Example 10.1

Health Care Reform

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act, popularly known as the Health Care Reform Act (hereafter, "the Act"). More than 2000 pages long, the Act represents a sweeping extension of the federal government's presence in the provision of health care, exceeded only by the introduction of Medicare and Medicaid in 1965.[1] Most of the provisions of the Act fall into one of four broad categories: expansion of health insurance coverage; restrictions on private health insurers; increases in revenues and cuts in medical expenditures, to ensure that the Act is roughly neutral with respect to the federal budget deficit over a ten-year period; and a number of pilot programs and demonstration projects run by various federal agencies designed to increase the quality or lower the cost of health care. This example highlights the more important provisions within each category.[2]

[1] Despite its title, a portion of the Act has nothing to do with health care. It relates to federal education policy, primarily reforms in the federal subsidies to students for higher education.

[2] Excellent summaries of the Act are contained in two publications by Wolters Kluwer business: CCH Tax Briefing: "Health Care Reform Act," *Special Report*, March 23, 2010 and CCH Briefing, "President Signs Health Care Reform," *Special Report*, March 23, 2010. See also "Health Care Reform Bill Summary: A look at What's in the Bill," March 21, 2010, www.cbsnews.com/8301-503544_20000846-503544.html. The provisions of the Act discussed in this example were taken from these sources.

EXPANSION OF HEALTH INSURANCE COVERAGE

The primary motivation of the Obama administration in pushing for health care reform was to provide adequate health insurance coverage for most of the 50+ million people in the United States who did not have health insurance in 2009. This raises the immediate question of why the administration should care whether people have health insurance. The answer given by mainstream public sector theory is that the administration views health insurance as a merit good, a good deemed so essential that all citizens should be guaranteed a minimally adequate amount of it, regardless of their incomes. The merit good argument has been used in all the industrialized market economies to justify government provision of health insurance, which is the norm in every developed country other than the United States. The U.S. relies on private insurance far more than any of the other developed countries, such that the merit good argument in the U.S. was couched in terms of (nearly) universal access to either public or private health insurance.

To this end, the Act mandates that all citizens who do not receive health insurance through the Veterans Administration, Medicare, Medicaid, or their employers must purchase a minimally adequate amount of private health insurance by the end of 2013. The only exceptions are people whose incomes are so low that they are not required to file a federal personal income tax return.[3] The penalties for adults who fail to purchase health insurance are fairly steep: the *larger* of $95 or 1% of income in 2014, $325 or 2% of income in 2015, and $695 or 2.5% of income in 2016 and beyond. The merit good

[3] The exception was put in terms of tax filing because people will have to demonstrate on their federal personal income tax returns each year that they have health insurance for themselves and their families.

aspect of the mandate can be seen in the considerable subsidies that the federal government will provide so that the mandate is not a great burden to people with moderate to low incomes. The subsidies take a number of forms.

First, the uninsured will purchase the insurance in insurance exchanges run by the states, in which all insurers compete for customers. The federal government will subsidize the states' costs of establishing the exchanges. The idea is that the competition among insurers within the exchanges should help to keep insurance premiums as low as possible for a given amount of insurance coverage. The exchanges should also encourage insurers to offer more choices for people, from minimally adequate to more extensive plans.

Second, all states are required to offer Medicaid to individuals and families at or below 133% of the federal poverty line by 2013, and to expand Medicaid coverage to childless adults by 2014. The federal government will pay the full costs of all people who become newly eligible under these provisions from 2014 to 2016. Thereafter, the federal contribution for the medical expenses of the newly eligible recipients declines in a series of steps to 90% in 2019, and remains at 90% from then on. In contrast, the standard federal Medicaid reimbursement formula for states varies from 55% in the richest states to 83% in the poorest states.

Third, the federal government will offer tax credits against the premiums for health insurance purchased on the state exchanges for individuals and families whose incomes are between 133% and 400% of the federal poverty line. The range includes families of four with incomes of $29,377 to $88,000, and individuals from $14,000 to $43,000 (2010). The incomes are automatically indexed for inflation because the poverty

line is indexed for inflation. The tax credits are designed on a sliding scale so as to limit the percentage of income that these families and individuals are forced to spend on health insurance. The limits rise from 2% of income at 133% of the poverty line to 9.5% of income at 400% of the poverty line.

