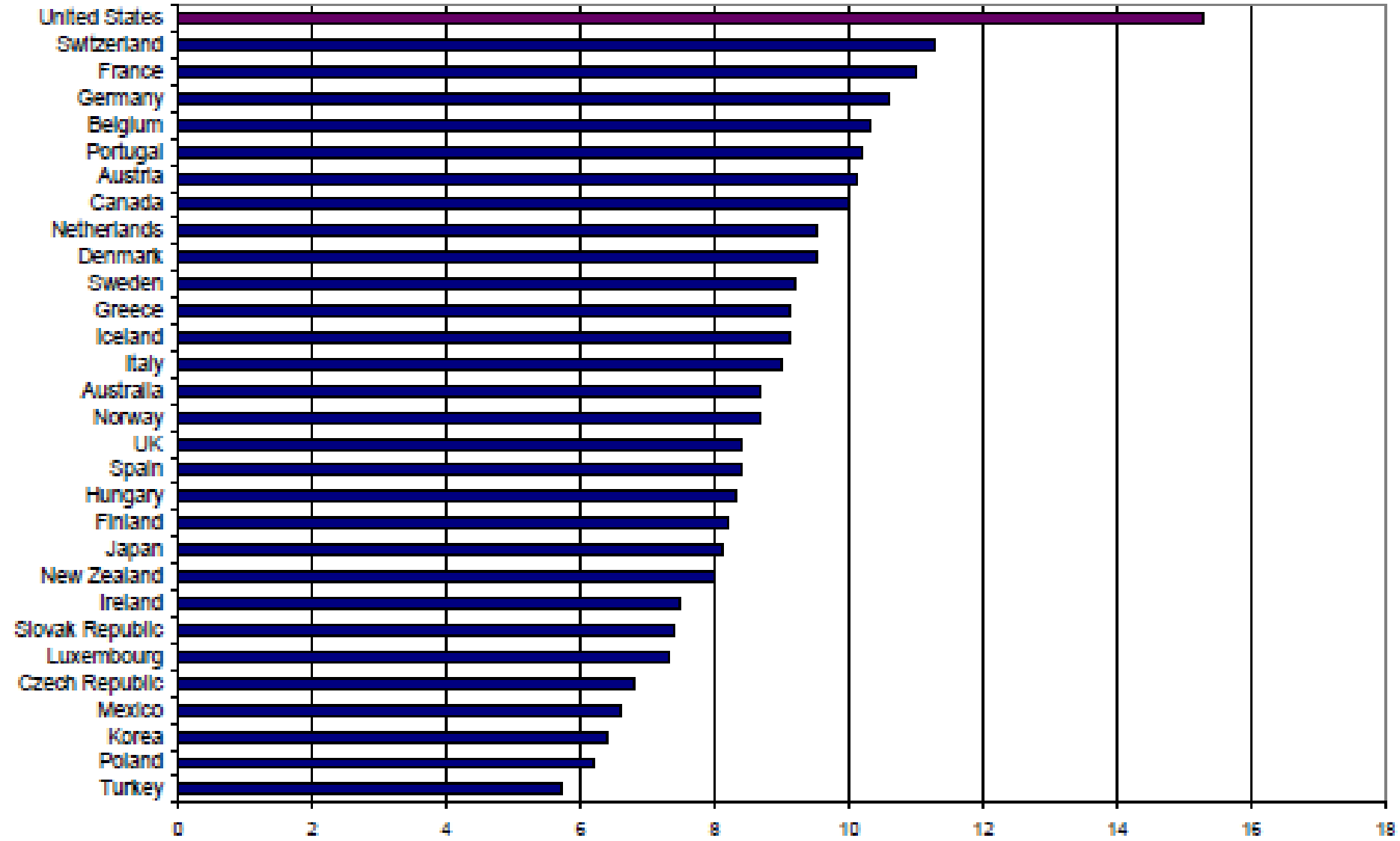
U.S. Healthcare Reform: What's the Problem? What's Being Done About It?

Topics @ Ten

October 21, 2012

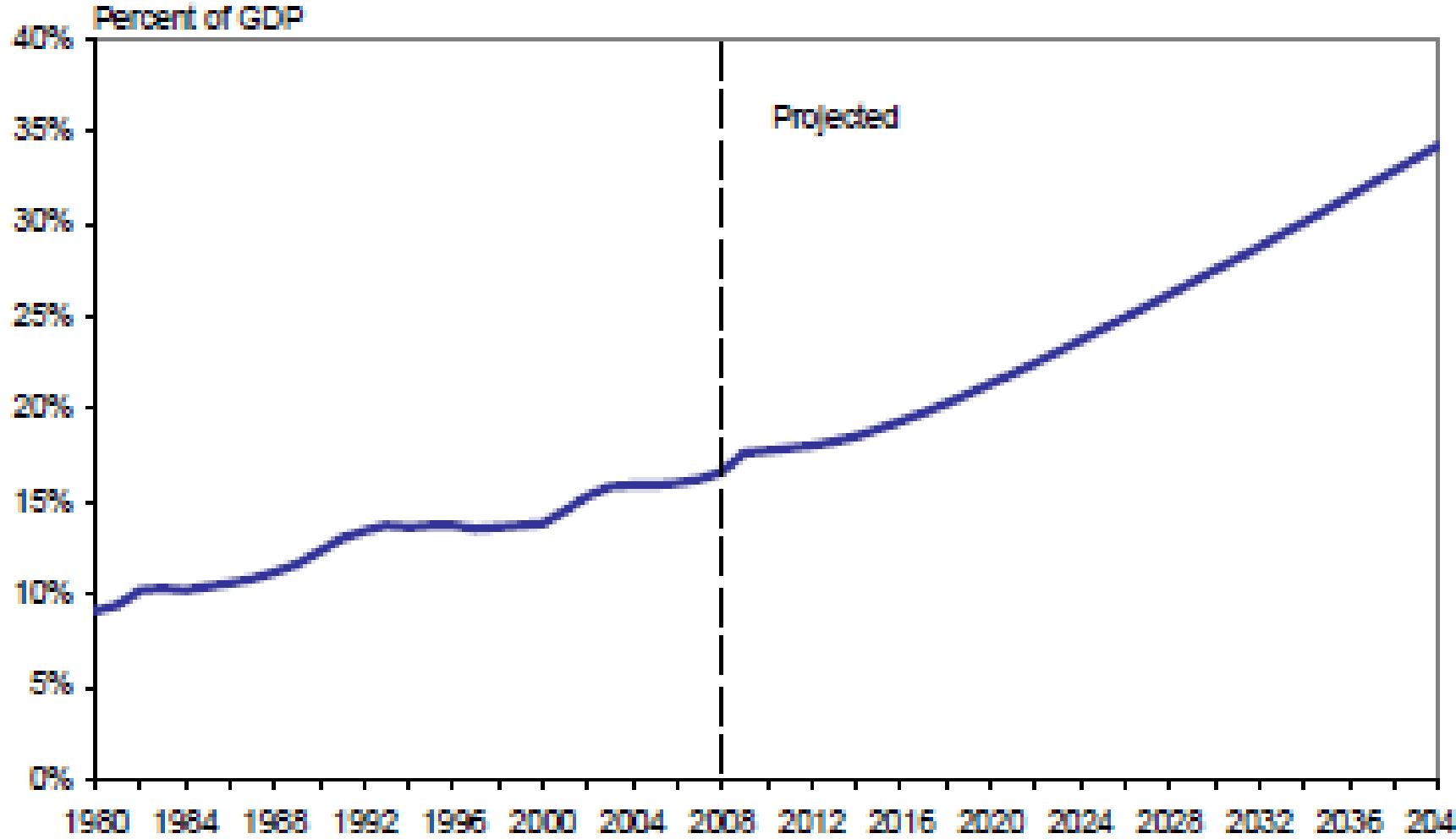
Figure 8: International Comparison of Health Care Spending as a Share of GDP, 2006



