



Adjusting the Prescription

Improving the ACA

*A Policy Brief by the Committee for Economic
Development of The Conference Board*

Adjusting the Prescription: Improving the ACA

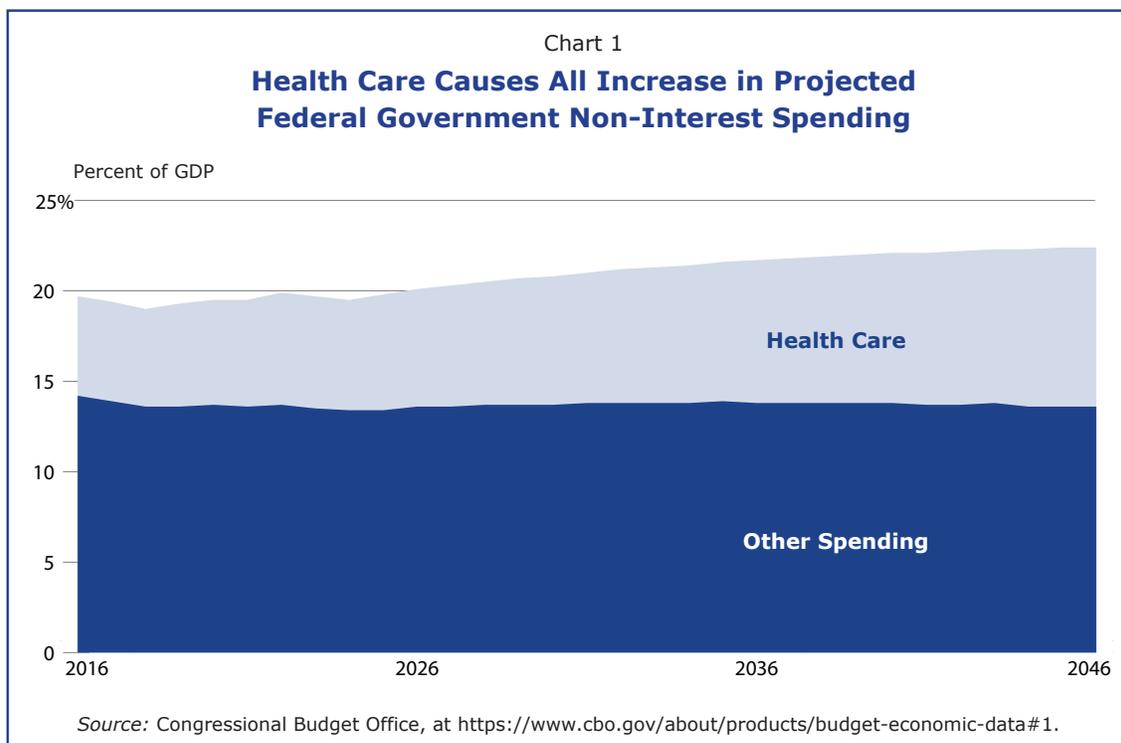
Introduction

The cost of US health care — for families, businesses, and government — has been spiraling upward for decades (Chart 1).¹ At the same time, many Americans remain uninsured and the quality of coverage available has been declining.

“What really matters is whether the nation can transition to a health care system in which consumers drive plans and providers to deliver quality, affordable care — that is, value — by making their own cost-responsible choices of insurance plans that meet their needs.”

The Patient Protection and Affordable Care Act of 2010 (known informally as the ACA) was a well-intentioned attempt to deal with these issues, but, in CED’s view, it has fallen short.² Further reform is necessary to retain the ACA’s positive elements, while simultaneously improving upon it to build a better health care system for all Americans.³

Some people focus on whether the ACA should be “repealed and replaced” or merely “reformed.” With respect, this is a distinction without a difference. Some features of the ACA are both popular and desirable, and most likely they will be retained however the change is characterized. What really matters is whether the nation can transition to a health care system in which consumers drive plans and providers to deliver quality, affordable care — that is, value — by making their own cost-responsible choices of insurance plans that meet their needs. Alternatives that fall short of this standard will not solve the nation’s multifaceted health care problem, which is described below.