Private employers are not required to continue health insurance coverage for their employees. But the Act exacts very severe penalties for large companies (>750 employees) who drop their coverage and offers subsidies for small companies (<50 employees) with low average salaries to maintain or offer coverage. If a large company drops its coverage, and any *one* of its employees is subsidized with a tax credit when purchasing insurance in one of the state exchanges, then the company pays a penalty each month equal to $168 X [its total number of employees – 30]. Small companies receive tax credits up to 35% of the employer's contribution to their employees' health insurance from 2010 to 2013. From 2014 on, they can purchase health insurance for their employees through state insurance exchanges that are separate from the individual state exchanges, and receive tax credits up to 50% of the employer's contribution in 2014 and 2015.

RESTRICTIONS ON PRIVATE INSURERS

The Act places a number of restrictions on private insurers designed either to reduce the costs to the insured or to promote coverage. There are two main cost reducers, both applied to private insurers who offer Medicare part B (physician visits) and part D (prescription drugs) plans to the elderly, and to the straight Medicare plans that the elderly can also choose. Under part B, starting in 2011, insurers must offer the elderly

annual wellness visits and personalized prevention services at virtually no cost to the insured. This has the additional obvious intent of reducing health case costs through prevention of illness rather than having to pay for treatment after an illness occurs. Under Medicare part D, the so-called donut hole in prescription drug reimbursement is reduced in a series of steps, and then virtually eliminated by 2020. Before the passage of the Act, the insured who chose part D were subsidized for a substantial portion of their prescription drug costs each year until the total costs reached $2,700 (2010). Then they received no subsidy at all until the total costs reached $6,154, after which they were subsidized again for virtually all their costs. The range from $2,700 to $6,154 is the "donut hole" that will be eliminated.

The restrictions designed to promote coverage take many forms. The more important among them restrict the insurers' ability to deny coverage. A common practice among health insurers was to refuse to cover people who have certain preexisting medical conditions because they entail higher risks to the insurers. Under the Act, the insurers can no longer deny coverage to children because of a preexisting medical condition. This restriction takes effect in 2010. Starting in 2014, insurers also cannot deny coverage to adults because of a preexisting medical condition. The adult restriction was put off until 2014 to allow the insurers to add people who were previously uninsured through the state exchanges. The uninsured tend to be younger than average and have lower risks of becoming ill, and would thereby offset the higher risks of adding adults with preexisting medical conditions.[4]

[4] Until 2014, adults who have been denied coverage because of preexisting medical conditions were able to buy insurance through a new federal program designed specifically for them.

Another common practice of health insurers is to rescind the coverage of their policyholders who have become ill. Starting in 2010 under the Act, insurers can no longer do this.

Two other restrictions that promote coverage are worth noting. One is that young adults can stay on their parents' insurance plan through age 26, whether the plan is purchased in a state exchange or provided by an employer. Another is that insurers cannot place lifetime limits on the amount of insurance payments provided under each policy, and the setting of annual limits on insurance payments is restricted as well. Both restrictions take effect in 2010.

In 2010, The Congressional Budget Office (CBO), which provides nonpartisan analyses of proposed legislation to Congress, estimated that the combination of the coverage expansion provisions and the restrictions on insurers would achieve the administration's goal of a substantial increase in insurance coverage. The CBO projected an increase of 32 million people added to the insurance rolls by 2019, leaving only 23 million people uninsured. The breakdown of the projections is as follows: 24 million people will purchase private health insurance through the state exchanges and there will be 16 million additional enrollees in Medicaid and the Children's Health Insurance Program (CHIP) . Offsetting this 40 million increase will be a loss of 5 million people who give up their private insurance to join one of the public programs and 3 million people who will lose coverage previously provided by their employers, for a net addition of 32 million people. The percentage of Americans with health insurance will rise from 83% to 94% by 2019.[5]

[5] Congressional Budget Office, *Letter to Nancy Pelosi*, Speaker, U. S. House of Representatives, March 20, 2010, pp. 9-10. The estimates in the letter were prepared jointly with the Joint Committee on Taxation.

