Consumer Financial Issues in Health Care

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In 2013, the USA spent $2.9 trillion on health care, over twice the amount spent in 2000 and nearly four times that spent in 1990. Per capita health spending was $9255, up from $4878 in 2000 and $2855 in 1990 (U.S. Department of Health and Human Services, 2014). Between 1990 and 2008, health care spending increased 7.2 %, about 2 % points above average annual GDP growth (Sisko et al., 2014). From 2009 to 2013, the effects of the Great Recession, federal government sequestration, and increased cost sharing in the private health care market slowed health expenditure growth to historically low rates ranging between 3.6 % and 3.8 % (Dranove, Garthwaite, & Ody, 2014). Between 2013 and 2023, however, economic recovery, health needs of an aging population, and the effects of extensive health insurance market reforms are expected to generate an average annual increase in health spending of 5.7 %. By 2023, health-related expenditures are projected to comprise 19.3 % of GDP, up from 17.2 % in 2012; 13.4 % in 2000 (Sisko et al., 2014).

No industrialized nation spends more on health care, including those that provide health insurance to all citizens (National Coalition on Health Care, 2012). In 2012, the USA spent 42 % more per capita on health care than Norway, the next highest per capita spender, 90 % more than Canada, and 168 % more than the United Kingdom (Organization for Economic Cooperation and Development, 2014). At 24 % of the federal budget in 2014, spending on Medicare, Medicaid, the Children's Health Insurance Program, and Affordable Care Act marketplace subsidies is one and a third times that of military spending and rivals Social Security as the largest sector of the federal budget (Center on Budget and Policy Priorities, 2015).

Some argue that spending a relatively high amount on health care is not a problem. It simply reflects the fact that, as a prosperous nation, we can afford to spend more on health care (Pauly, 2003). The market is meeting the demand for more care, better care, and use of more costly technical equipment for medical diagnosis and treatment. This perspective seems to be in the minority, however (Chernew, Baicker, & Hsu, 2010).

Many watching the health care market are uneasy. They foresee growth in health spending continuing to outpace expected GDP growth over the next decade and seriously question the sustainability of such growth (Centers for Medicaid and Medicare Services, 2014; Howell, 2014; Lave, Hughes-Cromwick, & Getzen, 2012). They watch cautiously to see the ways recent complex and extensive health insurance market reforms will affect costs and care in the health care market. They foresee the demands that 77 million

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Baby Boomers will place on Medicare and Medicaid and wonder about the long-term viability of these public health care programs (Baicker, Shepard, & Skinner 2013). They worry that more federal and state dollars allocated to health care will mean fewer dollars available for other necessary goods and services (Squires, 2012).

Between 1960 and 2007, a marked shift in the sectors paying health care costs occurred. Gruber and Levy (2009) note that although the tripling of the share of GDP devoted to health (from 5.2 % to over 16 %) during that time was well known, less recognized was the decreasing share of private sector health spending (68–47 %) and, within private sector spending, the decline in share of dollars devoted to out-of-pocket spending (69–26 %) versus health insurance premiums. They concluded the increased role of government and private insurance in the health market has helped to mitigate the household level health care spending burden, citing the fact that between 1960 and 2007 private out-of-pocket spending did not quite double, whereas, in real per capita terms, there was a five-fold increase in private health spending ($700–$3500) and a 13-fold increase in government health spending ($250–$3500).

Despite this relatively favorable trend in household level health spending, there is evidence 'crowding out' occurs, at least for some. Participants in the 2014 Employee Benefit Research Institute Health Confidence Survey reported that, despite having health care coverage, rising health care costs forced cut backs in other household budget items. Over one-fourth (27 %) had reduced retirement saving. About half (47 %) had reduced other savings. One in five (21 %) reported that health care bills made it difficult to pay for basic necessities (21 %) and other bills (32 %) (Employee Benefit Research Institute, 2014). While policy makers, health care providers, and insurers debate the cause and cure of high and rising health care costs, consumers face the daunting task of making critical health care decisions for themselves and family members in a complex and dynamic market. This chapter describes the characteristics of and key players in that market. Reasons given in the academic and popular press for high and rising health care costs are evaluated. Effectiveness of insurance in keeping health care attainable and affordable for consumers is explored. Recent changes in the health insurance market under the 2010 Patient Protection and Affordable Care Act as amended by the 2010 Health Care and Education Reconciliation Act (hereinafter referred to as ACA) are discussed. The chapter concludes with suggestions for future research.