Source: Organization for Economic Cooperation and Development, OECD Health Data, 2008 (Paris: OECD, 2008).
Note: For countries not reporting 2006 data, data from previous years is substituted.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Figure 1: National Health Expenditures as a Share of GDP, 1980-2040

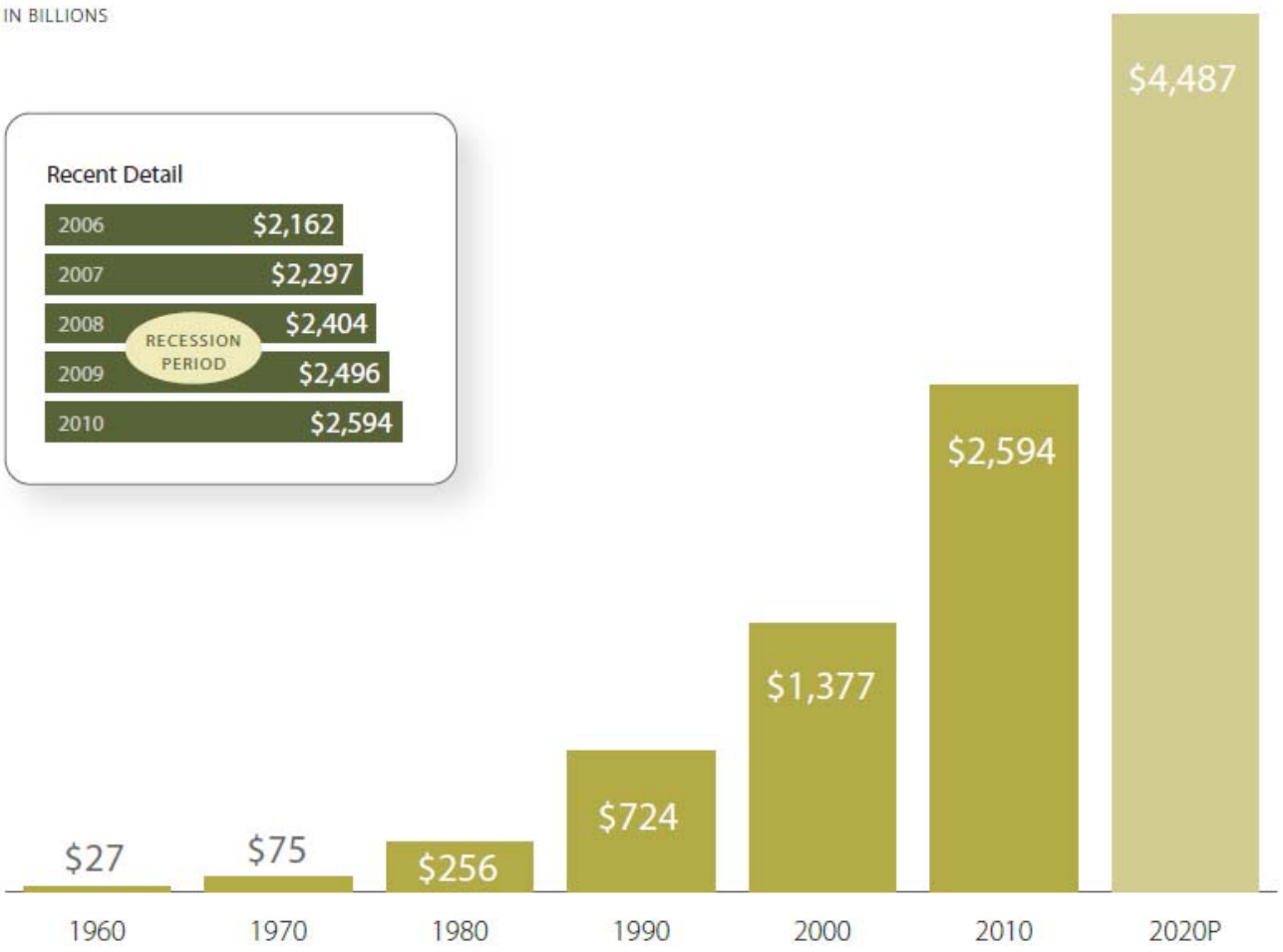


Source: CEA calculations.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Health Spending

United States, 1960 to 2020, selected years



Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

Health Care Costs 101
Spending Levels

National health spending reached nearly $2.6 trillion in 2010 and is projected to reach $4.5 trillion in 2020.