Guiding Principles for Health Care Reform

Health care is simultaneously a deeply personal — even existential — issue and a more mundanely economic one. The personal consequences are known to all of us. Economically, many households fear the financial risk of a prolonged illness or serious injury. Health care costs are the most frequent cause of personal bankruptcy.⁴ And, from a national perspective, growing health care costs have profound implications for the country's long-term fiscal health.

In light of health care's very central role in our well-being, CED believes strongly that:

- *Every American should have access to health care.*
- *Care should be of high quality.*
- *Care should be affordable.*

The physician–patient relationship is central to health care — both when we are healthy and especially when we are not. It is important to respect the validity of the physician–patient relationship and to protect it. But, as a nation, we must not forget that health care, like any good or service, must ultimately be paid for. Regardless of whether the ACA is deemed to have been reformed or replaced, it should not worsen the long-term US public debt outlook.⁵

Better outcomes through market-based reform

Reforming health policy is complex due to the unique role health care plays in our lives. Fortunately, increased reliance on market-based incentives has the potential to decrease costs, improve quality, and promote innovation, while increasing access to coverage. Long-term improvement will require the right balance between government and free-market forces. The best way to achieve this balance is through a market-driven system based on private-sector competition and cost-conscious consumer choice.

This cost-conscious, market-based competition is the same force that motivates producers to provide the best possible quality at the lowest possible cost in virtually every other industry.

Such reforms will lead to greater quality, affordability, and access to health care because consumers will have greater opportunity and incentives to make economizing choices. Increased competition will lead insurers and health care providers to improve what they offer and do in order to gain and satisfy consumers.

"...increased reliance on market-based incentives has the potential to decrease costs, improve quality, and promote innovation, while increasing access to coverage."

Markets incentivize providers to innovate continuously so that they can both improve quality and hold down costs. The opportunity for profit encourages other providers to enter, giving consumers more choices and increasing competitive pressure to raise quality and hold down costs. Market-based competition will be at the core of any successful health care system.

How health care differs from other markets

Although a simple free market represents the ideal for providing goods and services, health care's distinctive characteristics make a pure market approach impossible. Health care diverges from an ideal free market on both the supply and the demand sides.

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On the supply side, the problems inherent in our current fee-for-service reimbursement are fundamental and well-known. Health care providers have good intentions. The reimbursement *system*, however, provides constant rewards to the most expansive view of patients' needs. Providers under fee-for-service reimbursement have less-compelling reasons to adopt practices (even purely business practices, such as personnel optimization or back-office management) that could cut costs without affecting quality. Contrast this with other parts of the economy where producers seek any opportunity to cut costs without reducing quality.

“Government has a role in making health insurance affordable for those who cannot afford the true cost of premiums on their own.”

On the demand side, the fact that third parties pay the bulk of most Americans' health care bills means that consumers have little incentive to economize on costs. Markets work because customers try to get the most from their limited numbers of spendable dollars and, in making their choices, send vivid signals to suppliers. But if someone else is paying the bill, the consumer believes that available dollars are *not* limited.

Two additional factors contribute to the need for some government role in the health care market. First, many Americans cannot afford the true cost of health insurance premiums. In the consumer markets for luxury foods, clothing, or automobiles, that is an acceptable fact of life. But with health care, society as a whole recoils.

Second, health care differs from the classic free market extolled in textbooks due to large imbalances in information and market power between consumers and providers of health care. Health care is not a standardized product or service, where consumers easily can comparison

shop for price and quality. Even if someone wanted to, it is effectively impossible to learn the quality or price of most medical procedures before receiving them. More fundamentally, understanding various illnesses and health conditions, their potential treatment options, and the likely outcomes and risks requires highly technical expertise that health professionals spend years acquiring. Americans turn to their physicians to tell them what health services they should receive for this very reason.

