TIAA-CREF institute

POLICY BRIEF

FEBRUARY 2011

MISCONCEPTIONS ABOUT HEALTH INSURANCE MARKETS AND HEALTH REFORM

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EXECUTIVE SUMMARY

Several myths about health insurance pervaded the health reform debate and interfered with plans for implementation. Many are built on a kernel of truth, but the simplification of complicated issues can lead to conclusions that are misleading, or just wrong. In this article, we draw on economic principles and empirical research to examine the arguments that underlie these misconceptions and the fundamental challenges these issues pose for the successful implementation of health reform.

1. ***Misconception: People need health insurance because health care is expensive.*** *Reality*: We need health insurance not because health care is *expensive* (it is), but because it is *risky*.

2. ***Misconception: Covering the uninsured will pay for itself: spending will go down because they will get care that is cheaper than what they get now in the ER.*** *Reality:* Increasing coverage is expensive, but can be money well spent.

3. ***Misconception: Preventive care pays for itself: health care spending will go down if we invest more in prevention.*** *Reality:* More prevention would be great for our health, but not necessarily our wallets.

4. ***Misconception: If everyone had insurance coverage, everyone would get high quality health care.*** *Reality:* insurance is no guarantee of high quality care.

5. ***Misconception: Employers can and should shoulder more of the burden of rising health care costs for their employees.*** *Reality:* Employees pay for the health insurance that they get through their employer, no matter who writes the check to the insurance company.

6. ***Misconception: High medical malpractice awards have driven up health care spending dramatically and driven providers out of practice.*** *Reality:* The malpractice system may be broken, but defensive medicine accounts for only a small share of health care spending.

7. ***Misconception: Pharmaceutical company profiteering is responsible for driving up health care costs.*** *Reality:* While there are reasons to question the value of new innovations in the pharmaceutical industry, targeting manufacturers' profits is unlikely to improve value or health.

8. ***Misconception: Moving to high deductible plans would have fixed our health care system's problems by lowering expenditures and increasing value.*** *Reality:* Greater patient cost-sharing would help, but it's not the magic bullet that some make it out to be.

9. ***Misconception: Having a single-payer would have fixed our health care system.*** *Reality:* Despite the calls of many for a single payer system in the recent debate, the evidence on this point is a lot more mixed than advocates suggest.

INTRODUCTION

We know that our health care system is not delivering the consistently high-quality, high-value care that we should expect. Successful implementation of health reform will depend on moving beyond these misconceptions to improve the coverage and value of health care our system delivers.

The recent passage of the Patient Protection and Affordable Care Act (PPACA) will dramatically change the landscape of health insurance coverage in the U.S. The passage of the law is the first step down a long and complex road, however: there are aspects of the implementation that will shape the actual impact of the Act on both cost and coverage. Understanding the effects of the legislation and evaluating different implementation options depends on understanding insurance markets and health care fundamentals.

Several misconceptions about health insurance pervaded the reform debate and continue to color the debate on implementation. While many were based on genuine concerns and built on a kernel of truth, the simplification of complex issues often led to misleading conclusions. In this piece, which draws on a recent article we authored in *Health Affairs*, we use economic principles and empirical research to dispel these misconceptions and to draw lessons about the issues that will drive the success of implementation.[1]

MISCONCEPTION: PEOPLE NEED HEALTH INSURANCE BECAUSE HEALTH CARE IS EXPENSIVE.

Reality: We need health insurance not because health care is *expensive* (it is), but because it is *risky*. We face the risk of becoming ill and then needing to pay for vital and expensive medical care, and insurance is a way to protect against that risk. Lots of other things are expensive, including housing and college tuition, but we don't have insurance to help us purchase them because they are not uncertain in the way that health risks are. If it were certain that we'd fall sick, or if falling sick were entirely under our control, we would need to purchase health care but we would not need health *insurance*.