http://www.chcf.org/publications/2012/08/health-care-costs-101

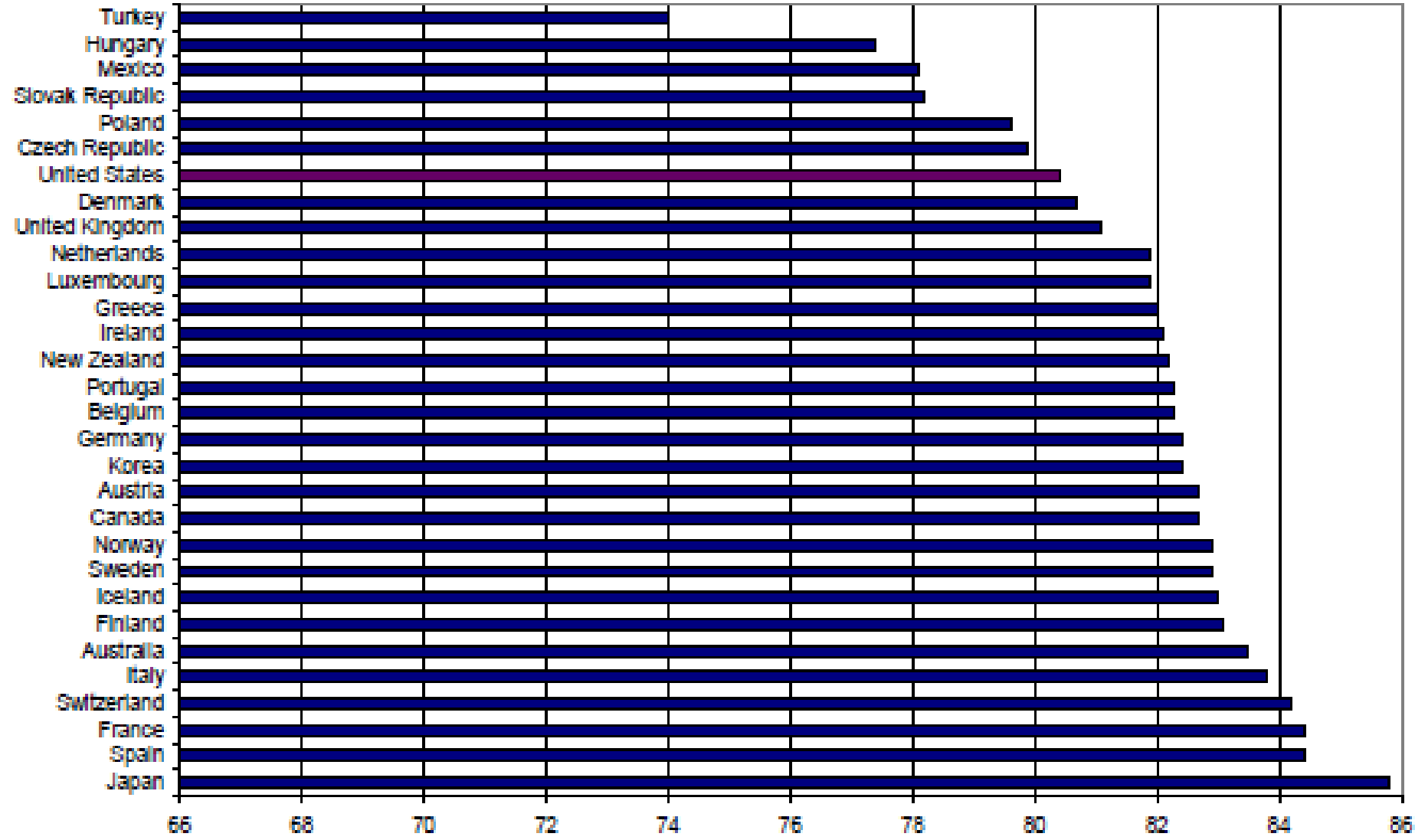
Some unpleasant facts.

- 44,800 excess deaths occurred annually due to lack of health insurance according to a 2009 Harvard study.
- USA has a higher infant mortality rate than most of the world's industrialized nations.
- A 2001 study in five states found that medical debt contributed to 46.2% of all personal bankruptcies.
- According to the WHO, the United States spent more on health care per capita ($7,146) than any other nation in 2008

A 2004 Institute of Medicine (IOM) report said: "The United States is among the few industrialized nations in the world that does not guarantee access to health care for its population."

http://en.wikipedia.org/wiki/Health_care_in_the_United_States

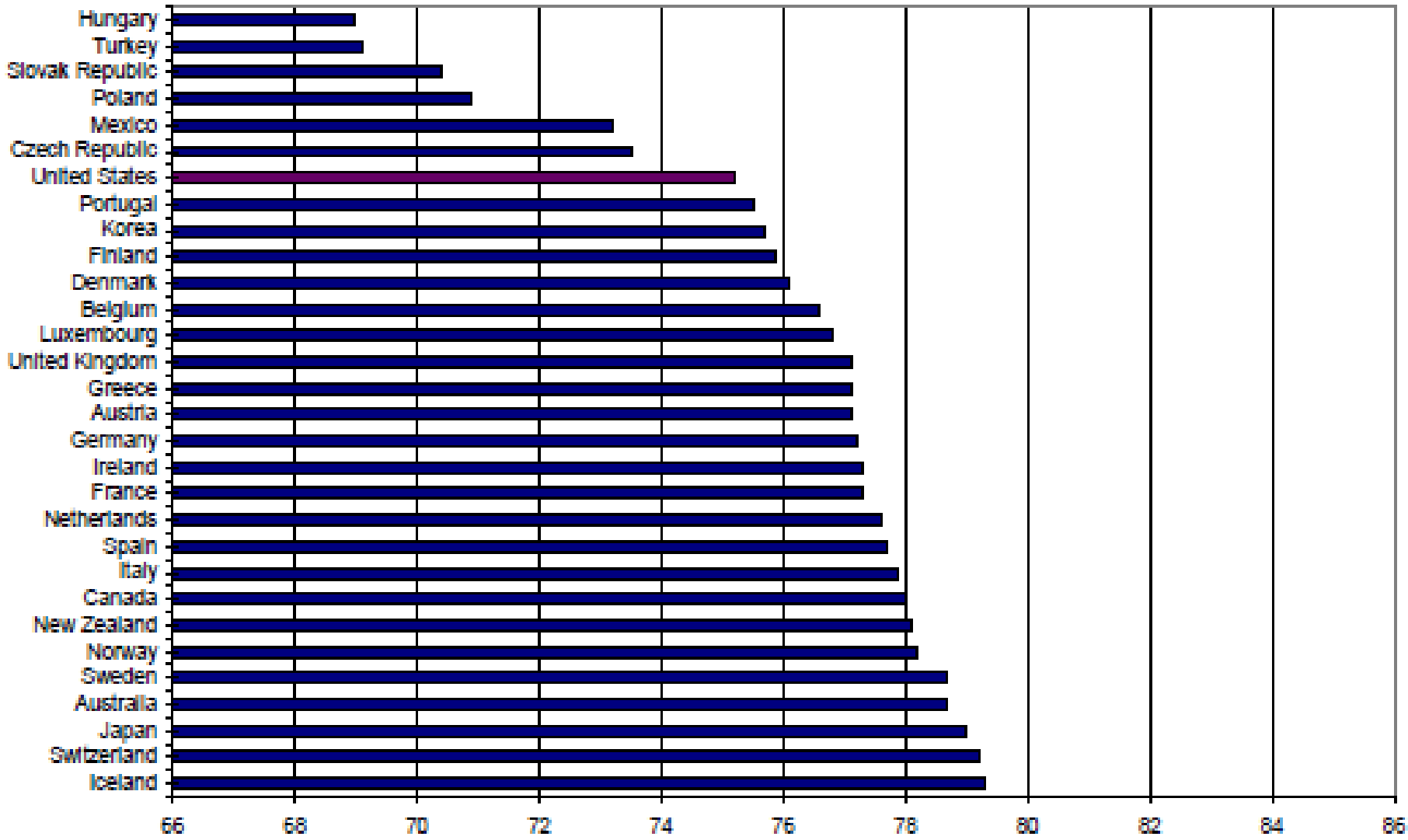
Figure 9a: Female Life Expectancy at Birth, 2006