ACHIEVING DEFICIT NEUTRALITY

The CBO estimated that the Act will cost $940 billion over the first ten years, from 2010 to 2019.[6] To offset these costs, the Act contains a number of separate revenue enhancers and expenditure cuts.

Revenue enhancers—The revenue enhancers consist of both taxes and fees, which were projected by the CBO to raise approximately $400 billion by 2019. There are five tax increases of note.

1. The Social Security system, which includes Medicare, is financed by a payroll tax on wage and salary income, paid in equal amounts by both employees and employers. The Medicare portion of the tax on employees is 1.45%, with no limit on income. Starting in 2013, the tax on the employee's portion was raised by .9% to 2.34%, but the increase applies only high income taxpayers: single taxpayers with $200,000 or more of total income and couples who file joint tax returns with $250,000 or more of total income.
2. Starting in 2013, a new Medicare tax of 3.8% was applied to unearned (investment) income, with no upper income limit. The tax applies only to high income taxpayers, those with the same income thresholds as for the .9% increase in the tax on wage and salary income.

[6] *Ibid.*, Table 2.

3. In 2010, taxpayers could currently deduct medical expenses that exceeded 7.5% of their income on the personal income tax returns. The income floor was raised to 10% after 12/31/2012[7]
4. A 40% excise tax is levied on the premiums of so-called "Cadillac" insurance plans that provide top-flight insurance protection deemed excessive under the Act. They are defined as plans costing more than $10,200 for an individual and $27,500 for a family. The tax takes effect in 2018.
5. The Act contains a number of other new excise taxes, the most important of which is a tax on the manufacturers and importers of medical devices (excluding commonly purchased items such as eyeglasses and hearing aids). This tax takes effect in 2014. There is also a 10% excise tax on tanning salons effective 7/1/2010, another attempt in the Act to promote the prevention of illness.

The new fees are unimportant relative to the taxes. They are levied mostly within the health care sector, such as on health insurance providers (effective in 2014) and brand name pharmaceuticals (effective 2011).

Expenditure cuts- The vast majority of the expenditure cuts are centered on Medicare. Three are especially important. First, payments to physicians under Medicare were scheduled to be cut by 21% in 2010 under previous legislation and this cut was maintained under the Act. Second, the automatic increases in the annual payments to hospitals under Medicare are reduced substantially under the Act. And, third, private insurers who offer plans to the elderly under parts B and D of Medicare received higher payments than were made for the same services under the standard Medicare plan. These

[7] Taxpayers age 65 and over retain the 7.5% floor until 12/31/2016.

payments are now frozen at 2010 levels and will remain frozen until the standard Medicare plan payments catch up to them.

The CBO projected that all the revenue enhancers and expenditure cuts in the Act would more than fully offset the increased costs. They estimated that the Act would reduce the federal budget deficit by $143 billion from 2010-2019.[8]

PILOT PROGRAMS AND DEMONSTRATION PROJECTS

When the Act was being vigorously debated among Democrats and Republicans in the House and the Senate, most of the attention was focused on the first three categories. To give one highly contentious example, many Democrats favored offering a public option within the state insurance exchanges, under which people could choose to buy their coverage from the federal government. They felt this was the best way to ensure that private insurance premiums would be reduced. The Republicans unanimously rejected the public option, fearing that it would ultimately be the death-knell of the private health insurance industry.

In contrast, the many pilot programs and demonstration projects in the Act received relatively little attention in the Congressional debates, and almost none in the media. Yet Harvard's David Cutler believes that the ultimate success of the Act will depend on just these relatively small programs and projects.[9]

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[8] $124 billion of the $143 billion reduction in the federal budget deficit under the Act comes from the health reform portion of the Act and $19 billion from the education reform portion of the Act. CBO, *op. cit.*, p. 2.

[9] David Cutler, "Analysis and Commentary: How Health Care Reform Must Bend the Cost Curve," *Health Affairs 29:6*, June 2010, 1131-1135.