Insurance works by pooling risks: many people pay a premium up front, and then those who face a bad outcome (getting sick) get their health care bills paid out of those collected premiums. The system stays afloat because while sick people receive benefits that are greater than their premiums, there are enough healthy people receiving benefits that are lower than their premiums that the average premium can pay for the average benefit for the pool as a whole. Insurance is valuable because enrollees do not know ahead of time what their health costs will be, and face a risk of needing much more health care than they can comfortably afford. Insurance reduces this financial risk: the more uncertainty there is, the more you value the insurance. Once insured, enrollees should be guaranteed that their premiums will not rise just because they got sick, which is not always the case today. Nor are insurers held responsible for missed diagnoses or complications that affect a later insurer (including Medicare, the public insurance program for those over age 65). These are the real reform issues that are often glossed over in the confusion about the role of health insurance.

Because insurance is about reducing risk for an individual by diversifying these risks across a pool of households, it is impossible to "insure" against an adverse event that has already happened, for there is no longer any uncertainty. A well-functioning health *insurance* system cannot be designed around the transfer of resources to uninsured sick people: uninsured Americans who are sick need health care, even expensive health care, but not health insurance. This is why a ban on basing health insurance premiums on preexisting health conditions can only work in the presence of an individual mandate. The mandate ensures that people buy insurance before they know whether or not they will require expensive health care.

It is important to distinguish between *private* insurance and *social* insurance. Social insurance is about redistributing resources – from rich to poor, from healthy to sick. Private insurance markets can pool risk in a population ex ante before bad (insurable) events occur, but they cannot redistribute resources ex post from populations with known low need to populations with known high need. This redistribution is a primary function of public programs.[2]

MISCONCEPTION: COVERING THE UNINSURED WILL PAY FOR ITSELF: SPENDING WILL GO DOWN BECAUSE THEY WILL GET CARE THAT IS CHEAPER THAN WHAT THEY GET NOW IN THE ER.

Reality: This is a common and deceptively appealing argument for expanding insurance coverage: we could spend less and get more, and who could be against that? But, as with most prescriptions that promise something for nothing, this misconception finds little empirical support. The health insurance coverage expansions in PPACA are very expensive, but the costs are balanced by increases in revenues from other sources. This is why the law overall does not increase the deficit – not because covering the uninsured is free.

Yes, ER care for the uninsured is inefficient and might have been avoided through more diligent preventive care. But research demonstrates that insured people consume more care than uninsured people – which is why the provisions in PPACA that increase coverage raise, not lower, government spending.

Why do the insured consume more health care than the uninsured? Insured patients do not face the full cost of seeing a physician or requesting a procedure (they only pay a copayment whose size is much smaller than the true cost of seeing a physician), so they are likely to receive care even if its costs exceed its benefits. This well-documented phenomenon is known as 'moral hazard' (even though there's nothing moral or immoral about it, and many non-economists do not accept the notion that patients respond to prices). This incentive to get more care is reinforced at the system level: when Medicare was introduced in 1965, providers made spectacular investments in high-tech care; hospital spending surged over 25 percent in 5 years.

This doesn't mean that covering the uninsured isn't money well spent. Spending more to expand insurance is not a problem if it generates more value than it costs (and the view that health care is a right is not inconsistent with this framework). First, and often overlooked, is the security that insurance provides against the uncertainty of unknown health care expenses: it reduces anxiety and medical bankruptcies and helps to smooth out the potentially enormous financial "shocks" that come with an unexpected illness. The value of this financial smoothing alone is estimated to be almost as much as the cost of providing people with insurance. Second, much of the additional health care that the newly insured would receive is likely to be quite therapeutic (But this is by no means automatic. As we discuss below, being insured is not enough to guarantee good health care.) Expanding health insurance is worth it for these reasons – but not because it would save money.[3]

MISCONCEPTION: PREVENTIVE CARE PAYS FOR ITSELF: HEALTH CARE SPENDING WILL GO DOWN IF WE INVEST MORE IN PREVENTION.