Source: Organization for Economic Cooperation and Development. OECD Health Data, 2008 (Paris: OECD, 2008).
Note: For countries not reporting 2006 data, data from previous years is substituted.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

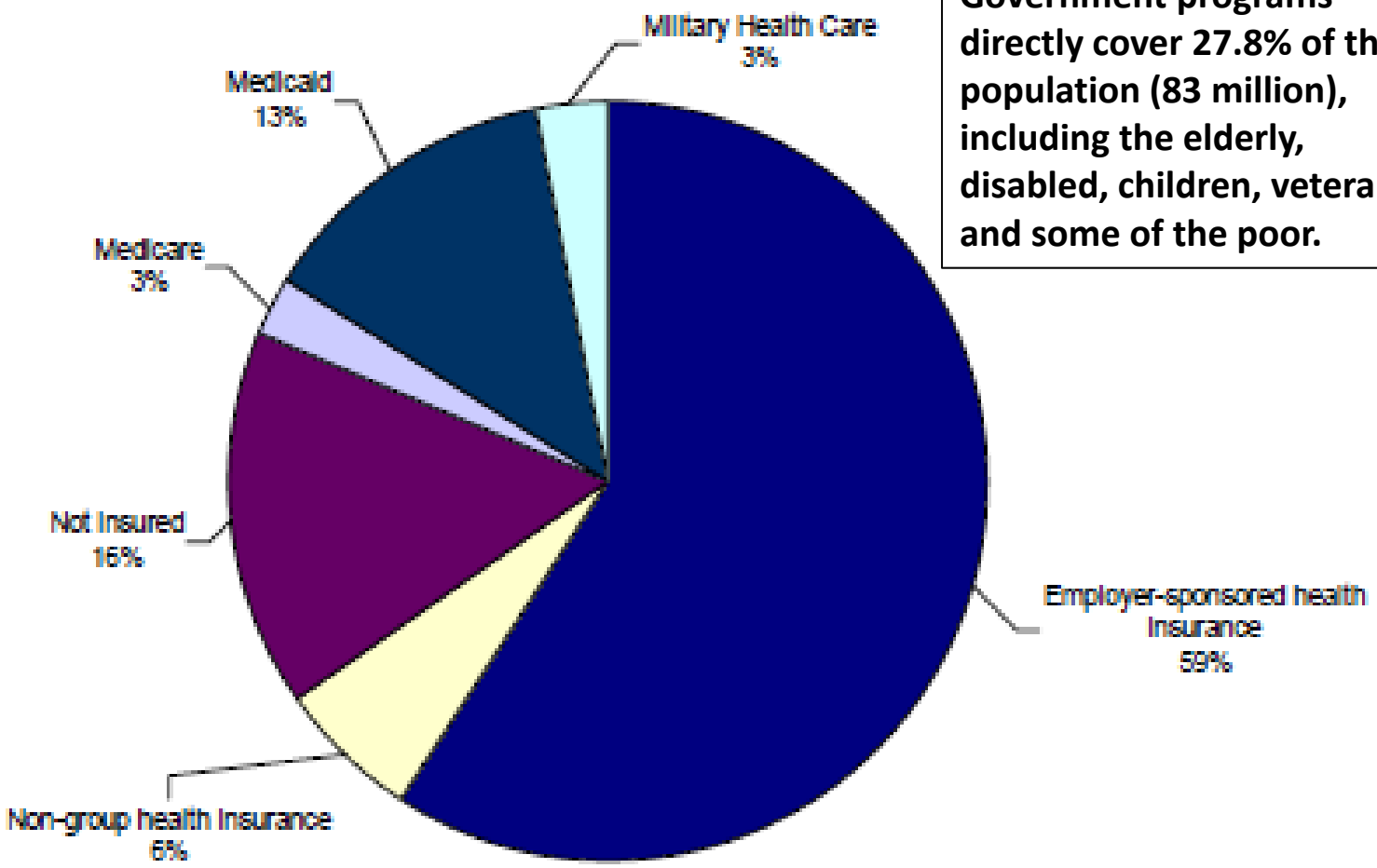
Figure 9b: Male Life Expectancy at Birth, 2006



Source: Organization for Economic Cooperation and Development, OECD Health Data, 2008 (Paris: OECD, 2008).
Note: For countries not reporting 2006 data, data from previous years is substituted.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Figure 2: Health Insurance Status of Non-Elderly Individuals in the United States, 2007