A major complaint against the Act is that it appears to do little to reduce the costs of health care, which for a very long time now have been rising faster than the overall rate of inflation. Cutler notes that outright waste in the provision of health care in the U.S. is enormous, with estimates running as high as 30% or even more. For example: people with serious illnesses often get passed from specialist to specialist who conduct duplicate tests on the same patients; highly expensive equipment is used to diagnose illnesses when much less costly diagnoses would suffice; payments to physicians are made on a fee-for-service basis, which gives them an incentive to conduct more tests than necessary; the U.S. would get much more return per dollar if it spent more on prevention and less on treatment; and so forth. The waste explains why the U.S. spends far more per capita on health care than any other developed country while achieving outcomes that are, on average, no better and often worse. The only way to reduce the ever-rising costs of health care is to remove the waste, and it is the pilot programs and demonstration projects under the Act that are attempting to do just that. Cutler is optimistic that these programs and projects can achieve a significant reduction in the waste if they are pursued aggressively.

There are so many small pilot programs and demonstration projects under the Act that we can mention only a few examples. One pilot program under Medicare will experiment with value based pricing (VBP), in which a portion of the payments given to hospitals for high cost services such as cardiac, surgery, and the treatment of pneumonia will be based on the quality of the outcomes achieved. Along with this, physicians are given financial incentives to collect meaningful quality data for their specialties. Also, hospitals in the 25th percentile and below in hospital-acquired illnesses such as staph

infections will pay a penalty. Another project will offer what is known as bundling, making a single payment for treating each episode of an illness. This has been shown to effect considerable cost savings relative to the traditional fee-for-service system in the few instances that it has been used in the U.S. A third example is the formation of a national council of representatives from many federal agencies to develop nation-wide health promotion and prevention strategies. Obesity, which has become an epidemic in the U.S., is an obvious target, given that it greatly increases the risk of diabetes, heart attacks, and strokes, all expensive illnesses to treat. Cutler believes that the best chance of success for the Act in reducing costs in the long run is to give top priority to these programs and projects: conduct all of them and do so as fast as possible.

Cutler's prediction is probably correct, but it is not at all clear that cost containment can be achieved, even if the various pilot programs and demonstration projects in the Act are as successful as Cutler thinks they can be.

An important distinction to make in thinking about health care costs is between reforms that cause a one-time decrease in costs and reforms that change the rate of increase in costs. Figure 1 illustrates. The log of medical expenditures (ME) is on the vertical axis and time is on the horizontal axis. Line 1 indicates the growth path of health expenditures, with the rate of growth represented by the slope of the line. (The slope of the log(ME) is the rate of growth of ME).