Market for Health Care

Characteristics of Health Care

Health care is a multifaceted consumer good. It has qualities of a public good. Society benefits when health care maintains worker productivity and reduces spread of communicable disease (Smith, Beaglehole, Woodward, & Drager, 2003). It also has qualities of a private good. Our health status directly affects the quality of our lives, so we purchase health care to benefit ourselves. In addition, each of us is personally responsible for making lifestyle choices that either enhance or detract from good health (Resnik, 2007). Economists consider health care to be an aspect of human capital, an investment that we make in ourselves to enhance our productivity. In a now classic article, Michael Grossman introduced the idea that "good health" can be likened to a durable capital good that produces "healthy time" (Grossman, 1972). Recognizing the public and private benefits of good health, Grossman noted that healthy time is desirable because it makes the person who possesses it more productive in work in the market and at home. With good health, leisure activities can be enjoyed to a greater extent and a person's overall quality of life is improved as well.

Economists also view health care as a normal good (Leung & Wang, 2010; Newhouse, 1992). As our resources increase, we want more or better health care. It is generally not controversial for an individual to purchase as much health care as desired as long as that individuals pays his or her own medical bill. When government or insurance companies pay some or all of health care

costs, however, considerable debate can arise regarding the type and amount of healthcare costs that should be shared. Given limited resources, constraints are imposed. The government sponsored health care programs—Medicaid for the low-income or Medicare for older Americans—provide a limited amount of basic health care only to those meeting strict eligibility standards. Historically, private insurance cost controls have taken various forms such as limiting enrollment, refusing payment for certain types of care, limiting access to specialists, or imposing annual or lifetime dollar limits on coverage. However, ACA provisions now restrict these cost-containment strategies (Kaiser Family Foundation, 2013).

Health care consumers are often at a disadvantage. In marketing terms, health care is a "high credence" consumer item (Sharma & Patterson, 1999). Unlike the market for consumer durables such as automobiles or microwaves, objective, unbiased assessments of quality are not readily available. Local markets may offer few choices of health care providers and comparison of service quality is difficult. No objective ranking of hospital quality exists nor are doctor's error rates public information. Most consumers interacting with medical personnel or purchasing medical treatment or equipment lack the technical knowledge necessary to judge the quality of what they receive even after purchase (Sharma & Patterson, 1999).

Explosion of health-related information on the Internet has not necessarily helped consumers. Health educators caution the Internet has no "quality filter." Anyone can develop an official-looking website, and claim medical expertise but offer biased, misleading, incorrect, or even fraudulent information. Consumers with limited information-evaluation skills are especially vulnerable to such deception (Cline & Haynes, 2001). Consequently, consumers must place a high level of trust, or credence, in the health care provider. Unfortunately, this trust is sometimes misplaced. A recent Commonwealth Fund survey of approximately 20,000 sick adults in Australia, Canada, France, Germany, the Netherlands, Norway, New Zealand, the United Kingdom, and the USA found 11.2 % of all respondents had experienced a medical or medication mistake or lab error. Error rate in the USA was 14.3 %, second only to Norway (17 %) (Schwappach, 2014). Estimated annual cost of measurable medical errors in the USA is $17.1 billion (Van Den Bos et al., 2011).

Sectors of the Health Care Market

The health care market operates in the public and the private sector. Medicaid and Medicare are government-funded health insurance programs. Medicaid is a social welfare program for low-income individuals and families of all ages. It is jointly funded by state and federal dollars, and managed at the state level. Medicare is an entitlement program for those aged 65 and older. It is funded and administered by the federal government.

Public health care spending was 44 % of national health expenditures in 2012; the remainder was private spending (Centers for Medicaid and Medicare Services, 2014). For fiscal year 2015, the $331 billion and $529 billion allocated to Medicaid and Medicare, respectively, represent a little over one-fifth of projected federal budget outlays (Office of Management and Budget, 2014).