Reality: More prevention would be great for our health, but not necessarily our wallets. Some preventive care has been shown to be cost-saving – such as flu vaccines for toddlers or targeted investments like initial colonoscopy screening for men aged 60-64 – but most prevention results in greater spending and better health outcomes. Consider the example of a lethal and fast-acting disease: if you could develop a vaccine that would prevent people from getting this disease, they would live longer and healthier lives, but over the course of their lives they would contract other illnesses that might be very expensive to treat, and would eventually die from something that might require more health care than the lethal disease. Their lifetime health spending would be higher because of the vaccine, not lower. Does this mean that the development and wide-spread use of this vaccine would be a bad thing? Of course not. But we should be spending money on prevention with the intention of improving health, not saving money.

It is worth drawing a distinction between preventive screening and preventive behaviors. An example of the first is screening for diabetes or breast-cancer, and of the second are persuading patients to eat better or be more compliant with their diabetes medications. The first type of prevention—preventive *care*—is not always cost-effective at improving health. Estimates suggest, for example, that screening all 65-year-old men for diabetes, rather than just those with high blood pressure, costs almost $600,000 per year of life gained, compared with some screening procedures for newborns that cost less than $200 per year of life gained. Some measures may even raise costs and worsen health outcomes in the long run, such as screening for slow-growing cancers in older populations that results in risky surgeries without the promise

of increasing life-expectancy. On the other hand, encouraging good preventive *behaviors* may be cost-effective, but our knowledge of how to change patient behavior is in its infancy. While this strategy may pay off, it remains unproven at this time. Indeed, many trials of comprehensive interventions that have attempted to change behaviors have failed.[4]

MISCONCEPTION: IF EVERYONE HAD GENEROUS INSURANCE COVERAGE, EVERYONE WOULD GET HIGH QUALITY HEALTH CARE.

Reality: Simply covering the uninsured isn't enough to ensure broad access to the best care our system has to offer. An immense literature in medicine finds that even among patients insured by the Medicare program (which is universal health insurance for people over the age of 65), there are enormous differences in quality: in fact, in areas where the *most* is spent on Medicare beneficiaries, they are the *least* likely to get high quality care. Mammograms, flu-shots, the use of beta-blockers and aspirin for heart-attack patents, rapid antibiotics for pneumonia patients, and the use of simple laboratory tests to evaluate the management of diabetes are all lower in higher-spending areas. Higher spending isn't even associated with lower mortality. So we should discard the over-simplified notion that more spending guarantees better care or even basic preventive care.

When these results showing the lack of relationship between spending and quality were first reported there were two predictable responses by skeptics: that high spending areas had sicker patients who were (appropriately) less likely to receive these therapies, and that patients in high-spending areas had higher satisfaction even if their measurable health outcomes were the same. Neither claim is supported by the evidence: there is no evidence that sicker patients are less likely to receive these therapies, nor do patients in high-spending regions report being more satisfied with their care.

What, then, do patients in high-spending areas get? They are no more likely to receive surgery, but they're likely to have more specialist visits and much shorter intervals between office visits, more diagnostic and imaging services, and much more intensive care in the end of the life. These are services of uncertain clinical benefit—trials have not established the "optimal" number of office visits for a patient with diabetes, or the number of times a cardiologist should evaluate a person with chest pain. High-spending areas have a physician workforce that is comprised of a greater share of specialists rather than generalists. And while specialists may be very good at treating specialized conditions (in addition to using expensive procedures with questionable health benefits), their presence may also introduce the possibility of "coordination failures," making it more difficult to deliver less-intensive preventive and routine care of known high value.

In summary, while it is certainly true that having health insurance has the potential to increase access to high-quality health care, the link is by no means automatic. Simply insuring the uninsured will give them access to the sort of health care that the rest of us receive: a combination of valuable care, overuse of interventions with little proven benefit, and the under-use of important therapies. This is better than no care, but it highlights the challenges faced by health reform: health insurance alone does not guarantee good health care[5]

MISCONCEPTION: EMPLOYERS CAN AND SHOULD SHOULDER MORE OF THE BURDEN OF RISING HEALTH CARE COSTS FOR THEIR EMPLOYEES.