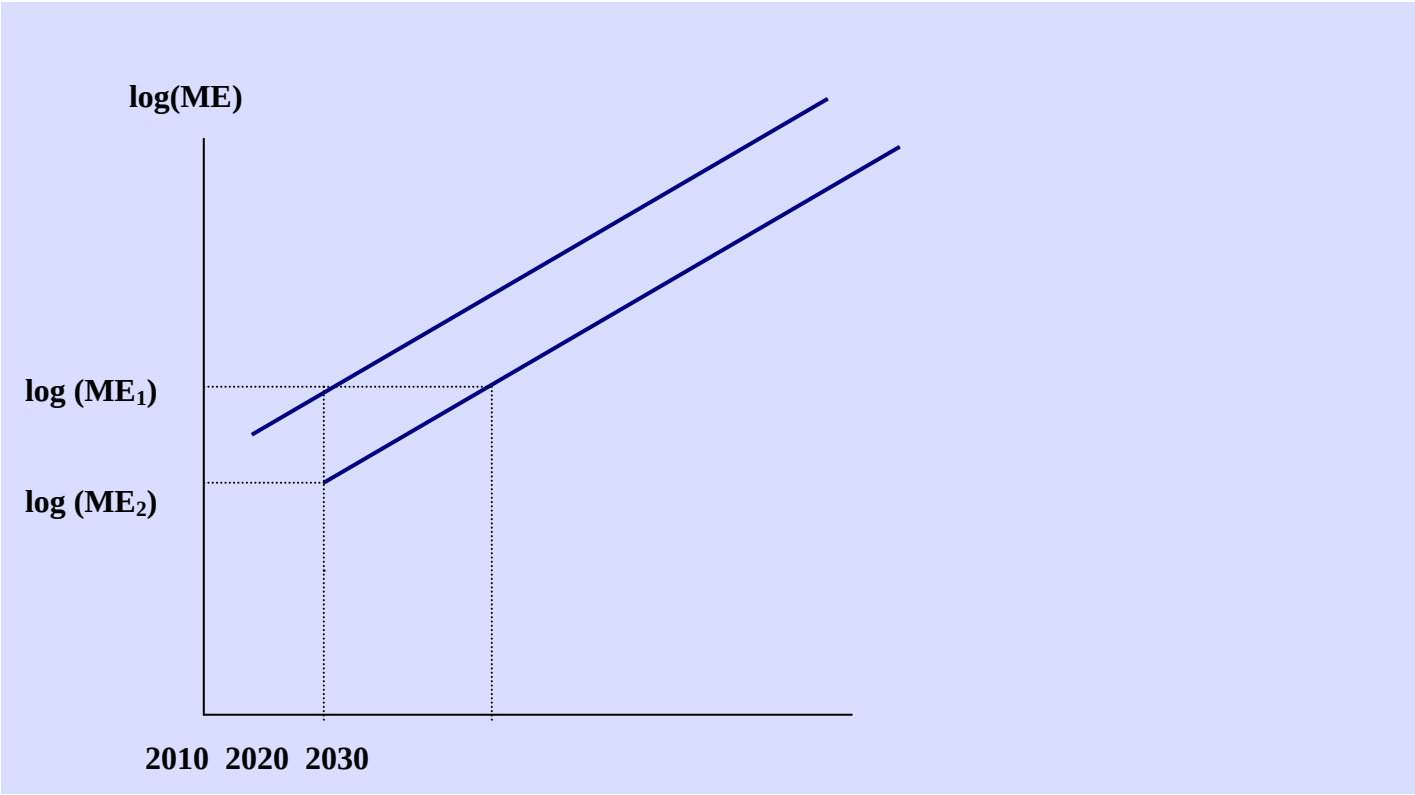

Figure 1

According to the figure, medical expenditures are equal to ME_1 in 2010 and assume, for the sake of the example, that society would not like them to be any higher. Suppose one of the pilot programs in the Act shows how to reduce waste and achieve a one-time reduction in costs from ME_1 to ME_2, all occurring in 2010. The growth line of medical expenditures shifts down to $\log(ME_2)$ in 2010, and then medical expenditures continue to grow along line 2 at the same rate as along line 1 (both lines have the same slope). Eventually medical expenditures will reach ME_1 again, assumed to be in 2020 in the figure, and continue to grow from there.

The general point of the example is that one-time reductions in costs merely postpone the day of reckoning when health costs are deemed to be too high. Rates of

growth always dominate one-time changes. The only way to achieve lasting decreases in medical expenditures so that they grow more slowly than expenditures generally is to reduce the rate of growth in expenditures, to flatten the line as the health economists put it.

Unfortunately, attempts to flatten the line run into a nasty problem uncovered in a widely cited study by Joseph Newhouse. He analyzed the factors that are driving the rate of growth in medical expenditures and concluded that more than half of the growth is attributable to technical change. This is an other-things-equal estimate, the independent effect of technical change on medical expenditures, holding constant the effects of other cost-increasing factors such as the aging of the population, litigation, and administrative costs.[10]

Newhouse's conclusion regarding technical change is really discouraging even if it is only roughly accurate. In almost all other industries, technical change reduces costs. Think of the rapidly decreasing cost of computing power in the past few decades as a particularly powerful example of cost-reducing technical change. Yet in medicine technical change raises costs.[11]