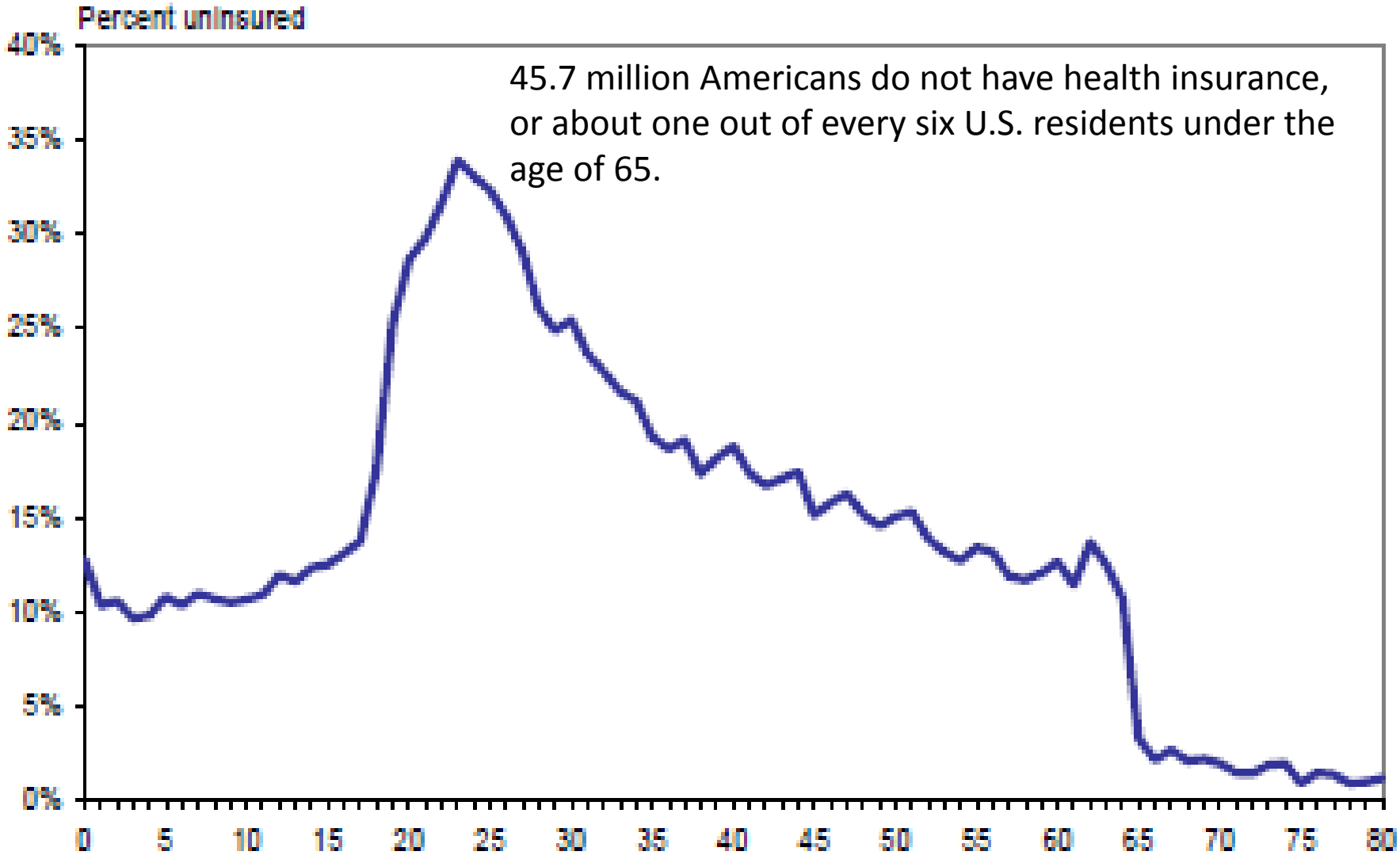


Government programs directly cover 27.8% of the population (83 million), including the elderly, disabled, children, veterans, and some of the poor.

Source: U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2007.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf
http://www.census.gov/prod/2008pubs/p60-235.pdf

Figure 6: Percent of Americans Unisured by Age

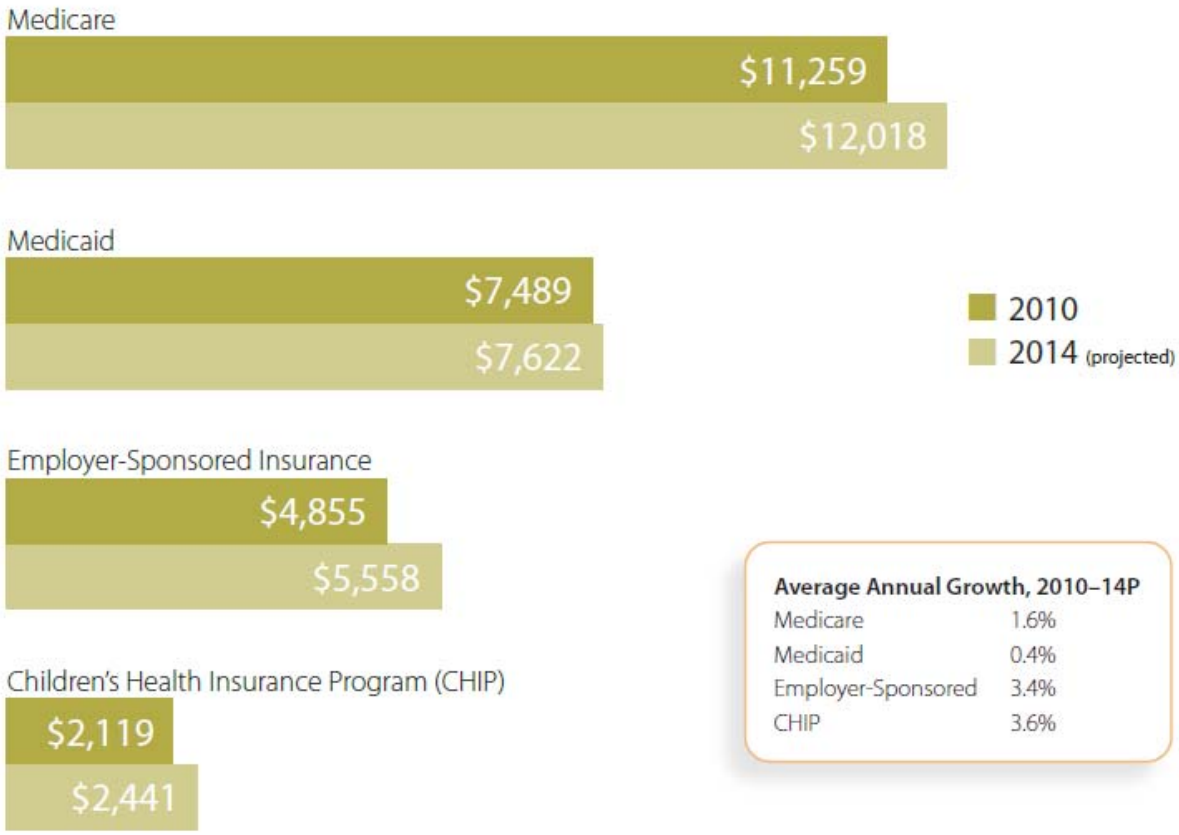


Source: U.S. Census Bureau. 2006 Annual Social and Economic (ASEC) Supplement.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Health Spending Per Enrollee

United States, 2010 and 2014



Average Annual Growth, 2010–14P	
Medicare	1.6%
Medicaid	0.4%
Employer-Sponsored	3.4%
CHIP	3.6%

Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act. Medicare physician payment rate reductions will take effect in 2013; new Medicaid enrollees in 2014 are expected to be younger and healthier than current enrollees, holding down per enrollee spending.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

Health Care Costs 101
Spending Levels

Medicare spending per enrollee was 2.3 times higher than employer-sponsored insurance spending per enrollee, mainly reflecting the greater health care needs of the elderly and disabled. CHIP's per enrollee spending is consistently less than half that of other insurers.