In 2013, about two-thirds of the population had private health insurance (of the remainder, 15.6 % had Medicare, 17.3 % had Medicaid, 4.5 % had military health care, and 13.4 % were uninsured). Of that group, 11 % had purchased coverage directly. About half (53.5 %) had group health insurance as an employee benefit (Smith & Medalia, 2014). Purchase of health insurance through an employer is generally cheaper than individual purchase due to the reduced administrative costs for the insurance provider. Further, employer-paid premiums are tax-free to the employee and provide a tax deduction to the employer. But, not all employees have this option. Health insurance as an employee benefit is available more often to full-time versus part-time private industry workers (86 % vs. 23 %) and to those working in medium to large establishments (≥100 workers) versus small establishments (84 % vs. 57 %) (U.S. Bureau of Labor, 2014).

Although private insurance can take several forms, providers operate on the same basic principles. Purchasers exchange premium dollars for help paying covered medical expenses. Deductibles (amount paid before the insurance company will pay), co-pays (amount paid for a given service), and co-insurance (a percentage of health care cost borne by the insured) are used to share medical costs and create incentive for the insured to minimize medical expenditures. Often, the insurance company will offer incentives for preventive care services and using health care providers within a given network.

A major part of health market reform under ACA is mandated health insurance coverage. Those who are not eligible for coverage under Medicaid or Medicare and do not have access to or choose not to purchase employer-provided group health insurance can enter a marketplace (exchange) created under the Act. This marketplace offers four tiered plans named after metals with increasing value: bronze, silver, gold, and platinum. Bronze plans generally have the lowest premiums, but highest potential out-of-pocket costs, whereas it is the reverse for platinum plans. Subsidies and tax credits are available to help moderate and low-income individuals afford coverage in this new marketplace. Fines are imposed for nonparticipation to motivate compliance (Kaiser Family Foundation, 2013).

Dynamics of the Health Care Market

The health care market has several players: policy makers, purchasers, insurers, providers, and suppliers. Policy makers establish and enforce the laws and regulations that govern exchange in the health care market. Individuals, employers, and governments purchase health care services or health insurance. Insurers collect money from health insurance purchasers to reimburse health care providers when claims are made. Health care providers use the money they receive to pay suppliers for such things as medical equipment, medical supplies, and pharmaceuticals (Bodenheimer, 2005a).

Competing interests exist. Payments made by purchasers and insurers constitute revenue to health care providers and suppliers. Not surprisingly, purchasers and insurers favor finding ways to reduce costs, whereas providers and suppliers resist cost containment. Bodenheimer (2005a) calls this conflict the "fundamental battle in the health care economy" (p. 848). Internal "skirmishes" create additional tensions. Insurance companies would like to reduce payments to providers, but want more money from purchasers. Pharmaceutical makers demand a high price, but hospitals negotiate for a low price. If an insurance provider caps reimbursement to a physician group, primary care physicians may disagree with specialists regarding distribution of the check (Bodenheimer, 2005a). According to economic theory, competition should drive costs down, but in the health care market, it has not.

Why Health Care Costs Are High

Various reasons for high and increasing health care costs have been proposed. Some explanations focus on factors outside the health care market. Economic growth and an aging population are cases in point. The economic growth argument is simple. Richer nations can afford more health care. Thus, it should be no surprise that as the GDP of a country increases the dollar amount allocated to health care grows as well. Indeed, if the overall economy is growing, spending more on health care need not result in less spent on other sectors of the economy (Chernew, Hirth, & Cutler, 2003, 2009). Critics of this view note that the ratio of per capita health expenditures to per capital GDP in the USA far exceeds that of other industrialized countries. Consequently, an expanding economy is not a sufficient explanation for rising health care costs in the USA (Bodenheimer, 2005a; Kaiser Family Foundation, 2011).

Population aging has been offered as another potential reason for rising health care costs. It seems a plausible explanation. Over the past several decades, growth in the population aged 65 and older has outpaced growth of younger age groups (West, Cole, Goodkind, & He, 2014).

Per capita health expenditures for persons over age 75 are 5 times higher than those for persons age 25–34 (Reinhardt, 2003; Yamamoto, 2013). It seems reasonable, then, that countries with an older population would spend more on health care than countries with a younger population. But, research indicates an aging population accounts for less than 7 % of the growth in health care expenditures (Reinhardt, 2003; Yamamoto, 2013). In multivariate analyses of cross-sectional, cross-national data, no significant relationship has been found between the proportion of aged in a nation and national health expenditures (Gruber & Wise, 2002; Richardson & Robertson, 1999).