Reality: Employees ultimately pay for the health insurance that they get through their employer, no matter who writes the check to the insurance company.

The view that we can get employers to shoulder the cost of providing health insurance, and much of the debate underlying the new employer mandate in PPACA, stems from the misconception that employers pay for benefits out of a reservoir of profits. Regardless of a firm's profits, however, valued benefits are paid primarily out of workers wages. While workers may not even be aware of how much their total health premium is, employers make hiring decisions based on the total cost of employment, including both wages and benefits such as health insurance, maternity leave, disability and retirement benefits. They provide health insurance not out of generosity of spirit, but as a way to attract workers – just like wages. When the cost of benefits rises, wages fall (or rise more slowly than they would have otherwise), leaving workers bearing the cost of their benefits in the form of lower wages.

The uncomfortable arithmetic of this wage-fringe offset is seen in other contexts – for example, workers bear the costs of workers compensation, and mandated maternity benefits primarily reduce the wages of women of child-bearing age. When it is not possible to reduce wages, employers may respond in other ways: employment can be reduced for workers whose wages can't be lowered, outsourcing and a reliance on temp-agencies may increase, and workers can be moved into part-time jobs where mandates do not apply. This means that employer mandates have the potential to decrease employment as well as slow wage growth, depending on the size of the penalties and details of implementation.

This also means that the connection between health care costs and the "international competitiveness" of U.S. industry is murky at best: higher health costs lower workers' non-health compensation, rather than firms' profitability. It also bears mentioning that while the cost of health insurance has risen steadily over the last 20 years, the share of the premium paid to insurers directly by workers has remained constant at just under 30 percent – but this division does not change the fact that in the long run workers pay for the benefits they get through their employer.

This is not to say that there aren't advantages to getting insurance through an employer instead of on the individual (non-group) insurance market, especially when the individual market does not provide risk pooling – a limitation that is not rectified by the exchanges created under PPACA. Employer plans are currently the primary avenue for risk-pooling – where people with common risks form a common pool, and then those who become sick do not see an increase in premiums in subsequent years. In the absence of effective risk-pooling or a combination of mandatory participation and complete social insurance, healthy patients pick lean insurance offerings and sick patients pick more generous plans, and premiums for these policies diverge. It is this risk-pooling that is the main advantage to access to employer policies, not the fact that employers nominally pay part of the premium.[6]

MISCONCEPTION: HIGH MEDICAL MALPRACTICE AWARDS HAVE DRIVEN UP HEALTH CARE SPENDING DRAMATICALLY AND DRIVEN DOCS OUT OF PRACTICE.

Reality: It is commonly asserted that high malpractice awards are the reason that health care spending in the U.S. is larger and growing faster than in other countries. Trade associations such as the American Medical Association and the insurance industry have forcefully argued that litigious patients and lawyers spurred on by reckless juries have driven up malpractice payments and, in turn, malpractice insurance premiums. Some physicians respond by practicing "defensive medicine" – ordering medically unnecessary tests and procedures to reduce the threat of litigation. Others have been forced to leave practice. The story is compelling and makes for sensational cover stories. But it overstates the role of the medical malpractice system.

There are both direct and indirect costs of malpractice litigation. Direct costs, which include the cost of defending claims, payments made on claims, and the administrative costs of liability insurance, are less than half a percent of health care spending (under $10 billion out of the approximately $2.4 trillion the U.S. spent on health care in 2008). 70 percent of this is the cost of payments, 20 percent the cost of defending against claims, and 10 percent the cost of administering malpractice insurance.