The market for health insurance — which is what most health care consumers “purchase” rather than purchasing services directly from health care providers — also is highly complex. Even among highly educated Americans, how many actually understand what co-pays, deductibles, co-insurance, and maximum out-of-pocket limits are and how they interact to determine ultimate costs? Consumers need decision support in the highly complex world of health insurance.

Finally, most health care necessarily is local. Especially when we are seriously ill or injured, few can travel far for treatment. As a result, compared to other industries, it is easier for health care providers to achieve geographic monopolies (such as through hospital space or investments in specialty equipment) and use that market power to charge higher fees.⁶ Another geographic challenge of health care is the difficulty of adequately and efficiently serving rural areas, where low population density can reduce both the choice of and access to providers.

Consumers, providers, employers, and government are all part of the solution

For the reasons described above, government has a necessary and appropriate part to play even within a primarily market-based approach to health care. Government has a role in making health insurance affordable for those who cannot afford the true cost of premiums on their own. Americans value life and health, and they do not want to see individuals going without needed care due to inability to pay.

“Government’s role...is to provide essential support and guidance, not control.”

Government also has a role as the provider of information that doctors and patients can use to make their own decisions. While the doctor–patient relationship is central, consumer preferences should motivate how health insurance plans deliver care and interact with patients, which will require research and data to develop standards of practice for physicians and guidance for patients.

Government’s role in that process is to provide essential support and guidance, not control.

Patients and consumers also have an integral role in helping health care reform succeed by making good decisions about their health, both in terms of investing more in being healthy and making informed decisions about the health care they use. And employers are well situated to drive “positive disruption” through their ability to encourage healthier behaviors from their employees and through aggressive adoption of preventive and chronic care programs.

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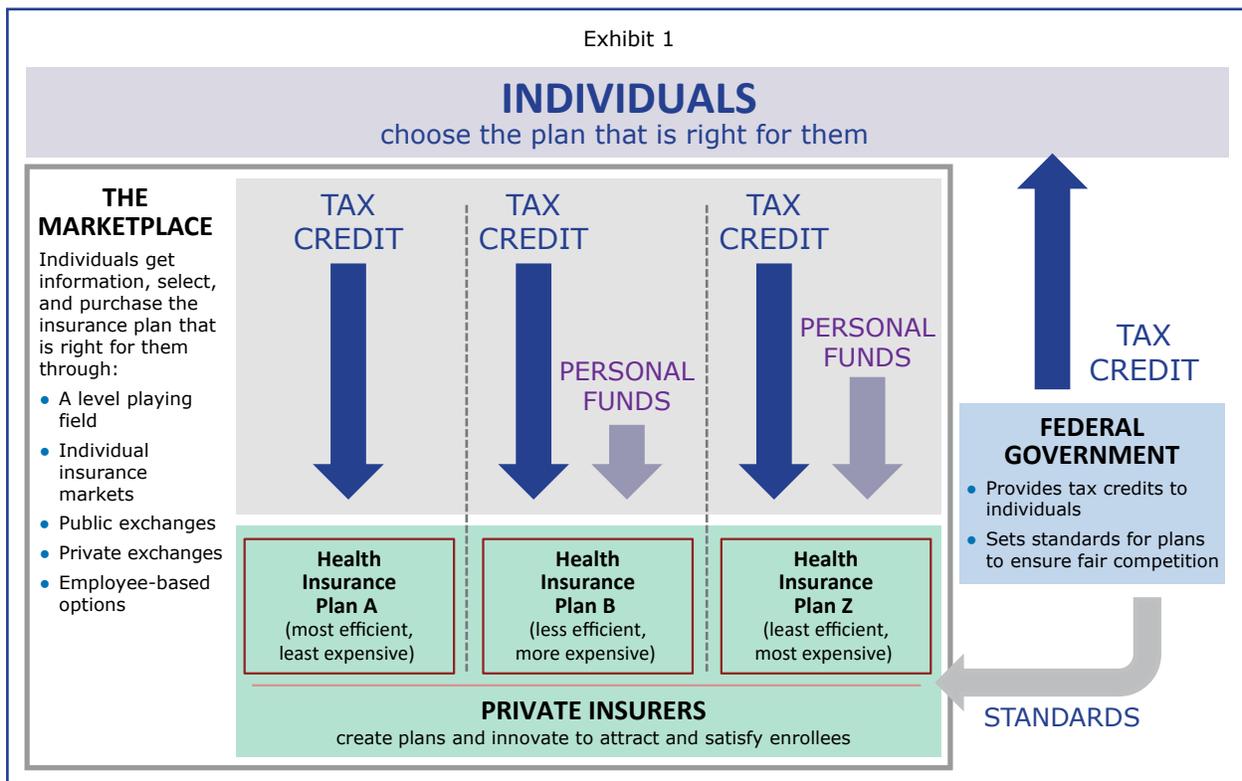
Specific Recommendations for Replacing/Reforming the Affordable Care Act