Factors within the health care market such as excessive administrative costs, market power of health care providers, and absence of effective cost-containment measures have also been blamed for raising health care costs (Bodenheimer, 2005a, 2005b). Some evidence exists to support this claim. A 2002 study found administrative costs in private insurance were about four times larger than administrative costs in public health care programs such as federal and state Medicaid programs (12.8 % vs. 3 %, respectively). In 2011, the cost spread was wider −17 % for private insurance vs. 2 % for Medicaid. Advertising and marketing expenses constituted much of this difference (Archer, 2011; Levit et al., 2004). Bodenheimer (2005b) notes that integration of financing and service delivery, whether in public or private plans, reduces administrative costs.

Health care providers in the USA have relatively more market power (i.e., ability to raise prices without losing business) than health care purchasers. Bodenheimer (2005c) traces this differential to hospital and physician control of the Blue Cross Blue Shield organizations that initially offered health insurance in the USA. Lucrative reimbursement formulas for hospitals and physicians were established in these initial health care plans and later replicated in Medicare. International comparisons indicate that US physicians are paid more than their non-US counterparts for performing similar services. In the USA, average physician income is 5.5 times larger than average employee income; in Sweden and the United Kingdom, the ratio is 1.5 (Laugesen & Glied, 2011; Reinhardt, Hussey, & Anderson, 2002).

Evidence from other countries suggests that capping health care spending can control growth in medical costs. In Germany and Canada, increases in physician fees are connected to the quantity of physician services. If physicians increase visits or procedures, the payment per each item is reduced so that an annual expenditure cap is not exceeded. The United Kingdom uses a globally budgeted system where monies for all services are budgeted in advance. The USA uses a similar approach with Veterans Affairs hospitals. Critics of cost controls express concern that budgets might not allow purchase of high quality care, the decision-making processes among all players are complex and special interests can dominate (Bodenheimer, 2005b).

Economists and policy analysts generally point to technological innovation as the prime driver of the high and increasing cost of health care. As an example, technological innovations in the treatment of heart attacks have lessened the need for invasive surgery and has sped patient recovery. But, use of these innovations requires more capital (specialized labs), labor (specialized physician training and caregiver time to oversee patient recovery), and expenses related to teaching physicians how to use the new technology (Bodenheimer, 2005b).

Spread of technology is quicker and cost per unit of service is higher in the USA than in other developed nations (Reinhardt et al., 2002; Schoen et al., 2012). This difference has been attributed to generous insurance payments made to physicians and hospitals that use new technology and to push from physicians or health care consumers wanting to use the new technology (Adler-Milstein, Kvedar, & Bates, 2014; Pearl, 2014). In this type of environment, incentive for overuse of technology exists.

Several agencies in the USA assess the cost and benefit of technological innovation, including the Medicare Coverage Advisory Committee, the Veterans Affairs hospital system, and the Technology Evaluation Center of the Blue Cross/Blue Shield Association (Garber, 2001). Influence of the scientific reports from these agencies is limited to the interests of health insurance providers, however. Results from a study of large insurers indicated that manufacturers and

early adopters of medical technology had considerable influence over health care coverage decisions whereas health care consumers had very little say (Chernew, Jacobson, Hofer, Aaronson, & Fendrick, 2004).

Role of Health Insurance in Reduction of Health Care Costs

Health insurance plans have evolved over time in response to demand for ways to help consumers lower their out-of-pocket costs for health care and to provide protection against potentially catastrophic financial loss due to treatment of illness, injury, or disability. In 1965, amendments to the Social Security Act established two federal health insurance programs, Medicaid for the low-income and Medicare for those over age 65. Others must turn to the private market to obtain health insurance. Employer-sponsored group insurance plans typically have had lower premiums and fewer barriers to entry as compared with private insurance plans. In addition, employers often subsidize premium cost in part or in full as an employee benefit. Thus, it is not too surprising that for the past decade, 6 in 10 Americans under age 65 have obtained their health coverage through an employer-sponsored insurance plan, whereas less than 8 % have purchased private insurance (Fronstin, 2013).

Types of health insurance have changed over time. Currently, consumers or employee benefit administrators can choose from fee-for-service, managed care, or high deductible 'consumer driven' health care plans. Cost containment is a goal of each type of health insurance. The incentive and payment structures used to achieve that end differ, however.