http://www.chcf.org/publications/2012/08/health-care-costs-101

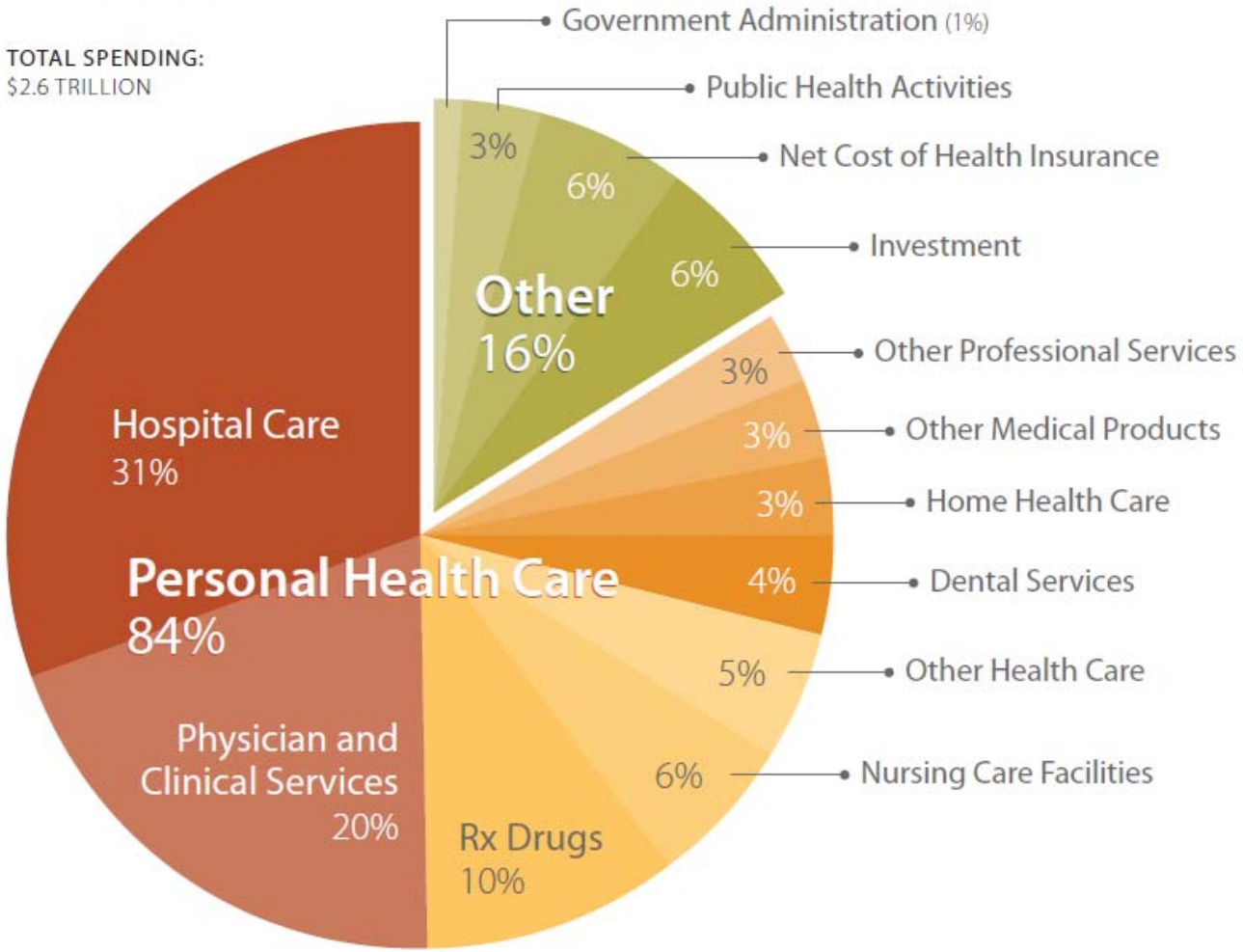
More than $43 billion is spent by taxpayers to help pay for costs incurred by uninsured that can't afford emergency care.

- In 2008, total government spending to reimburse uncompensated care costs incurred by medical providers was approximately $42.9 billion.23
- In the absence of reform to slow the real growth rate of health spending and a subsequent rise in the uninsured, we project that the real annual tax burden of uncompensated care for an average family of four will rise from $627 in 2008 to $1,652 (in 2008 dollars) by 2030.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Health Spending Distribution, by Category

United States, 2010



Notes: Health spending refers to National Health Expenditures. See Appendix A for details on category breakdown; additional information on category definitions at: www.cms.gov and methodology at: www.cms.gov. Categories may not sum to 100% due to rounding.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

Health Care Costs 101
Spending Categories

Hospital and physician services combined accounted for just over half of health care spending. Prescription drugs, the third largest spending category, accounted for another 10%.

SPENDING CATEGORY DEFINITIONS

Government administration includes the administrative costs of health care programs such as Medicare and Medicaid.

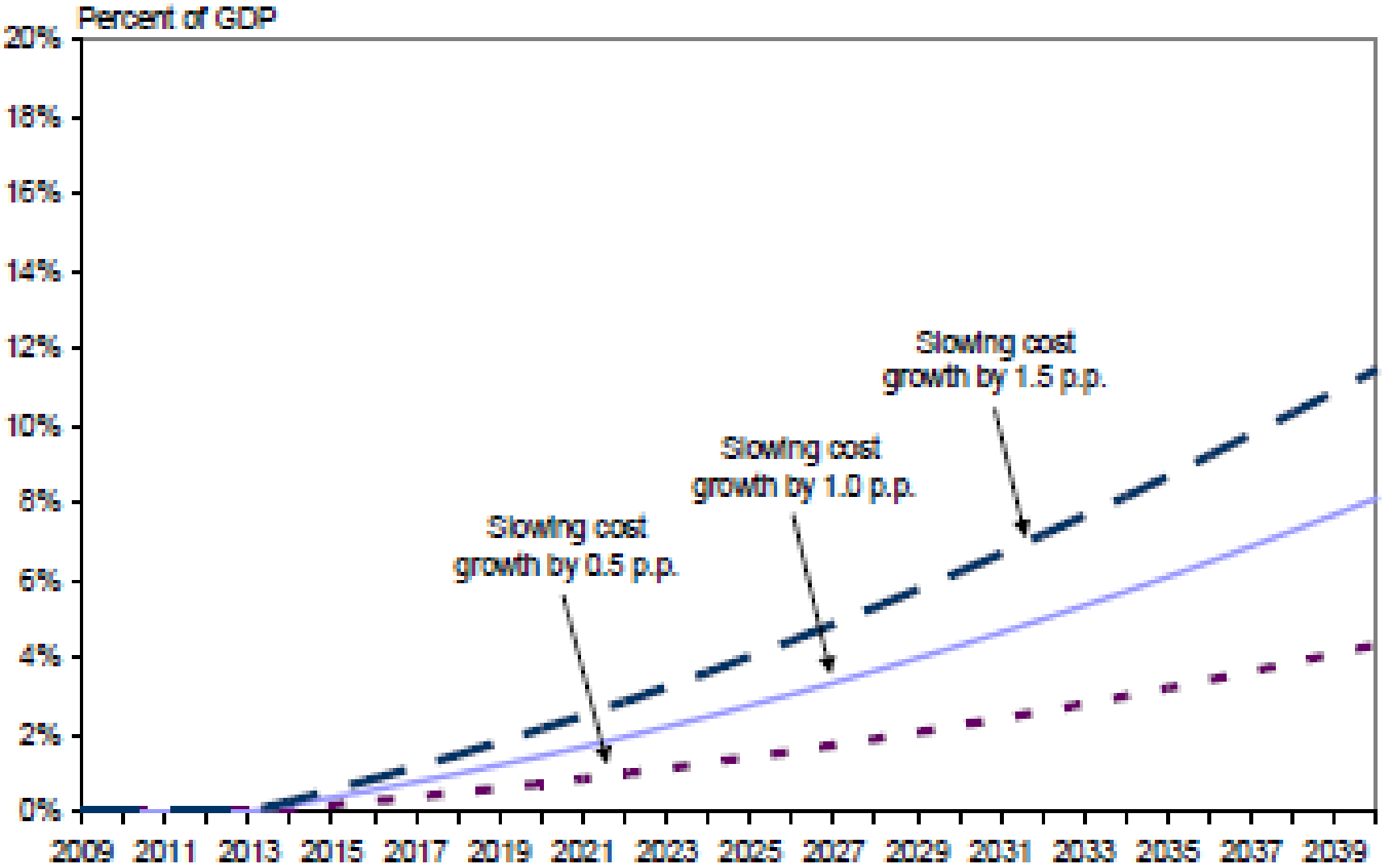
Net cost of health insurance reflects the difference between benefits and premiums for private insurance.

