SPEA *Insights*
School of Public and Environmental Affairs (SPEA) · Indiana University
June 2011

Health Reform in a Nutshell

KOSALI SIMON
Professor
School of Public and Environmental Affairs
simonkos@indiana.edu

Summary

Rising health care costs and the large number of uninsured are vexing public policy issues in the U.S. We currently spend about $8,000[1] per capita on health care (or 17% of GDP (Figure 1), yet a growing fraction of Americans – close to 17% of the population or 51 million[2] Americans in 2009 (Figure 2) are without health insurance – and still the U.S. ranks toward the bottom among nations of the Organisation for Economic Cooperation and Development (OECD) in life expectancy and infant mortality.[3] Although the comprehensive new law known as the Affordable Care Act (ACA) was enacted last year to "overhaul" the U.S. health care system, there is confusion about what it encompasses, and what it is expected to do when its main provisions are implemented in 2014. Will the law accomplish universal health insurance? Will it improve quality of care while reducing the growth of health care costs? In this *Insight* brief, I provide a short summary of the ACA's main features from an economist's perspective and comment on likely impacts and issues.*

The views expressed are solely those of the author and do not imply endorsement by Indiana University or the School of Public and Environmental Affairs.

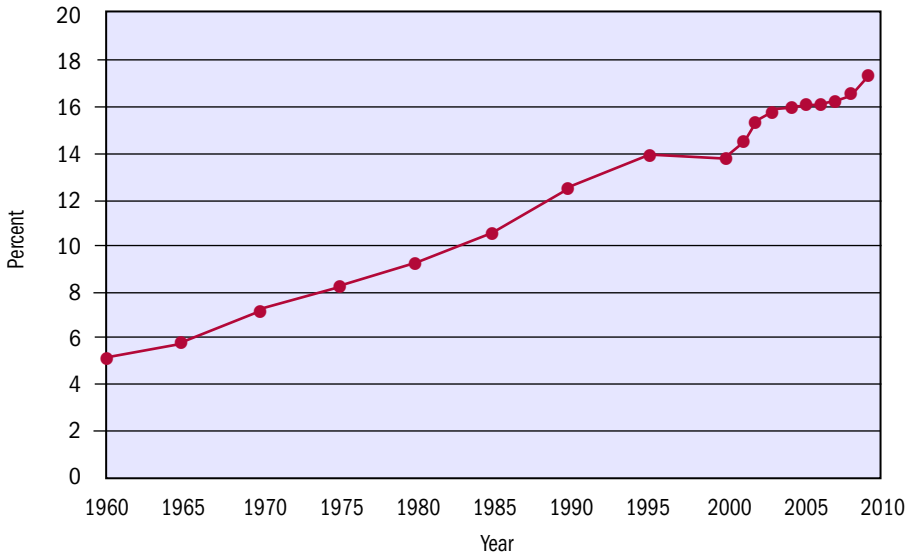

Figure 1. National Healthcare Expenditures as a Percent of GDP, 1960-2009. Source: *NHE Summary Including Share of GDP, Calender Years 1960-2009, available at: http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage*

Peer Reviewers: Bradley Herring, Assistant Professor and Director, PhD Program in Health Economics & Policy, Bloomberg School of Public Health, Johns Hopkins University and Jean Abraham, Assistant Professor, School of Public Health, University of Minnesota

*The legislation covers close to 1,000 pages. For the sake of brevity, many features of lesser significance from the author's perspective are left out of this essay. Full details may be obtained from http://docs.house.gov/energycommerce/ppacacon.pdf (The Patient Protection and Affordable Care Act of 2010, Public Law 111-148, 111th Cong., 2nd sess. May, 2010) and the Kaiser Family Foundation 2010.