Fee-For-Service

Prior to the 1980s, employer-sponsored health plans were typically fee-for-service plans (Kaiser Family Foundation, 2006). With these plans, consumers pay a fee for a service rendered, and then apply for reimbursement of covered costs. Fee-for-service type plans include basic health care, major medical and comprehensive medical coverage. Basic health care typically pays for hospital, surgical, and physician costs with little or no deductible, but covered expenses are quite limited. Major medical insurance covers a broader array of medical services to pay for high cost services. The ACA limits maximum out-of-pocket costs (in 2015, $6600 for individual, $13,200 for family) (U.S. Centers for Medicaid and Medicare Services, 2015). Prior to ACA, insurance providers would set maximum limit on high cost services, typically $1 million. Consumers in a major medical insurance plan share costs in the form of annual deductibles (an amount paid out-of-pocket before insurance pays), and co-insurance (a percentage of health care costs paid by the insured up to a so-called stop-loss limit, above which the insurance company will pay 100 % of the cost). Comprehensive health care is similar to major medical, but deductibles are usually smaller and a broader range of inpatient and outpatient services covered (Bajtelsmit, 2006).

Managed Care

In the 1970s, concern for rising health care costs and equitable access to health care services led to development of managed care plans (Gruber, Shadle, & Polich, 1988). Health Maintenance Organizations (HMOs) were the first such plans. Preferred Provider Organizations (PPOs), and Point of Service (POS) plans soon followed.

Managed care plans endeavor to control costs by contracting directly with health care providers and controlling access to health care services. Health care providers receive financial incentives for keeping costs down. Preventive care such as annual exams, immunizations, and diagnostic tests is emphasized. Low co-pays (typically $5–$20) encourage consumers obtain treatment before health conditions worsen and more costly intervention is required.

HMOs, PPOs, and POSs have different coverage limitations. HMOs are more restrictive. To have their health costs covered consumers must use a health care provider that has contracted with the HMO. A referral must be obtained from

a primary care physician before a specialist can be seen. PPO plans allow consumers to use health care professionals who have not contracted with the PPO plan; however, consumers will share a larger portion of the cost of care if they do so. A POS plan resembles a PPO, but the participating physicians are part of an HMO, so coverage is often more comprehensive than in a PPO. Also, co-pays in a POS are typically lower than in a PPO (Bajtelsmit, 2006).

The cost reductions associated with managed care plans spurred a rapid transfer out of fee-for-service plans among employers. In 1988, 73 % of workers had fee-for-service plans. After that, enrollment in fee-for-service plans dropped dramatically, representing less than 1 % of employer-sponsored health plans by 2014. Initially, HMO type plans drew the greatest interest of employee benefit administrators. Between 1988 and 1996, the market share of HMOs virtually doubled, rising from 16 % to 3 %. Enrollment peaked in 1996, and then slowly declined to 13 % of the employer-sponsored health care market by 2014.

Ironically, the HMO design features that contributed to cost reductions also generated consumer dissatisfaction. After analyzing the results of 39 different studies of HMO quality, Miller and Luft (2002) concluded that success in cost containment had come at the price of limited access to health care services and reduction in health care quality. Policy pricing was also an issue, but in different ways in the public and private sector. Riley, Tudor, Chiang, and Ingber (2006) cite instances of government overpayment of Medicare HMOs in the mid-1990s. In the private market, HMO firms waged fierce price wars in an attempt to expand their enrollment base. For many firms, the lowered premiums failed to cover operating costs, resulting in substantial financial loss (Gruber et al., 1988).

Current Distribution and Price of Employer-Sponsored Health Care Plans

The proportion of employers offering the PPO form of managed care has steadily grown, perhaps due to the greater degree of choice given to health care consumers as compared with HMO plans. Among workers with an employer-provided health care plan in 2014, 58 % had a PPO, 13 % had HMO coverage, 8 % had a Point of Service Plan (POS), whereas less than 1 % had a fee-for-service plan. Worker enrollment in high deductible health plans has grown markedly from the 4 % share in 2006 when the plans were just beginning to be offered as an option to 20 % of employer plan enrollment by 2013 (Kaiser Family Foundation, 2014).

A 2014 survey of employer-sponsored health benefits indicates that employers paid the average annual highest premium contribution for PPO plans ($17,538 for single and family plan coverage combined), followed by HMO plans ($17,170), and POS plans ($16,370). Employer contributions were lowest for high deductible plans ($15,410). Worker contributions to a health insurance vary by type of plan. On average, workers needing family coverage would pay the lowest premiums with a PPO plan as compared with HMO or POS plans ($4877 for a PPO plan vs. $5254 for an HMO plan, or $4849 for a POS plan). Conversely, single employees would have the lowest premium with a POS plan ($984 for a POS plan vs. $1134 for a PPO plan or $1182 for a POS plan) (Kaiser Family Foundation, 2014).