Other health care refers to the category other health, residential, and personal care.

Other medical products refers to durable medical equipment and non-durable medical products.

http://www.chcf.org/publications/2012/08/health-care-costs-101

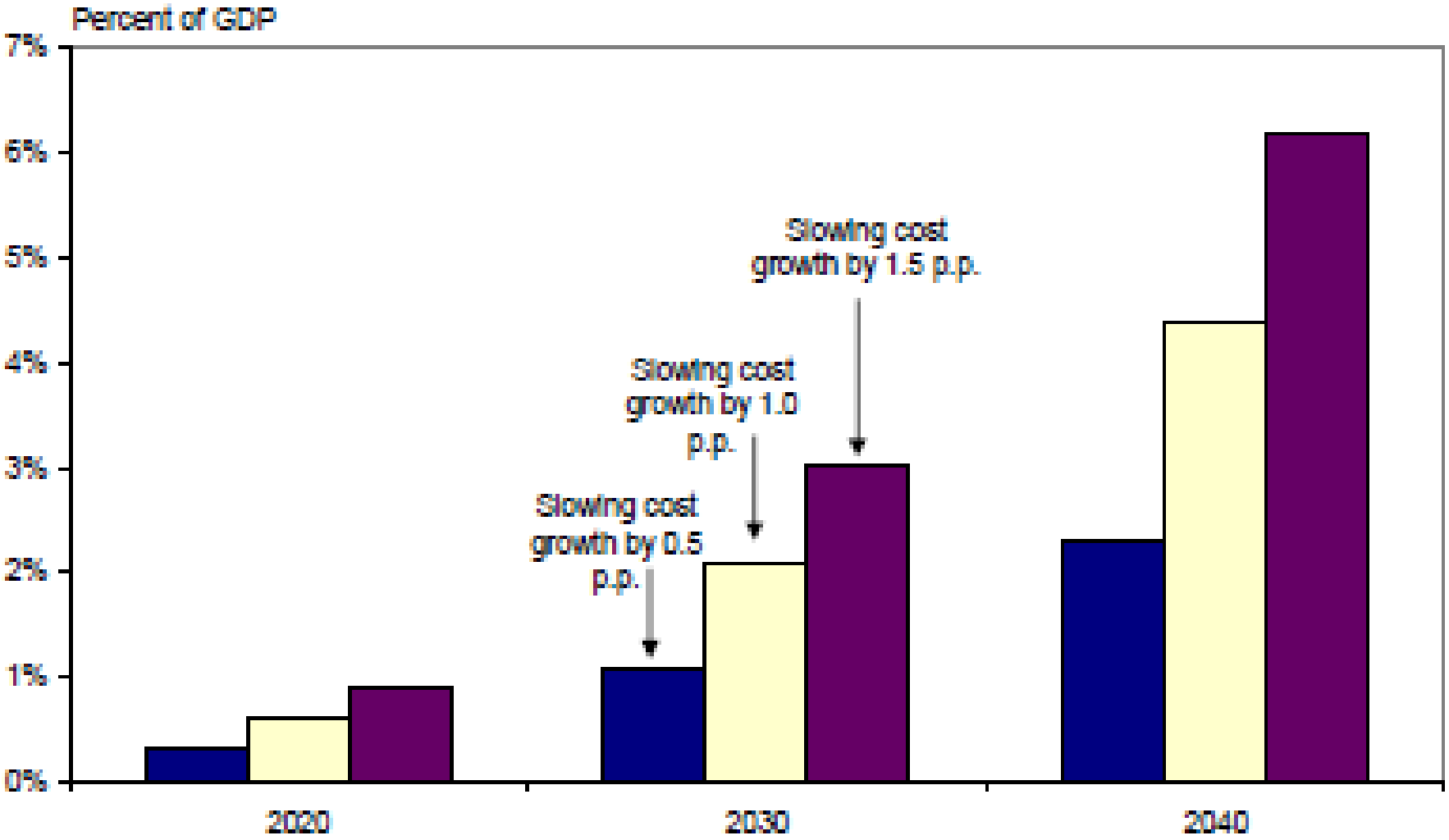
Figure 12: Impact on GDP of Improved Efficiency in Health Care



Source: CEA calculations.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Figure 14: Reduction in Federal Budget Deficit Due to Health Care Reform



Source: CEA calculations.