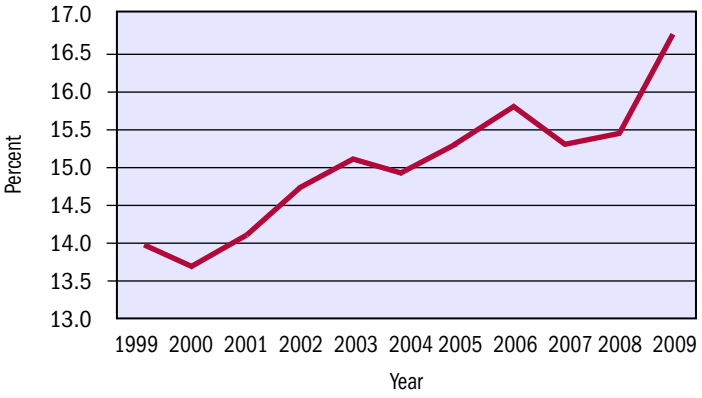

Figure 2. U.S. Percent Uninsured, 1999-2009. Source: *U.S. Census Bureau at http://www.census.gov/hhes/www/hlthins/data/historical/index.html.*

Overview of the Affordable Care Act

In a nutshell, the ACA law aims to correct almost all problems identified in the U.S. health insurance and health care arenas. Two main themes define the ACA: (1) provisions to get more people insured, and (2) attempts to control costs and raise revenue, while improving quality. How exactly the efforts will affect access, costs, and quality remains to be seen, but they are expected to have significant implications for health insurance and health care in the next decade.

ACA Main Features

- *Expand health insurance coverage*
  - Workers from low to moderate income families who do not have access to affordable coverage from employers receive help from the government for buying health insurance in regulated "exchanges."
  - Medicaid becomes available to all low income adults (earning below about $30,000 a year for a family of four).
  - Large employers are required to provide health insurance to workers, or pay a fine. Small employers receive temporary subsidies, and access to exchanges.
- *Control costs and raise revenue while improving quality*
  - Restructure and reduce payments for Medicare services and reform the manner in which these services are provided. These efforts are intended to encourage both higher quality outcomes and lower costs of services: e.g., restructure Medicare reimbursements for preventable hospital readmissions and hospital-acquired conditions, and develop Medicare pilot programs for systems such as "bundled payments" (paying for an episode of care rather than service by service) to foster greater coordination of care and quality.
  - Levy "Cadillac" taxes starting in 2018 on health insurance plans that become too expensive, partly to deter health insurance prices from rising, and partly to raise revenue.
  - Establish an Independent Payment Advisory Board to suggest further (limited; see below) ways to reduce Medicare cost growth rates; support research that compares effectiveness of different treatment options; encourage adoption of health information technology.
  - Impose new Medicare taxes on individuals, such as an increase in Medicare Part A and tax rates on unearned income for high earners, as well as higher taxes (fees) on the pharmaceutical, medical devices, and health insurance sectors. (About half of the costs of expanding coverage will come from reductions in Medicare spending, and about half from new taxes.)

Expected Effects of the ACA's Approach to Expanding Health Insurance Coverage

Greater Access

Through the combination of Medicaid expansions, subsidies, and mandates in the ACA, the Congressional Budget Office (CBO) forecasts that 32 million people[4] will gain new coverage, leaving approximately 6 percent of the non-elderly legal population without health insurance. The CBO also predicts that the ACA will change the *type* of coverage held by millions.

Sixteen million more people will be insured by Medicaid when the program expands to provide free coverage to all adults under 133 percent of the federal poverty level[5] (at this writing about $30,000 for families of four). Currently, the maximum level of income at which adults qualify for Medicaid varies by state and family status, but is generally well below the poverty level.[6] Children qualify for Medicaid – or its cousin, the Children's Health Insurance Program – up to much higher levels of family income, so they are not affected by the Medicaid expansions in the ACA.

In addition, 29 million will receive health insurance through "exchanges," which are regulated marketplaces through which private companies will sell non-group health insurance. This number includes some who will be moving out of current insurance to exchange insured, in addition to the otherwise uninsured gaining new coverage through the exchange. Families of four making up to about $90,000 a year will receive government subsidies for health insurance purchase, but those subsidies reduce as income rises. Additionally, 6 to 7 million more individuals will have newly offered coverage through the workplace, as a result of incentives for employers to provide insurance.

Additional avenues to cheaper coverage may also facilitate reductions in "job lock," for example, allowing individuals to retire earlier than they otherwise may have, because of the availability of health insurance outside of their jobs prior to age eligibility for Medicare.