Consumer-Driven Health Care

Consumer-driven health care plans (CDHPs) were introduced in 2001 in response to rising health costs and consumer dissatisfaction with the strictures of managed care. Rather than contain costs by limiting consumer choice, CDHPs broaden consumer choice and financial responsibility. Consumers bear a large portion of health care costs, creating a financial incentive to obtain lower cost, higher quality services. The plans provide information, typically via the Internet, to help consumers make thoughtful choices in managing their health (Bundorf, 2012; Fronstin, 2010). Some plans give consumers broad discretion selecting physicians and hospitals and designing their own network and benefit plans. Other plans limit choice to a predetermined list of network options and benefit packages. Generally,

only one carrier's products are offered. Employers pay a fixed amount toward purchase of selected services. Employees pay the remaining cost (Gabel, Whitmore, Rice, & LoSasso, 2004).

Tax-advantaged ways to cover high deductibles came with Health Reimbursement Accounts (HRAs) in 2001 and Health Savings Accounts (HSAs) in 2004. Employers fund HRAs and decide which health costs are covered. When the account is depleted, the employee pays out-of-pocket until the deductible (typically $1000 for an individual, $2000 for a family) is met. At that point, the plan becomes a traditional major medical plan. Employees cannot contribute to an HRA or invest account funds. Unused dollars rollover to a subsequent year but are not portable if an employee leaves. HSAs addressed these limitations. Employers and employees can fund an HSA. Investing is allowed and neither principal nor interest is taxed if used for qualified medical expenses. Unused dollars rollover and are portable when leaving employment (Ebeling, 2011; Gabel et al., 2004).

CDHPs are now second only to PPO plans in proportion of US employers offering them as a benefit option (58 % vs. 79 %) and in health plan enrollment (20 % vs. 58 %). About a third of employers offering CDHPs couple them with HSAs instead of HRAs (18 %) or no company sponsored savings (6 %) (Kaiser Family Foundation, 2014; Miller, 2013).

Evaluation of CDHPs is mixed. Consumer satisfaction with CHDPs has consistently lagged that of comprehensive plans, although it has risen slightly over time. Complaints center on inadequate information regarding cost and quality of health services, the critical feature for plan success. Still, even with good information, the high credence qualities of health care make choice difficult. Consumers must carefully evaluate implications of various plan options after assessing own and family member's health risks. Effective choices require a certain level of technical knowledge that few seem to have. In a recent survey, although 3 out of 4 Americans reported feeling confident they knew how to use health insurance, when given plan information only 1 in 5 could correctly calculate out-of-pocket cost (Paez & Mallery, 2014). Consumers also had difficulty objectively evaluating tradeoffs between policies regarding premium cost, co-pays, and deductibles (Paez et al., 2014).

Direct payment of health costs in CDHPs has influenced consumer behavior, but not always in desired ways. CDHP plan participants are more cost-conscious and more apt to talk with medical providers about treatment options and generic drugs. But, they are also more likely than comprehensive plan participants to forgo health care or medication due to cost even though both groups have similar rates of medical service utilization. CDHPs have had no effect on the number of uninsured. They seem to best serve the young and healthy that incur few health care costs or the affluent that can afford the high deductible. Cost reductions appear to be modest and mostly beneficial for employers (Fronstin, 2010; Fronstin & MacDonald, 2008).

Health Insurance Reform

Health insurance is not attainable or affordable to all. Between 1999 and 2012 the proportion of uninsured of all ages in the USA averaged 14.7 %, ranging between a low of 14.2 % in 2000 to a peak of 16.7 % in 2009. Rates for young adults aged 18–34 were much higher, ranging between 20.5 % and 28.4 % during the same time period (U.S. Census Bureau, 2012).

