The Affordable Care Act and the Future of Medicare: An Economist's Perspective

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Background: High Cost and Disparities of U.S. Health Care

- U.S spends 18% of GDP on health care, by far the most of any nation.
- Rate of health care spending growth far higher than growth in U.S. economy.
- By 2080, health spending projected to be 40% of GDP.
- In spite of this, health comparisons with other countries are unfavorable to U.S.
- Large disparities in health and longevity by income and race. Black/white male differences in health have not narrowed in last century.

Background: Private Health Insurance

- Prior to ACA, one in five non-elderly lacked health insurance coverage = 50 million persons.
- Primary source of coverage for non-elderly employer-sponsored health insurance (ESI).
- ESI common because (1) provides risk pooling and (2) large tax subsidy provided to ESI. U.S. government forgoes about $200 billion/year by excluding compensation in form of health insurance from income and payroll taxes.

Background: Public Insurance and Individual Private Health Insurance Coverage

- Two major forms of public insurance coverage, Medicare and Medicaid. Latter primarily covers low-income children and supplements Medicare for long-term care.
- Thus, most uninsured, not the poorest but "working poor,"
- Individuals without access to ESI and Medicare/ Medicaid left to private individual market. Such non-group insurance was expensive and subject to "preexisting conditions exclusions." In this sense, individual private market provided limited protection against major financial risk from illness.

Table 1
Sources of Health Insurance Coverage in the United States, 2009

	People (millions)	Percentage of Population
Total Population	304.3	100
Private	194.5	63.9
Employment-based	169.7	55.8
Direct purchase	27.2	8.9
Public	93.2	30.6
Medicare	43.4	14.3
Medicaid	47.8	15.7
Uninsured	50.6	16.7

Source: Fronstin (2010).

North Carolina Statistics Prior to ACA Implementation

- How North Carolinians get their heath Insurance

Through employers 4.6 million

Medicare: 1.6 million

Medicaid 1.4 million

Individual policies: 435,000

Uninsured: 1.5 million

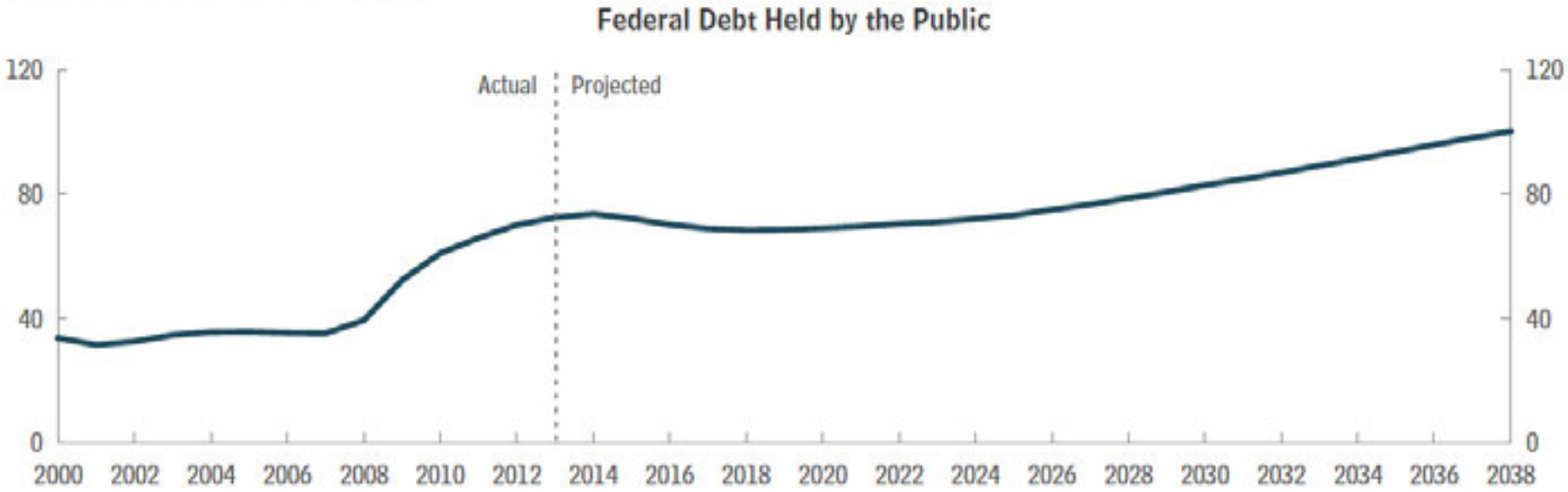
Federal Debt and Deficits

- Federal debt has risen appreciably, particularly since Great Recession
- When I took my first economics course, I learned that the federal debt is no problem since we owe it to ourselves. This is no longer true.
- A major cause of projected deficits is projected public spending on personal health care services

