Even monopolies don’t charge arbitrarily high prices; instead, monopolists choose prices to maximize their profits. A higher price would mean higher profits on each product but fewer customers.
“The Affordable Care Act: More Health Care Services at Lower Cost?”

After reading the article, answer the following questions:

1. According to the article, what were the two main goals of the Affordable Care Act (ACA) with respect to health insurance?
   a. Limit government coverage and decrease costs to consumers.
   b. Decrease doctor salaries and provide coverage to more individuals.
   c. Decrease doctor salaries and improve the quality of care.
   d. Decrease costs to consumers and provide coverage for more individuals.

2. Which is a payment provided by the government to encourage consumers to buy health insurance?
   a. Tax
   b. Subsidy
   c. Fee
   d. Profit

3. Which of the following does not describe a way consumers pay for health care?
   a. Paying for private health insurance that in turn pays providers
   b. Paying taxes to fund government systems such as Medicare
   c. Paying directly with a credit card or cash
   d. Paying through the insurance plan of your child if you are elderly

4. In what year were the exchanges (marketplaces) of the ACA established?
   a. 2010
   b. 2014
   c. 2016
   d. 2017

5. In which type of market is a firm most likely to have market power?
   a. Monopolistic
   b. Oligopolistic
   c. Competitive
   d. None of the above
6. In what range of years did health expenditures grow most quickly for the typical person in the United States?
   a. 2003 to 2009
   b. 2010 to 2013
   c. 2014 to 2017
   d. There is not enough information to determine the answer.

7. What is the Herfindahl-Hirschman Index for a market with two firms, one having 99.5 percent of the market and the other having 0.5 percent?
   a. 49.75
   b. 100.00
   c. 2,475.06
   d. 9,900.50

8. According to the article, which of the following components of the ACA could put upward pressure on health insurance costs to consumers?
   a. Insurers covering preexisting conditions that often require expensive treatment
   b. A lack of competition in health insurance markets
   c. Incentives for more consumers to own health insurance policies
   d. All of the above