Unintended Outcomes

Not all low-income families will receive government help when purchasing coverage. In order to be eligible for assistance, workers cannot have access to affordable employer-based health insurance. Although large employers are encouraged by the ACA to provide their workers with affordable health insurance or face fines, the fines are much lower than the cost of providing coverage to employees. Therefore, some large employers with a predominantly low-skilled workforce may decide to drop their coverage altogether. This would benefit their workers who could now obtain government subsidies. This could also reduce employer operating expense. Thus, the CBO predicts roughly 10 million people could lose employer coverage due to this behavior.

In addition, the fact that small firms do not face a fine (as do large firms) for not offering health insurance may cause movement in the low-skilled labor force away from large firms. Depending on the assumptions made about how employers and employees adjust to the incentives created by the law, the number of Americans for whom coverage will change could be several times larger than the CBO estimates. Moreover, government assistance that is conditional on the unavailability of affordable employer insurance also causes a financial disadvantage for workers and employers who "do the right thing" – i.e., what is intended by the law – by arranging their compensation to be partly in the form of health insurance. The reason for this, as noted above, is that the fine for large employers who choose not to offer affordable health insurance is not much of a comparative penalty.

An alternative policy to expand coverage that avoids equity problems and lessens the distortions created in the labor market is to extend Medicaid coverage for adults to the level currently used for children, which is twice the poverty level (with some appropriate phase out provision). This would both enable families to coordinate coverage under the same plan for all members, and result in the government explicitly taking responsibility for all low-income families below a certain level of financial wellbeing.

Also, notably absent from this overhaul is something economists have stated for years should be reformed, i.e., the tax deductibility of employer health insurance. Currently, the nation forgoes about $250 billion in lost taxes because money put aside by the employee and employer for health insurance premiums is tax deductible.[7] This tax code provision is regressive, and economists believe it leads us to purchase insurance policies that are more generous than we would otherwise, which contributes to the high rates of growth in health care spending. The Cadillac tax on expensive health insurance policies does serve to some degree to counteract this tax benefit for those plans, but a much less cumbersome and uniform provision would be to remove this tax deductibility provision altogether, which would bring in a large amount of revenue and remove an artificial means by which employer-provided health insurance looks cheaper than individually purchased health insurance.

Federal Government Expenditures, Quality, and Revenue Issues

Federal Government Expenditures

Medicaid expansions and exchange subsidies will be costly to the government, yet the ACA law proposes not to incur any net spending increases.[8] In fact, the CBO predicts it will *reduce* the federal deficit by between $124-$210 billion over the next ten years.**

The expansions in coverage alone are expected to cost about $940 billion over the same period. The natural question is, who will pay for them?

Furthermore, not only does this law aim to increase access and improve the quality of health care, it aims to do so while reducing the growth of health care costs – and raising revenue for deficit reduction. That is extremely ambitious, and economists' forecasts (as well as the forecast of the Center for Medicare Services [CMS] chief actuary Richard Foster[9]) vary widely about how much cost savings are possible.

Many believe that the ACA may lay the foundation for broad changes to the Medicare program's delivery and payment systems, the effects of which will likely permeate through the rest of the health care industry, as changes in Medicare often do. The law targets Medicare payment cuts where economists currently think there is over-payment, such as the private sector alternative to traditional Medicare (the "Medicare Advantage" program). Currently, the government provides Medicare Advantage insurers a generous reimbursement for providing care for Medicare beneficiaries. The ACA will reduce these reimbursements. Also, provider payments under the Medicare program will be reduced by lowering the automatic raises built into the payment formulas in the future. Roughly $500 billion over the next ten years will come from these reductions in Medicare payments to private health plans, physicians, hospitals, and others.[10]***

Quality

Much of the restructuring of Medicare payment systems and amounts will be to encourage better coordination of care, improved

---

** The first number represents the CBO estimate for the 2010-2019 time period, and the second number represents the CBO estimate for the 2012-2021 time period.