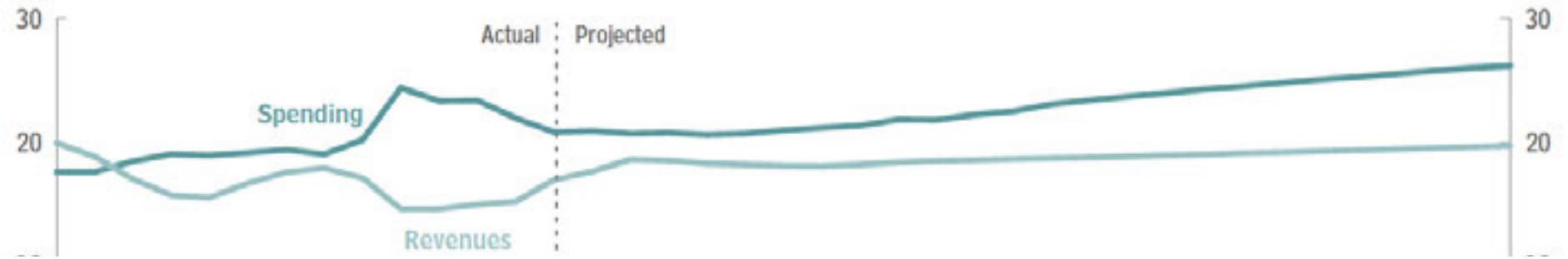
Figure 1.

Debt, Spending, and Revenues Under CBO's Extended Baseline

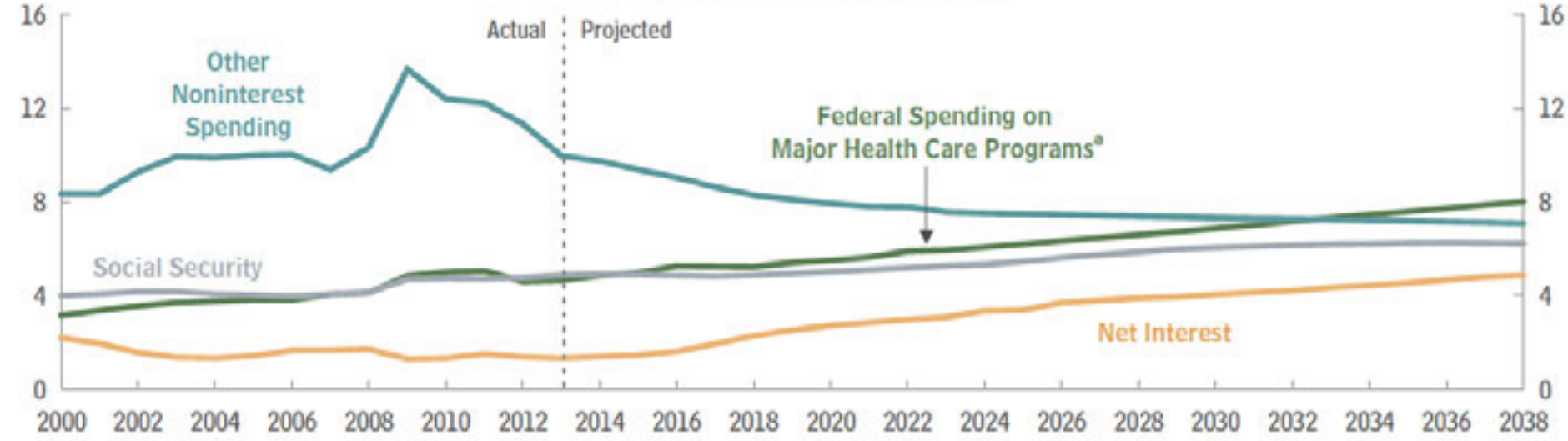
(Percentage of gross domestic product)



Total Spending and Revenues



Components of Total Spending



Broad Outline of the Affordable Care Act

- Core of ACA a "three-legged stool."
- (1) Reforms to the non-group (individual) private health insurance market;
- (2) Mandate that most individuals have health (insurance coverage;
- (3) Public subsidies to make health insurance affordable for lower income families.