Americans generally have judged some elements of the ACA to be positive and those should be retained. Specifically, reform or replacement legislation — whichever term is preferred — should continue to:

- Prohibit insurance companies from denying coverage or charging higher premiums due to preexisting conditions;
- Prohibit lifetime limits for health care costs;
- Prohibit “rescission” of coverage for immaterial inaccuracies of reporting on applications;
- Allow parents to include their children on their policies until age 26; and

- Require standardized and simplified enrollment and paperwork for health insurance.

However, policymakers must understand the prerequisites of these benefits. In particular, purely voluntary enrollment in health insurance without discrimination against preexisting conditions would encourage the healthy to refuse to contribute to the risk pool until they become sick. That would lead to an insurance “death spiral” in which premium costs rise because the healthy do not pay premiums, thus encouraging more of the healthy to refuse to enroll and raising premiums still further. Accordingly, the following recommendations for changes to the ACA are chosen to spread the costs and benefits in a market-oriented, sustainable way.



1. Provide all Americans refundable tax credits to buy health insurance

Every American should receive a refundable, advanceable⁷ tax credit, usable only to purchase health insurance (Exhibit 1, p. 6). The amount of the tax credit should equal the annual premium of the second-lowest-priced insurance plan available in the individual's region that meets basic standards of coverage.⁸ Individuals who choose a more expensive plan could use the tax credit toward the cost, but they would be personally responsible for the premium cost over the tax credit amount. This tax credit will help prevent "job lock" because individuals would no longer need to stay in a job they no longer want simply to obtain affordable health insurance.

All applicants accepted at the same price

Insurance plans would be required to accept every applicant and to charge uniform premiums, regardless of age or preexisting medical conditions.

Fiscally sustainable financing through broad-based taxes

The tax credits should be financed with fair, broadly based taxes rather than deficit-financed. The funding source should not be linked to people's selection of particular health insurance plans.

Minimum coverage standards

Minimum quality and coverage standards for health insurance plans will be necessary to discourage a "race to the bottom" that would tempt insurers to post unrealistically low premium prices to attract uninformed consumers. To protect consumers, regulations would specify coverage standards for health insurance plans (and standardized language within the plans) to meet those coverage requirements. The coverage standards should include a defined list of conditions that plans must cover and the services required to remedy those conditions. The development of these standards will require input from all parts of the health care system and will be controversial, but essential — just as are similar standards in current state insurance regulation.

Equal credits for all Americans without means testing

If the tax credits are financed through broadly based taxes, then every American would be entitled to tax credits through the program because all Americans will have contributed their fair share toward paying for it. Tax credits should not be means-tested, so that program administration is simple and insurance plan pricing fully transparent.

Co-pays and deductibles help make people cost-conscious, but the out-of-pocket cost share must not be so large that typical consumers cannot afford it. Partial or even full coverage of co-pays and deductibles must be available for consumers who now are Medicaid-eligible.

"Every American should receive a refundable, advanceable tax credit, usable only to purchase health insurance."