Having a significant proportion of the population uninsured is a social concern. Although uninsured poor can rely on Medicaid, the health needs of uninsured non-poor can go unmet or worsen to the point that emergency care is necessary (Timmermans, Orrico, & Smith, 2014). Unpaid hospital bills are passed on to those with insurance in the form of higher costs. Uninsured children have less access to health care, exacerbating the health problems of special-needs children in that population (Newacheck, McManus, Fox, Hung, & Halfon, 2000; Olson, Suk-fong, & Newacheck, 2005). Inadequate treatment for illness or chronic conditions (e.g., asthma) can affect a child's ability to learn and days in school, which in turn affects future economic productivity.

Concerns regarding the uninsured coupled with frustrations with the expenses of fee-for-service plans, limitations of managed care plans, and the significant consumer issues associated with CDHPs spurred heated discussion regarding national health care. Advocates asserted basic health care is a right, not a commodity to be purchased only by those who have the means (Geyman, 2003; Woolhandler & Himmerstein, 2002). Opponents argued that government intervention in the health care market would lead to greater inefficiency, decreased consumer choice, and higher taxes (Amadeo, 2015).

Years of debate over health care reform culminated in passage of the 2010 Patient Protection and Affordable Care Act amended by the Health Care and Education Reconciliation Act (commonly referred to as ACA). ACA is not national health care. It is, however, the most complex, extensive, and comprehensive revision of the US health care system since creation of Medicare and Medicaid in 1965. (A full review of ACA is beyond the scope of this chapter. See Kaiser Family Foundation 2013 for an excellent summary of ACA.)

The main goals of ACA are expanding insurance coverage among the uninsured, controlling costs, and encouraging preventive care (Gable, 2011). ACA uses several mandates to accomplish these goals: adults must obtain health insurance or pay a fine; premium and cost-sharing subsidies are offered to low-income individuals, states need to expand Medicaid coverage; a new market for health insurance purchase was to be created; insurance companies could no longer refuse coverage for pre-existing conditions (Rosenbaum, 2011). Persons lacking employer-provided health insurance are to go to their state insurance marketplace to select a plan. Marketplace plans are classified by level of cost sharing. Platinum, gold, silver, and bronze plans cover 90 %, 80 %, 70 %, and 60 % of consumer medical costs, respectively. Consumers pay the rest. Catastrophic plans cover medical expenses only after a high deductible is reached ($6350 for individual, $12,700 for family), but three primary care visits and preventive care are available at no cost. Beginning in 2015, employers with 100 or more employees that do not offer affordable coverage will face financial penalties. In 2016, the mandate extends to employers with 50 or more employees.

The ACA has met strong opposition. Constitutionality of the individual mandate to have health insurance or pay a fine was brought before the Supreme Court. The mandate was allowed to stand, but the "fine" was redefined as a "tax," to be assessed and collected by the IRS (Musumeci, 2012a). Half of the states challenged the mandate to expand Medicaid coverage to cover more low-income individuals and families in the Supreme Court. As a result, Medicaid expansion became optional for states (Musumeci, 2012b). Another Supreme Court case arose when, on doctrinal grounds, several organizations opposed mandated inclusion of contraceptives in the "essential health benefits" that all new insurance plans had to include. Regulations were adjusted to allow such organizations to be exempt from including contraceptive coverage in employee plans. In addition to these challenges, the initial enrollment for the health insurance marketplace was fraught with extensive and prolonged technical difficulties, slowing initial enrollment, and threatening confidence in the new system.

ACA provisions take effect incrementally from 2010 to 2020, so it is too early to judge the effectiveness of the entire Act. What we do know so far is that there are new insureds. About half signed up for Medicaid, the rest enrolled in private plans in the new marketplace. Premiums increased for those whose prior insurance coverage was more limited than the now required essential list, but overall premiums have not risen as high as expected (Sanger-Katz, 2014). Due to increased business, the health insurance industry seems financially strong. A gap is growing in the number of uninsured between states that expanded Medicare and those that did not (Sanger-Katz, 2014).

Summary and Future Research Directions

In summary, health care is vital. There is no debate about that. Much difference of opinion exists, however, regarding the extent to which

rising health care costs should be a concern, what drives these rising costs, how health care resources should be allocated, levels and methods of public and private cost sharing, the need for reform in the health care market and the direction such reform should take. While discussion on these issues continues, consumers must make critical care decisions in a complex and dynamic marketplace. Several aspects of that marketplace present challenges to effective decision-making. Quality of health care services is difficult to impossible to evaluate prior to use. The type and level of cost sharing of various forms of health insurance must be weighted against expected health care needs. Further, broad change in the health care market is being progressively implemented under the 2010 Patient Protection and Affordable Care Act. The full effects of this change will take some time to be determined.