Individual Health Insurance Market

Reforms: Leg 1

- Premiums can vary by age, not by health status or gender. Cannot charge older persons more than 3x younger persons. However, insurers can charge smokers as much as 50% more than nonsmokers.
- Minimum standards set for insurance for non-group and small group markets, including specification of "essential benefits."
- Individual health plans available under ACA classified as Bronze, Silver, Gold, and Platinum. Bronze covers about 60% of medical costs, leaving 40% to individual. Platinum coverage about 90% leaving 10% to individual.
- Law creates an option for "catastrophic" plans for persons < 30. Premiums are lower than for Bronze plans but they cover just 3 physician visits and have other limits.

Insurance Mandate: Leg 2

- If individuals are guaranteed health insurance coverage at premiums set independently of health status, they may free ride, waiting until they are sick to purchase health insurance.
- Hence the mandate.
- Tie penalty to non-purchase: in 2014, fine or $95 or 1% of annual income whichever is greater, for those who qualify, but by 2016, fine will be 2.5% of income or $695/year
- Exemptions from mandate (see next slide)
- But also have public subsidies: leg 3

Exemptions from Mandate

- Household income < federal tax filing threshold
- If adult has income < 138 of FPL and lives in a state (e.g., NC) that opted not to expand Medicaid
- If the lowest cost health plan available > 8% of household income.
- Membership in health care sharing ministry. Incarceration except incarceration pending disposition of charges, membership in federally recognized tribe, membership in a recognized religious sect that objects to health coverage, lack of insurance coverage for < 3 months, unlawful presence in U.S.

Public Subsidies for Purchase of Insurance: Leg 3

- Two forms of subsidies under ACA: (1) Medicaid expansions=to 133% of poverty ($11,490 for individuals and $23,550 for family of 4); (2) Tax credits to offset cost of private non-group insurance.
- Tax credits: 100-133% FPL premiums not to exceed 2% of income (rest subsidized) to 300-400% FPL 9.5% of income.
- Also, if individuals have incomes below threshold for income tax filing or if cheapest health insurance option available > 8% of income, they are exempt from mandate penalty.

ACA Financed Through 6 Sources

- Reduction in payments to Medicare Advantage programs (14%);
- Reductions in Medicare payments, primarily through reduction of inflation adjustment provided annually to hospitals (33%);
- Increase in Medicare payroll tax by 0.9% and extension of that tax to capital income for singles with incomes > $200,000/year and families with incomes > $250,000/year (21%);
- New excise taxes on several sectors likely to benefit from ACA including insurers, pharmaceutical and device companies (11%);
- "Cadillac tax," non-deductible 40% excise tax on insurance products costing >$10,200 for an individual and $27,500 for a family in 2018 (3%) with values indexed by CPI in future years.
- And other revenue sources such as penalty payments by individuals and employers and on higher wages that result from reduced employer spending on insurance (21%).

ACA Cost Containment Provisions

- Cadillac tax
- Health insurance exchanges: state organized markets for individual and small group insurance designed to increase transparency, competition, and hence reduce premiums.
- Independent Payment Advisory Board: charged with re-designing payment policies under Medicare with decisions subject to up or down vote by Congress.
- New research institute for comparative effectiveness analysis.
- Pilot programs to test feasibility of alternative organizations and reimbursement structures to current system, e.g., Accountable Care Organizations.
- Other

The Massachusetts Experience with RomneyCare

- In April 2006, MA enacted health reform based on same 3-legged stool.
- MA implemented individual mandate to purchase insurance and created a new program Commonwealth Care which provides heavily subsidized insurance for families < 300% FPL.
- Program financed jointly by federal government and by an existing tax that financed care of uninsured.