Under this plan, individuals will have the opportunity and incentives to make cost-conscious choices. Individuals will be able to save money — dollar for dollar — if they choose less-expensive, more-efficient plans that meet basic quality standards. They will still be free to choose more expensive health insurance plans, but they will be responsible for the incremental cost if they do so.

Under this approach, insurers will have an incentive to organize with health providers to offer high-quality, affordable care that individual consumers want. Consumers could change plans freely at annual open seasons for any reason, but particularly if dissatisfied.

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2. Restructure and augment the ACA's public health care exchanges

Health insurance exchanges in essence are marketplaces for the purchase and sale of health insurance. They serve an important purpose in helping consumers shop for and compare health plans. They can facilitate informed consumer choice by enforcing protections and providing impartial information and guidance, and they are also simple mechanisms for consumers to enroll in a wide variety of high-quality plans. The public exchanges should be retained but improved.

First, exchanges should be open to all individuals in the region served by the exchange and offer all health plans that meet coverage standards. The exchanges should make plans available on a level playing field, with sound consumer protection and full information.

Second, the exchanges should correspond to the natural geographic market for the delivery of health care in a region, which might be larger or smaller than a particular state and might cross state lines.⁹ Determining market areas will require judgment and creativity: the markets should be based on geographic areas within which health care is practiced and marketed on a relatively uniform basis, rather than based simply on political boundaries, such as state lines.

3. In addition to public health exchanges, allow Americans to obtain insurance in a broad variety of ways

Health exchanges offer many advantages, but Americans should remain free to obtain health insurance through a wide variety of access points, including the individual insurance market, public exchanges, private exchanges, and employer-based insurance. Some employers might still want to band together in a private exchange as a benefit to their employees. Private insurance brokers and the individual market may continue to operate. Consumers' preferences and market forces will determine which access points (and insurance plans) will predominate, thereby contributing to a more competitive market for health care.

Consumers will continue to need apples-to-apples comparative information about plans, even if they are purchasing insurance outside a public exchange. Sound information standards should apply to all access points.

4. Use refundable tax credits to eliminate the individual mandate

Refundable tax credits would allow every American to obtain health insurance at no out-of-pocket cost through enrolling in the most-efficient, least-expensive plan in his or her region that meets his or her family's needs and preferences. Anyone who did not use his or her refundable credit to enroll in this least-expensive plan would be passing up cost-free health insurance. Even if some Americans delay obtaining health insurance, they still would have paid (directly or indirectly) the broadly based taxes that finance the system and, thus, would have fulfilled their responsibilities to contribute to the risk pool.¹⁰

5. Use public health exchanges to eliminate the employer mandate

This proposal would provide every American access (through the health exchanges and other access points) to purchase health insurance and the financial means (through the refundable tax credit) to do so. Under this approach, it would no longer be necessary to require employers, regardless of size, to offer health insurance to their employees. Employers that want to devote resources to provide health plans for their employees will be free to do so. But firms that do not will be able to rely on the market to provide high-quality affordable care to their employees.

"This proposal would provide every American access...to purchase health insurance and the financial means...to do so."

The ACA suffers from tension between the employer mandate to provide coverage and the reality that many firms, especially comparatively smaller ones, are not well suited to do so. Smaller firms often lack the administrative economies of scale and the capacity for the complex task of delivering health insurance. Similarly, many lack enough employees to create a stable risk pool. Sometimes a small company's health insurance premiums will suddenly skyrocket simply because its employees were sicker than average that year or because a particular employee (or his or her family member) experienced a catastrophic illness or injury. If employees have the option to buy affordable insurance on public exchanges where risk is pooled more broadly, there will no longer be the need to require employers to offer health insurance.

The tax treatment of employer insurance must be on a level playing field with the tax treatment of insurance purchased on the exchange. An employee choosing his or her employer's plan still should be required to contribute his or her tax credit in payment for the health coverage. If the firm chooses to spend more than the amount of the tax credit on delivering health care coverage, then the excess should be attributed to the employee as taxable income.