Three frequent stakeholder claims about the growth of *direct* costs are suspect. The first misleading claim is that payments against physicians have sky-rocketed: it is often backed by data that are not adjusted for inflation, and without accounting for either reductions in jury awards or the fact that 95 percent of payments are settlements, not jury awards. The second claim is that payment increases are driving malpractice premiums up, and it also is not supported by the data: states where payments shot up are not states where malpractice premiums increased. The vagaries of the insurance underwriting cycle better explains the movement in malpractice premiums. The third claim is that areas with more litigation have seen greater reductions in the physician workforce. Even the largest estimates of this alleged exodus are small (3 percent), and there is no evidence of adverse effects on patient access to care.

More difficult to measure are the *indirect* costs generated when providers practice defensive medicine. Estimates of these effects vary, but recent estimates suggest that total costs of the system are less than 2.5 percent of overall health

expenditures. Some providers claim that malpractice lowers their spending because they avoid risky patients. Others may increase their use of imaging services (reacting in part to rational fear of the substantial time and psychic costs of dealing with malpractice suits), but there is little evidence of downstream increases in surgical rates. Thus, while the indirect costs of the medical malpractice liability system may be more substantial than the direct costs, they are still too small to be the primary driver of rising spending.

This does not mean that the malpractice system is functioning well to compensate the victims of negligence, however. Doctors can purchase malpractice insurance to insure against the payments that are made to successful plaintiffs, but they cannot insure against the hassle and emotional costs of this litigation. These non-monetary costs may be large and have little social value as there is no party that benefits from their presence. Nor is there evidence that more claiming frequency raises the quality of care received by patients—as would be expected if the threat of litigation caused providers to be more diligent. Other studies show that many patients who have been harmed by malpractice are not compensated by the system, while many of those who are compensated did suffer injuries but were not the victims of malpractice. Reducing these errors of omission and commission and improving the U.S.'s embarrassing record on medical errors are the real areas for reform. A preoccupation with the nominal growth of jury awards and the unsupported belief that damage caps will fix the malpractice system will do nothing for the productivity and safety of U.S. health care.[7]

MISCONCEPTION: PHARMACEUTICAL COMPANY PROFITEERING IS RESPONSIBLE FOR DRIVING UP HEALTH CARE COSTS.

Reality: While there are serious reasons to doubt the value of new pharmaceuticals, targeting manufacturers' profits is unlikely to improve value or health.

There are three problems with the view that the big profits of "big Pharma" are a big problem. First, there is nothing inherently wrong with health sector companies earning profits – as in other industries, the potential for profits drives innovation. While it's true that the non-profit sector has made stunning advances in drug discovery, we have no evidence that it's been able to compete with for-profits in the business of drug-delivery – that is, the vital process of taking a compound and figuring out the formulation and dosage. Second, it isn't clear how big those profits really are. Profits are notoriously hard to measure in industries with substantial R&D investments, and the usual measure of profit margins (administrative profits as a share of sales) is problematic with this kind of investment structure. Third, consider the following calculation (based on Reinhardt's methodology): about 12 percent of the U.S.'s annual health spending (or $200 billion) goes towards prescription drugs. Pharmaceutical manufacturers keep about 78 percent of sales, with the rest going to retailers and wholesalers. If profits are 17 percent of this (which is probably a substantial overestimate, given that the largest pharmaceutical manufacturers report profits of around 10 percent), total profits would be only $30 billion. Thus even eliminating pharmaceutical profits altogether would save less than 1.8 percent of total spending at most, and would likely seriously dampen innovation.

The more legitimate concern about the pharmaceutical industry is that newer products may not be generating as much benefit as they cost. This problem reflects a flaw in our patenting system that may make it too easy to patent a marginal innovation. Pharmaceutical companies can use aggressive marketing to persuade physicians to prescribe medications with low value or to use medications for "off-label" indications. The former may be wasteful, but the latter can do harm, as in the case of the use of Nesiritide as "tune-up" therapy for congestive heart failure. Similarly, because of our reimbursement system that does not reward value, manufacturers of devices (such as CTs or MRIs) have strong incentives to persuade providers to adopt exotic technologies with unproven benefit. The taxes on pharmaceutical companies in PPACA may raise revenues, but do not target a root cause of rising health care spending. Improving the value of care delivered by pharmaceuticals, screening equipment, and many other components of the health care system depends on making it more profitable to deliver high-value care than low-value care – not on taking the profit out of medicine.[8]

MISCONCEPTION: GREATER PATIENT COST-SHARING WOULD FIX OUR HEALTH CARE SYSTEM'S PROBLEMS BY LOWERING EXPENDITURES AND INCREASING VALUE.