RomneyCare Results

- Dramatic expansion of health insurance coverage —60-70% decline in uninsured.
- No apparent shortage in primary care physicians created as indicated by change in wait times.
- Share of population with usual source of care, share with a physician visit in last year, share receiving preventive care, share receiving dental care up 2006-8.
- Rate of employer-insured individuals increased (”crowd-in”)
- Mandate implementation smooth: 98% of tax filers have complied.

RomneyCare Results, cont.

- Costs of administering heath reform low. Connector was given $25 million in seed funding. As of 2011, $20 million remains.
- Reform has been popular.
- Premiums have fallen dramatically in non-group market. NO meaningful impact evident on employer-sponsored premiums.
- Cost of reform at full implementation very close to original projections.

Implications for the ACA

- See CBO projections on next slide.
- CBO projected little drop in employer-sponsored coverage, large increased in public insurance and non-group insurance with uninsured drop of 32 million.
- CBO projected about $940 billion in new spending offset by $1,080 billion in spending reductions and revenue increases with first deade deficit reduction of about $140 billion.

Table 2
CBO Estimates of the Impact of the ACA

Population Effects in 2019 ($Million)		
	Baseline (No ACA)	Effect of the ACA
Uninsured	54	–32
Employer	162	–3
Non-group & other	30	–5
Exchange	0	24
Medicaid	35	16
Budget Effects ($Billion)		
	2019	2010–2019
Coverage Provisions		
Medicaid	97	434
Exchange Subsidies	113	464
Small Employer Tax Credits	4	40
Gross Coverage Costs	214	938
Offsets		
Spending Reductions	–117	514
Revenue Increases	–108	562
Gross Offsets	–225	1076
Net Budgetary Impact	–15	–143

Notes: Subcomponents do not add to totals due to rounding and other small differences in definitions.The difference between net budgetary impact and spending minus revenues is due to these issues as well as other non-coverage provisions.
Source: CBO (2010b).

Medicare Reform

- Projections include some reductions in Medicare spending, e.g., reductions in Medicare Advantage and hospital spending.
- Medicare mature program having been implemented in 1966.
- Enormously popular. "Don't touch my Medicare." versus a Socialist scheme in 1964.
- Many reform initiatives below the radar screen: bundling of services; competitively determined plan contributions; new organizational forms, such as Accountable Care Organizations, etc.

ACA and Medicare Reform Evaluation

Pluses

- Move toward universal coverage a major positive development, one that has alluded past Presidents.
- Cadillac tax was proposed during Reagan Administration and could not be implemented for lack of political support from conservatives.
- Analysts much more savvy than when Medicare and Medicaid implemented in 1966. No CBO then. Little data, etc. No field of health economics or health services research or health policy.
- Opposition to ACA and selected Medicare reform proposals is largely stakeholder driven.

Pluses, cont.

- Technological change has led to improvements in health and longevity in the U.S. especially among the oldest old. Even if the U.S. is not the best in terms of health and longevity, a lot of technological change leading to gains in health occurs in U.S.
- Lot of experimentation with alternative forms of financing and delivering health care services occurs in U.S.
- U.S. leader in research and education in this field.
- Some positive findings from reliance on market mechanisms(e.g., with Medicare Part D, drug program).

Minuses

- U.S. system very costly, outcomes mediocre, and access poor.
- Lack of constituency for health care reform. We know what to do. We have difficulty with follow-through. Dominance of vested interests. E.g., no complaints by opponents of ACA about tax subsidy of health insurance premiums. This clearly a distortion and counter to market principles. Opposition to being taxed for ACA exhibits lack of altruism.
- Alternative to ACA would have been (1) expanding Medicare to population as national health insurance; or (2) enacting a public health insurance option as part of the individual mandate.

Minuses, cont.

- Administrative cost of public insurance low. Have to make allocative decisions about use of technology as part of mandate.
- If history is a guide, CBO projections of savings attributable to ACA far too optimistic.
- In the long-run, society will need to make tough choices: e.g., age of eligibility for Medicare coverage, technology use and payment, bundling of services.
- These are collective not individual decisions.

Predictions

- Economists are bad at predicting and I am no exception.
- Predict more muddling along with some increase in percent of GDP spent on health care.
- Is this bad?
- No universal health insurance coverage in U.S., but no increase in percent uninsured either.
- ACA will not be repealed and will become more popular as it becomes fully implemented.