6. Risk-adjust premium revenue

Under this proposal, health insurance plans would be required to accept all applicants at a uniform price (for that geographic market), regardless of age or preexisting conditions. This potentially could unfairly penalize those health insurance plans and providers that end up enrolling a "sicker" population that has more costly conditions, or inducing plans to discourage sick people from enrolling. To prevent these problems, it will be necessary to risk-adjust premium revenues to compensate insurance providers that serve individuals who are "sicker" than the general population in that market. All premium revenue for a geographic market would go into a central fund rather than to the individual plans in that

region, and the fund would be distributed among the plans according to their stated premiums but adjusted for the relative riskiness of their enrollees compared with the population at large.

Risk adjustment of premium revenue will encourage plans to participate in the exchanges because plans that care for patients who are more costly, on average, would be rewarded for doing so.

7. Allow health insurance to be sold across state lines

Currently, health insurance is state regulated and, as a result, cannot be sold across state lines. This is one of the most significant barriers to competition, innovation, and the creation of a broader variety of insurance and health care plans. State regulatory requirements can differ significantly. The need to obtain new and additional regulatory approvals can inhibit even the most effective plans from expanding across the country.

To change this, our approach would allow an alternative federal regulatory path for insurance providers to get plans approved for sale nationwide. This would be an enormous boon to competition and innovation, since the finest health care plans more easily could market their expertise across the country.

Offering insurance across state lines will not be a panacea. A New York consumer, for example, could not buy an insurance policy at small-town rates and then carry it into a physician's office in midtown Manhattan. However, allowing insurance providers to offer plans in similar markets — even when they cross state lines — or to design plans for out-of-state market areas will enhance competition. And most significant, allowing highly efficient integrated systems to open new branches in high-cost areas could disrupt those stagnant geographic markets.

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8. Lower regulatory barriers to encourage innovative and “disruptive” providers and approaches to health care delivery

Perhaps most important, market-based health care reform will require both regulation and antitrust policy. Regulation should aim at fostering competition and ensuring the integrity of products and services, whether they are health care products and services — such as drugs and procedures — or insurance plans. Regulatory policy should encourage market entry by new and innovative types of plans (or by products or services that are effective substitutes for existing products and services) and protect consumers from unsafe treatments and unqualified providers.

“Regulation should aim at fostering competition and ensuring the integrity of products and services, whether they are health care products and services — such as drugs and procedures — or insurance plans.”

Regulation should set fair, uniform standards for plans, where necessary, and allow variety and innovation whenever possible. It will be challenging to decide where to draw the regulatory line, but drawing it skillfully will allow different health care plans to compete on a level playing field, while still encouraging innovation that adds value in the marketplace.

The insurance system must be open to new and disruptive plans and systems. Each observer of health care will have his or her own concept of the best plan design, but every alternative ultimately must be left to the verdict of the marketplace. New models will be developed continuously into the future, but, at any time, several alternatives will compete. The reason for such anticipated diversity is that different people have different preferences for coverage and care.

In sharp contrast, many policymakers and commentators seek to use the power of government to drive consumers into consumer-directed health plans (CDHPs), which would be coupled with tax-favored health savings accounts (HSAs). CDHPs are available at low premiums, but they feature larger-than-normal co-pays and deductibles. Consumers of modest means would pay their out-of-pocket costs when they are sick by relying on balances in their HSAs.

CDHPs are good choices for some consumers, and, like all alternative models that meet sound standards, they should be able to compete. But the health care system should not rely solely on CDHPs and HSAs. Instead, insurance should be a free market; it is neither appropriate nor constructive for government to try to impose its judgment on consumers.