Technical change occurs continually; it is not a one-time cost shifter. Therefore, in medicine, technical change is serving to steepen the growth line. This is why it is difficult to see how the U.S. can flatten the growth line so that medical expenditures increase less rapidly than expenditures generally unless new medical technologies serve

[10] J. Newhouse, "Medical Care Costs: How Much Welfare Loss?," *Journal of Economic Perspectives, 6, No. 3,* Summer 1992, 3-22.
[11] True, technical change also increases quality, but presumably not by enough to justify the cost increases for people who compare U.S. medical costs and outcomes unfavorably with those of the other developed countries.

to lower costs rather than raise costs, other things equal. And very few of the pilot programs and demonstration projects under the Act are targeting the technical change problem. [12]

In conclusion, reducing waste in the provision of medical care is an important goal. Achieving a given quality of care at lower costs is obviously worthwhile, and if the pilot programs and demonstration projects can point the way they should be considered a huge success. But some, if not most, of the cost reductions are likely to be one-time events. And even if some of the programs and projects reduce the rate of growth in medical expenditures, as Cutler believes they will, they are unlikely to achieve the long-run cost containment that everyone is hoping for so long as technical change continues to increase medical costs.

THE INITIAL RETURNS

As this is written in 2016, the Act has experienced some successes and some setbacks. The federal exchanges got off to a shaky start because of various computer glitches, delaying the start of the exchange enrollments to January 1, 2014. Medicaid expansions also started then. The initial results were encouraging, with millions of formerly uninsured citizens now insured. In 2013, 45.2 million people were uninsured; in the first year, 8.5 million of those people became insured[13]. Enrollments continued apace through 2016. When open enrollment ended for 2016, approximately 20 million people now had insurance under the Act, 12.7 million in the state and federal exchanges, and most of the

[12] The increase in coverage under the Act is undoubtedly a one-time cost increaser as many of its opponents charge, but its effect on costs in the long run will still be dominated by the effect of technical change on costs.
[13] Health Insurance Coverage in the United States 2014," Current Population Reports, P60-253, September 15, 2015, Table A-1, Census Bureau.

rest either low income individuals and families enrolled in Medicaid or young adults under age 26 enrolled under their parents' insurance[14]. Obamacare appeared to be on target to meet the CBO's 2010 projection of 32 million newly insured individuals by 2019. To reduce the number of uninsured is the main goal of the Act.

There was one initial setback, and it was substantial. When the Roberts Supreme Court ruled on the constitutionality of the Act in 2012, it allowed the penalty for not obtaining insurance to stand because it was essentially a tax. But it ruled that the federal government could not require the states to increase their coverage under Medicaid from 100 percent of the poverty line to 133 percent of the poverty line. Nineteen states that had limited Medicaid coverage to 100 percent of the poverty line elected to stay there and opted out of the expansion, despite the federal government picking up almost all of the costs[15].

Regardless of whether their motivation was political or budgetary, these states have placed a great burden on their citizens who are between 100 and 133 percent of the poverty line. The Act, anticipating that all states would accept the Medicaid expansion, starts the federal subsidies under the federal and state exchanges at 133 percent of the poverty line. Therefore, people between 100 and 133 percent of the poverty line in these states have no access to subsidized health insurance.

Finally, a storm cloud has arisen in the exchanges. Too many young, relatively healthy individuals have chosen to pay the tax rather than purchase insurance, with the result that many insurance companies are experiencing losses on the policies. The pool

[14] Obamacarefacts.com/obamacare-facts.
[15] Alabama, Florida, Georgia, Idaho, Kansas, Maine, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming. "Where States Stand on Medicaid Expansion Decisions, update 9/9/2016," National Academy for State Health Policy, www.nashp.org/states-stand-medicaid-expansion-decisions.

of the insured has been more adverse than they anticipated. Some big insurers, Aetna among them, are dropping out of the exchanges, which has two unfortunate consequences: some exchanges now have very few suppliers, some only one, and those insurers who remain have sharply increased their premiums. The problem is that the tax for remaining uninsured turned out to be much too low. It will be difficult to increase the tax, however, since the Republicans in the House and Senate would like to repeal the Act. This may well happen if Donald Trump is elected president.