Reality: Greater cost-sharing might help in some cases, but indiscriminant use might also cause harm. It is certainly true that first-dollar insurance coverage (that is, with very low cost-sharing) encourages use of care with very low marginal benefit and that greater cost sharing would help reduce the use of discretionary care of questionable value. But there is also evidence that patients under-utilize drugs with very high value when confronted with greater cost-sharing (whether because they lack resources or information). Worse, there is evidence that even $5 - $10 increases in copayments for outpatient care can result in some patients getting hospitalized as a result of cutting back too much on valuable care, more than offsetting the reduced spending.

There is no reason to think that the optimal insurance structure would look like the typical high-deductible plan. Rather, it might subsidize high-value care such as treatments to manage diabetes or asthma, while imposing greater cost-sharing on care of lower value, such as elective surgeries with limited health benefits. Of course, what may be valuable to one patient could be wasteful for another, and the key challenge for 'value based' insurance policies is to differentiate among these cases.

This does not mean that increased cost sharing isn't an important tool for improving the value of care, however. While most spending is indeed done by people with very high total costs (80 percent of health care dollars are spent by the 20 percent of people with the highest spending), well-designed cost sharing programs could still have substantial effects on spending decisions. First, most spending is not done in emergency settings. Second, even limited cost-sharing can have an effect on a substantial share of spending. This suggests that carefully designed incentives could have a big effect on improving the value of care delivered.[9]

MISCONCEPTION: HAVING A SINGLE-PAYER WOULD HAVE FIXED OUR HEALTH CARE SYSTEM.

Reality: Despite the calls of many for a single payer system in the recent debate, the evidence on this point is a lot more mixed than advocates suggest. In single-payer systems the government pays for health care, but this of course doesn't mean that the health care is free: people pay for it through higher taxes, which impose their own costs (rarely calculated by single-payer system advocates). Even more, it is not clear that moving to a single-payer system would cure our most pressing problems.

Our key challenges include spiraling cost growth, lack of accountability, and large (seemingly unproductive) geographic variation in health care spending. Are single payer systems more responsive to these challenges? Comparing the experience of Canada and the U.S. Medicare program sheds some light on this. Canada offers an example of a single-payer system: care provided by independent physicians and hospitals is "free" to patients, in that there are no copayments or deductibles. (Canadians still need to get insurance for prescription drugs, usually with cost-sharing.) The Medicare program is close to a single-payer system, although patients face some copayments. Unfortunately, both systems struggle with unfettered cost-growth that threatens their viability; the U.S. more than Canada. The two systems have different mechanisms for dealing with this pressure. The Canadian system rations resources, resulting in waits for some kinds of elective care (these waits are not inherently bad, but something that Americans may not tolerate). In response, there has been recent growth in private facilities that fundamentally undermine the "single payer" nature of the Canadian system, with private spending now comprising about 30 percent of Canadian health care spending (compared with over 50 percent in the U.S.). Medicare's unrestrained spending is gobbling up an increasing share of the Federal budget, crowding out other programs that could generate larger value. Moreover, both the Canadian system and Medicare exhibit enormous geographic variation in the quality and quantity of health care delivered, and in both more care isn't necessarily associated with better outcomes.