The thrust of CDHPs and their high deductibles is to require consumers to make micro-level choices, including among individual providers and treatments. This puts most CDHP enrollees into an all-provider, “fee-for-service” mode of care, which does not promote coordinated and continuing care. CDHPs have their greatest effect in deterring “preference-sensitive,” comparatively small-dollar expenses that are cumulatively less than the amount of the annual deductible. But the nation does not face a cost crisis in health care due to small-dollar expenses; rather, most health care dollars are spent on a comparatively small number of people who incur very large bills for multiple chronic conditions or catastrophic acute episodes. Those relatively few individuals know from the outset that their treatment costs will far exceed any CDHP deductible and thus have no incentive to limit their health care spending.

“...insurance should be a free market; it is neither appropriate nor constructive for government to try to impose its judgment on consumers.”

In addition, there is a danger that some consumers will incur substantial expenses and find that they cannot afford their CDHPs' co-pays and deductibles. This would be especially true for those who are responsible on their own for making the deposits in their HSAs. Many might postpone doing so in the face of other expenses and then find themselves unable to pay. One painful experience under the ACA has been comparatively low-income consumers attracted into high-deductible plans because of the low premiums, but then unable to pay their medical bills. Achieving coverage for all was believed to end the problem of hospitals with substantial unrecoverable billings, but with the ACA's incomplete coverage and the popularity of high-deductible plans, that has proved not to be the case.¹¹

“Government has an appropriate role to play in empowering the decision-making of patients, physicians, and other health care providers through the collection, funding, and communication of impartial research on what works in health care.”

If CDHPs prove to be effective at reducing health care costs, as some claim, then the premium costs of CDHPs might include full funding of the associated HSAs as a matter of course. However, this potential problem extends to all plans with high co-pays and deductibles, and consumers with modest resources should be fully informed when they exercise their choices.

9. Create an organization to support and communicate research on what works in health care

A lack of clear information is one of the biggest barriers to the effective functioning of free markets in health care. Government has an appropriate role to play in empowering the

decision-making of patients, physicians, and other health care providers through the collection, funding, and communication of impartial research on what works in health care.

Ideally, such an organization would facilitate the free flow of information from a variety of reliable sources. It would be an impartial research and data-sharing organization that would collect and disseminate information on what works in health care, including estimating the effectiveness of various treatments in particular circumstances. The organization also would fund and enable research on what works in health care and might perform some research itself. It would serve as a user-friendly clearinghouse for studies, evidence-based medicine, and recommended treatments for patients, physicians, and other health care providers.

While research is occurring that addresses some of these questions, the United States requires a more coordinated and aggressive approach to building the knowledge we need — both as individuals and as a nation — to make health care decisions that ultimately account for approximately 18 percent of the nation's GDP.¹²

We see such a research organization as a fundamentally redirected alternative to the ACA's Independent Payment Advisory Board (IPAB). The goal would be to inform the physician-patient relationship rather than potentially interfere with it.

10. Enact more aggressive tort reform

Our current malpractice system spends too much money, takes too long, and too often reaches the wrong conclusion. Expert courts and arbitration would cut the time taken to resolve malpractice disputes. The research entity described above could codify its findings on best practices into “safe harbor” treatment for health care providers, such that those who could document that they followed best practices would have a rebuttable presumption against malpractice.

Tort reform of this type will reduce costs by making the practice of “defensive medicine” unnecessary.

The Future of American Health Care: Higher Quality Care for All at Lower Cost

America's health care system is highly complex with many moving parts. Without actually enacting the reforms described in this brief, no one can say with certainty precisely how consumers, providers, and insurers will react. However, if the market-based reforms listed above are enacted, we believe that the United States will see the following benefits:

- Americans will be able to choose among a broad variety of health insurance plans, as providers are enabled and incentivized to innovate.
- Employers will continue (or begin) to offer plans for their employees but will not be required to do so if their circumstances are unfavorable.
- A more constructive employer role in providing health care to employees will emerge, one that is better matched to employer size and capabilities. Under this proposal, firms could offer plans to their employees, serve as exchanges for their employees, join private multiemployer exchanges, or merely provide advice to their employees. All such options would include risk adjustment of plan revenue, and all employees and plans would be treated equally regardless of employees' choices of plans.
- Consumer preferences and market forces will determine which health plans predominate, without imposed restrictions.
- From choice will flow a richer variety of plans, with more vigorous competition among them.
- Enhanced competition will lead to high rates of product and business-model innovation, as innovation extends across the entire health care enterprise, including both care itself and back-office support activities.