For purposeful dialogue on these health consumer issues to occur, quality research is needed to sort out myth and popular ideas from fact, to evaluate effects of existing policy and to explore possible effects of policy changes. Thoughtful contributions to the health care discussion are needed from a variety of subject matter experts.

Family and consumer economists can contribute expertise on a number of health care issues. A few examples will be noted here. First, better understanding of the dynamics of consumer choice in the health care market is needed. Economic theory underlying consumer-driven health care proposes that consumers use information to make optimal decisions. Observation of consumers in these plans indicates that, to the contrary, consumers are not always willing or able to process health care information and, faced with high deductibles, they forgo needed health care. Both outcomes, it could be argued, are not optimal for the consumer. What disconnects exist between the incentive structure perceived by consumers and the one intended by policy makers? What changes in information delivery might help the consumer better understand and use highly technical and complex health information? What alternate forms of cost sharing might lessen the financial anxiety of consumers while retaining incentive for cost reduction?

Second, families are primary caregivers for the ill and infirm. What are the short- and long-term financial outcomes of caring for a disabled family member in the home? Existing research suggests tradeoffs can be high. For example, in a study of the financial issues associated with having a child with autism, families reported draining retirement savings, taking on debt, and moving precariously close to bankruptcy to fund high out-of-pocket behavior therapy costs that insurance would not cover (Sharpe & Baker, 2007). Leiter, Krauss, Anderson, and Wells (2004) found that women with a severely disabled child under age 18 cut back labor hours or left employment to care for their child. What effect does this nonmarket production have on health care costs, both in the household and for society? When women leave market work for caregiving, what is the effect on the family's access to health care, or ability to save for long-term goals? How does focus of time and money resources on a disabled child affect the human capital development of the child and of siblings? How might outcomes differ if it is a parent or grandparent rather than a child that is disabled or in need of extensive care? As the proportion of aged in the population increases, concern for the provision and cost of their care will increase as well.

Third, Hispanic, Asian, and other ethnic population groups in the USA are increasing in number. This growing population diversity raises questions about similarity and difference in health care usage and expenditures by race and ethnic group. To what extent might minority populations prefer folk or traditional remedies to a clinical model of health care? How would such choices affect public health? How do language differences affect access to and usage of health care? To what extent do population sub-groups have specialized care needs?

Fourth, how might public and private resources be reallocated to create more equitable access to health care for all age groups? Even with Medicare, older individuals have high out-of-pocket costs for health care (Cubanski, Swoope, Damico, & Neuman, 2014). Population aging will strain resources to meet existing entitlements. At the same time, in 2013, 9.8 % of

children in poverty and 19.9 % of workers are without health insurance (Smith & Medalia, 2014). What factors are driving reductions in health care as benefit to current and retired employees? To what extent and under what conditions are HSAs or HRAs in high deductible plans an effective substitute for employer-funded health care?

Fifth, newer models of health care focus on informed choice and wellness. Methods of assessing and improving health insurance literacy are needed (Paez et al., 2014). Best practices in Internet delivery of health-related information need to be developed. Also, effects of the many and massive changes that ACA mandated in the health care payment and delivery system will need to be evaluated. Many of these changes have created new terms and processes that must be clearly understood to successfully navigate the evolving health insurance market.

Finally, in an era of increased cost sharing, a clearer picture of the dynamic relationship between health and wealth is needed. Do the healthy earn more and amass more wealth (McClellan, 1998) or can the wealthy purchase more and better health care (Ettner, 1996; Smith, 1999), or is a third factor, such as preference for future vs. current consumption at work (Barsky, et al., 1997)? Evidence to date regarding direction of causation is inconclusive.

In summary, consumer health care issues center on access, affordability, information quality, choice, equitable distribution across age, gender, racial and ethnic groups, and the role of health in accumulation of wealth. By the very nature of the case, demand for good heath and hence quality health care is virtually unlimited. To lose health is to lose life itself. But, resources to obtain that health have limits. Rising health care costs have begun to force some significant tradeoffs for individuals, households, and society at large. Current and coming demographic changes force more open consideration of cost sharing between the private and public sectors, employers and employees, and older and younger generations. To engage in meaningful, productive dialogue on these and other health-related issues, information obtained from further unbiased, scientific research is essential.

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