Some believe that a single-payer system could reduce administrative costs, fraud, and abuse. The most aggressive estimates suggest that the U.S. would save $160 to $200 billion per year by eliminating spending on excess billing, resolving disputed claims, and negotiating payments between providers and insurers. This is a lot of money, but is not likely a key component of system reform for several reasons. First, it represents only 10 percent of total health care spending and does not seem to be increasing in importance over time, so any savings would not likely slow the cost growth. Second, we do not know what share of that administrative spending is put to productive uses like reducing billing fraud, and should thus not be reduced. Third, we do not even know what the difference in administrative burden between Medicare and the Canadian system really is. For example, a large portion of these costs are calculated based on the value of physician time spent on paperwork, and since American physicians earn substantially more than Canadian physicians, administrative "costs" in the U.S. will mechanically be higher. As for the frequent observation that Medicare's administrative costs are lower than private plans in the U.S., some of that difference could be attributed to there being too little spent on monitoring and avoiding waste in Medicare, and to the fact that most hospitals and physicians who deal with Medicare have already implemented billing systems to serve their private clients.

Thus, while moving to a single-payer system might have resulted in a one-time drop in total spending, it would likely not have reduced the growth of spending nor address some of the system's most fundamental challenges.[10]

FALSE CONCLUSION: REFORM IS DOOMED TO FAIL BECAUSE WE DON'T KNOW THE ANSWERS TO THESE QUESTIONS.

Reality: We know that our health care system is not delivering the consistently high-quality, high-value care that we should expect. While there are many open questions in the design of the ideal system, with millions uninsured and rising costs threatening to swamp public and private budgets alike, maintaining the status quo was not the solution.

Now that PPACA is law, policy-makers must focus on the implementation of the provisions intended to expand coverage and improve the functioning of insurance markets. These efforts should center on increasing the value that we get from the health care system – by changing the way providers are reimbursed to encourage the delivery of high-quality and stemming the use of care of questionable value, focusing malpractice reforms on reducing errors, and understanding how to evaluate the gains and potential waste from the relentless avalanche of new technologies. Such efforts might make for bad politics but good public policy - and, most importantly, even better health.[11]

ABOUT THE AUTHORS

Katherine Baicker, PhD, is Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. She is a research associate at the National Bureau of Economic Research.

From 2005-2007, Professor Baicker served as a Senate-confirmed Member of the President's Council of Economic Advisers. She currently serves on the Editorial Boards of Health Affairs, the Journal of Health Economics, the Journal of Economic Perspectives and the Forum for Health Economics and Policy; is Vice Chair of the Board of Directors of AcademyHealth; is on the Congressional Budget Office's Panel of Health Advisers; and is a Commissioner on the Medicare Payment Advisory Commission.

Professor Baicker's research focuses primarily on the factors that drive the distribution, generosity, and effectiveness of public and private health insurance, with a particular focus on health insurance finance and the effect of reforms on the distribution and quality of care. Her research has been published in journals such as Health Affairs, the New England Journal of Medicine, the Journal of Public Economics, and the Quarterly Journal of Economics, and has been featured in the New York Times, the Wall Street Journal, Business Week, and on National Public Radio. She has given Congressional testimony on health reform before several House and Senate Committees.

She received her BA in economics from Yale and her PhD in economics from Harvard.

Amitabh Chandra is an economist and a Professor of Public Policy at the Harvard Kennedy School of Government. He is a Research Fellow at the IZA Institute in Bonn, Germany, and at the National Bureau of Economic Research (NBER). His research focuses on productivity and cost-growth in healthcare and racial disparities in healthcare. His research has been supported by the National Institute of Aging, the National Institute of Child Health and Development, the Robert Wood Johnson Foundation, and has been published in the American Economic Review, the Journal of Political Economy, the New England Journal of Medicine, and Health Affairs. He is an editor of the Journal of Human Resources, Economics Letters, and the American Economic Journal. Professor Chandra has testified to the United States Senate, the National Academy of Science, the Institute of Medicine and the United States Commission on Civil Rights. His research has been featured in the New York Times, the Washington Post, CNN, Newsweek, and on National Public Radio. He is the recipient of an Outstanding Teacher Award, the first-prize recipient of the Upjohn Institute's International Dissertation Research Award, the Kenneth Arrow Award for best paper in health economics, and the Eugene Garfield Award for the impact of medical research.

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