- The resulting health care system will elicit greater satisfaction from consumers, yield more stable government budgets, and make American businesses more competitive by reducing the crushing and rapidly growing costs of providing health insurance.

Beyond its life-or-death human impact, health care is the single crucial determinant of financial well-being in the United States today. It currently drains the budgets of households, businesses, state and local governments, and the federal government alike.

“Quality, affordable health care should be provided to all through the constructive use of market forces.”

Quality, affordable health care should be provided to all through the constructive use of market forces. The “invisible hand” of the market can work if the market is open and fair. In health care, that is a difficult standard because health care is highly complex, consumer information is limited, and important decisions are often made in emergencies and under emotional stress. Therefore, public regulation is needed, but it must be measured and well-directed to maintain both effective market forces and the human values that Americans hold.

We believe that this approach is the most promising answer to the continuing challenge of achieving health care quality, affordability, and access. We recommend these ideas to our fellow businesspersons and our elected policymakers as well.

Endnotes

- 1 NHE Fact Sheet, Centers for Medicare & Medicaid Services (www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpendedata/nhe-fact-sheet.html).
- 2 See *Adjusting the Prescription: Committee for Economic Development Recommendations for Health Care Reform*, Committee for Economic Development, April 23, 2015 (www.ced.org/reports/single/adjusting-the-prescription-ced-recommendations-for-health-care-reform) for details of CED's critique of the Affordable Care Act.
- 3 Also see *Modernizing Medicare*, Committee for Economic Development, October 19, 2016 (www.ced.org/reports/single/modernizing-medicare) for CED's recommendations for reforming Medicare.
- 4 Christina LaMontagne, "NerdWallet Health Finds Medical Bankruptcy Accounts for Majority of Personal Bankruptcies," NerdWallet blog, March 26, 2014 (www.nerdwallet.com/blog/health/medical-bankruptcy/).
- 5 *The Federal Budget Deficit and the Public Debt: Why and How to Deal with a Lurking Problem*, Committee for Economic Development, December 2016 (www.ced.org/pdf/CED-Fiscal-Health-Policy-Brief.pdf).
- 6 See the discussion in Alain Enthoven and Joseph Minarik, *Health Care in California and National Health Reform*, Committee for Economic Development, June 22, 2010 (www.ced.org/reports/single/health-care-in-california-and-national-health-reform) p. 20.
- 7 That is, the credit would be available to each household at the beginning of its policy period to pay its premium in a timely manner.
- 8 Alternatively, the amount of the tax credit could be set to the average premium of a small number of plans in the lowest tier of premiums in that market. The premium credit should not be set on the basis of the overall average of all plans. That would increase the credit in response to every premium increase by every plan — even the least efficient — and would reduce both consumer cost-consciousness and competitive pressure on plans. Coverage standards are set by state regulators under the current system; CED encourages alternative federal regulatory approval to encourage market-based competition across state lines.
- 9 Under the ACA, exchanges generally correspond to state boundaries.
- 10 People who fail to sign up for coverage at the outset of the new system could be enrolled in their region's least-expensive plans when they first seek care. Because all Americans will pay their share of the costs of the health care tax credits through the broadly based taxes that will finance the program, "continuous coverage" requirements are not necessary under the CED approach.
- 11 Robert Pear, "Many Say High Deductibles Make Their Health Law Insurance All but Useless," *New York Times*, November 15, 2015, p. A22 (www.nytimes.com/2015/11/15/us/politics/many-say-high-deductibles-make-their-health-law-insurance-all-but-useless.html).
- 12 Centers for Medicare & Medicaid Services, "National Health Expenditure Data, Historical" (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>).

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