***The ACA also establishes an Independent Payment Advisory Board (IPAB) to make legislative proposals to reduce Medicare costs further – if the provisions above do not result in Medicare cost growth staying at no more than one percent over the growth rate of the U.S. economy. However, this Board is severely restricted in the types of recommendations it can make. Currently, the recommendations made by the IPAB cannot include "increase Medicare beneficiary cost sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria."[11] Removing these restrictions would give cost containment efforts more teeth.

quality, and the control of cost growth. The ACA launches pilot programs that will pay providers bundled payments for treating acute and post-acute care episodes together (e.g., follow-up care or rehabilitation after surgery), which would prevent the health care system from viewing stages of care as discrete billable events. Similarly, the formation of ACOs is encouraged to foster greater coordination of care by having the primary care providers, lab services, and acute care providers all belong to the same organization. The aim is to move Medicare away from the costly fee-for-service system as much as possible, and to find better payment systems that would then be adopted by the private sector, once Medicare has demonstrated their effectiveness.

System-wide initiatives in health care delivery that would improve quality while reducing costs include supporting comparative effectiveness research that provides information about alternative treatment options, and encouraging widespread health IT adoption.

Revenue

A substantial amount of the revenue raised in the bill comes from a series of new taxes imposed on individuals and businesses, some of which will also provide incentives to lower costs. For example, starting in 2018, the "Cadillac tax" is a 40 percent tax placed on the excess cost of insurance policies that pass a certain threshold. In that year, this limit is set at $27,500 for family coverage, so policies that cost over this amount will be taxed 40 percent of the amount by which it exceeds this amount. The CBO expects this provision to bring in $32 billion over the next ten years (i.e., in just two years, since it does not go into effect until 2018), but it is also hoped that this provision will provide an incentive for insurers to make insurance policies leaner and lead to less cost growth.

Other taxes may be seen by some as purely punitive, or simply as revenue generators that could have negative labor supply and innovation incentives. The taxes paid on wages for Medicare will rise for those families earning above $250,000 a year by about one percentage point. Also, a new Medicare tax of 3.8 percent will be paid on unearned income by the wealthy. These provisions are expected to bring in $210 billion in the next ten years.[12]

Some new taxes are aimed at health care industries expected to receive a boost through the ACA. New taxes on the health care sector over the next ten years include the following: The insurance industry will pay $47 billion, the pharmaceutical industry will pay $16 billion, and medical device firms will pay a 2.9 percent tax on sales. However, economic theory warns that the ultimate taxpayer is not always the one targeted. Often, firms are able to pass on the taxes to consumers in the form of higher prices, especially in markets with patented products (monopolies). Therefore, while the ACA bill is structured to be paid for by changes in Medicare, as well as taxes on wealthy Americans and certain health care industries, the way that tax incidence works makes the ultimate tax burdens of the law less clear.

Conclusion

The ACA is an ambitious attempt to expand coverage to the uninsured, while taking the opportunity to restructure Medicare and to create new sources of revenue. Crafting cost controls and new taxes that work – but that do not stifle innovation – are challenging tasks. Reforming health care will be an ongoing conversation this nation will engage in for the foreseeable future, even after the ACA is implemented.

Endnotes

[1] https://www.cms.gov/NationalHealthExpendData/downloads/highlights.pdf
[2] http://www.census.gov/hhes/www/hlthins/data/historical/index.html
[3] www.oecd.org/dataoecd/30/54/43136879.xls
[4] http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf
[5] http://www.coverageforall.org/pdf/FHCE_FedPovertyLevel.pdf
[6] http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4
[7] http://www.nytimes.com/roomfordebate/2010/11/14/16-ways-to-cut-the-deficit/tax-the-health-insurance-spending-by-employers
[8] http://www.kaiserhealthnews.org/Daily-Reports/2011/March/31/elmendorf-and-foster.aspx
[9] http://www.huffingtonpost.com/2010/09/13/white-house-health-savings-not-meaningful_n_715626.html
[10] http://www.healthcare.gov/center/reports/affordablecareact.html
[11] http://docs.house.gov/energycommerce/ppacacon.pdf
[12] http://www.jct.gov/publications.html?func=startdown&id=3672

Further Reading

Kaiser Family Foundation. (2010). "Summary of New Health Reform Law." Available at http://www.kff.org/healthreform/8061.cfm

The author wishes to thank Abigail Kelly-Smith, master's candidate, School of Public and Environmental Affairs, for her research assistance in preparing graphs.