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

Patient Protection & Affordable Care Act ("ObamaCare") & Legal Challenges

- On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) became law, providing for major changes in health insurance.
- On November 14, 2011, the Supreme Court of the United States agreed to consider appeals to its rulings in *National Federation of Independent Business v. Sebelius* and *Florida v. United States Department of Health and Human Services*.
- The Court heard oral arguments March 26–28, 2012 and decided the consolidated case on June 28, 2012.
- Though the Supreme Court declared that the Commerce Clause did not protect the law, and that under that justification it was not constitutional, the Court declared the penalty was constitutional as a tax, upholding the individual mandate.
- The Court also limited the expansion of Medicaid initially proposed under the PPACA. All provisions of the PPACA will continue to be in effect, with some limits on the Medicaid expansion.

http://en.wikipedia.org/wiki/Constitutional_challenges_to_the_Patient_Protection_and_Affordable_Care_Act

Patient Protection and Affordable Care Act Highlights

- **Guaranteed coverage**: pre-existing conditions must be covered;
- **Equivalent rates**: insurers must offer the same premium to all applicants of the same age and geographical location without regard to gender or pre-existing conditions
- **Individual mandate** requires that all individuals purchase and comply with an approved private insurance policy or pay a penalty (tax)
- **Health insurance exchanges** will be launched by state, where individuals and small businesses can compare policies and premiums, and buy insurance (with a government subsidy if eligible).
- Low income individuals and families above 100% and up to 400% of the federal poverty level will receive subsidies on a sliding scale if purchase insurance via an exchange.
- **Expands Medicaid eligibility** up to 133% of poverty level, and simplifies the CHIP enrollment process.
- Sets minimum standards for health insurance policies
- **Annual and lifetime coverage caps are banned**.
- Very small businesses will be able to get subsidies if they purchase insurance through an exchange.
- Co-payments and deductibles are to be eliminated for select health care insurance benefits considered to be part of an "essential benefits package" for certain preventative care.
- Changes are enacted that allow a restructuring of Medicare reimbursement from "fee-for-service" to "bundled payments."

However, the Supreme Court overturned a provision of ACA, effectively allowing states to opt out of the Medicaid expansion, and a number states intend to do so. Those at or below 133% of the poverty line, but above their state's existing Medicaid threshold, will not be eligible for coverage;

http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

Summary of Funding

Summary of tax increases: (ten year projection)

- Increase Medicare tax rate by .9% and impose added tax of 3.8% on unearned income for high-income taxpayers: $210.2 billion
- Charge an annual fee on health insurance providers: $60 billion
- Impose a 40% excise tax on health insurance annual premiums in excess of $10,200 for an individual or $27,500 for a family: $32 billion
- Impose an annual fee on manufacturers and importers of branded drugs: $27 billion
- Impose a 2.3% excise tax on manufacturers and importers of certain medical devices:$20 billion
- Raise the 7.5% Adjusted Gross Income floor on medical expense deduction to 10%: $15.2 billion
- Limit annual contributions to flexible spending arrangements to $2,500: $13 billion
- All other revenue sources: $14.9 billion

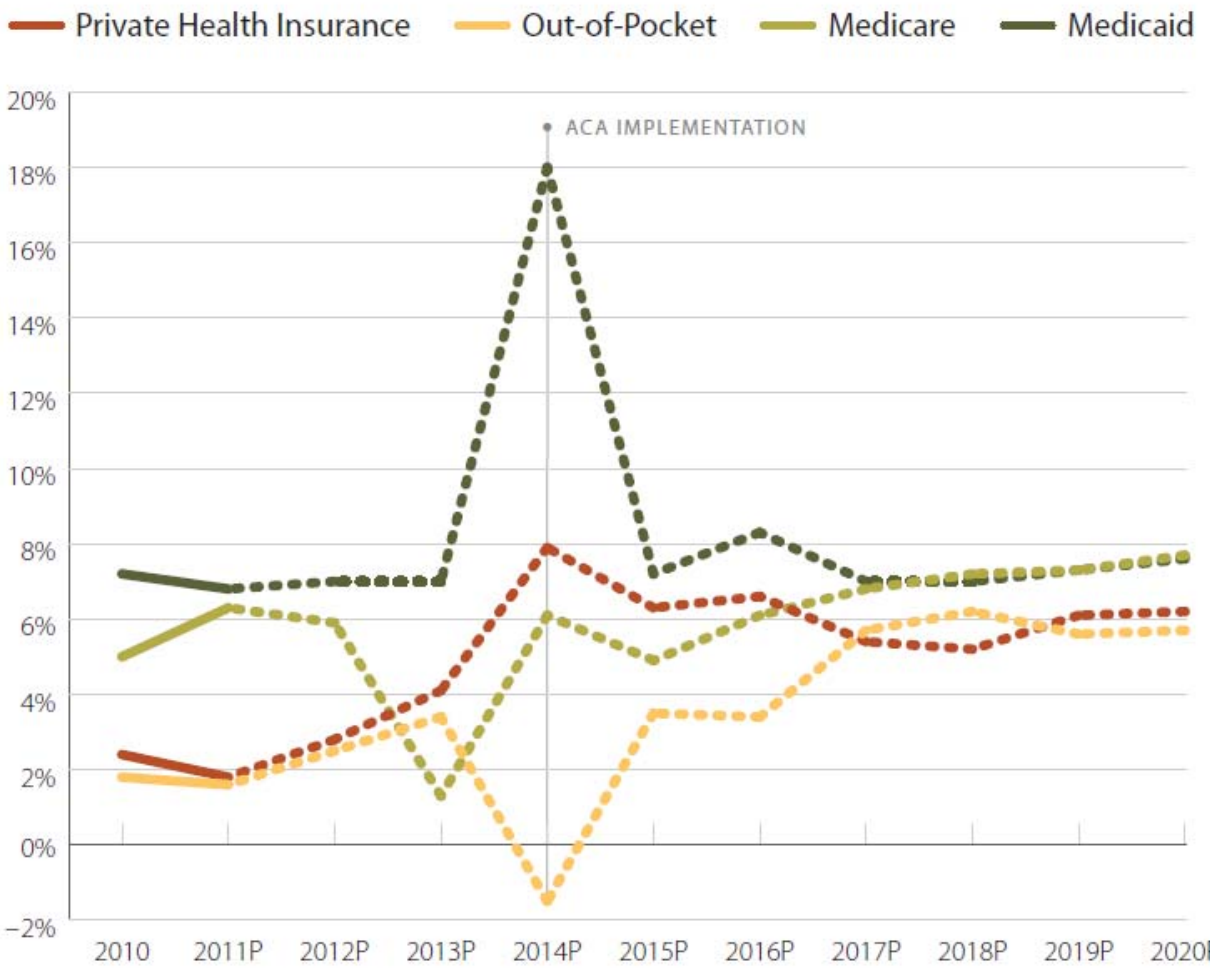
Summary of spending offsets: (ten year projection)

- Reduce funding for Medicare Advantage policies: $132 billion
- Reduce Medicare home health care payments: $40 billion
- Reduce certain Medicare hospital payments: $22 billion

http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

Annual Growth Rates, by Payer

United States, 2010 to 2020



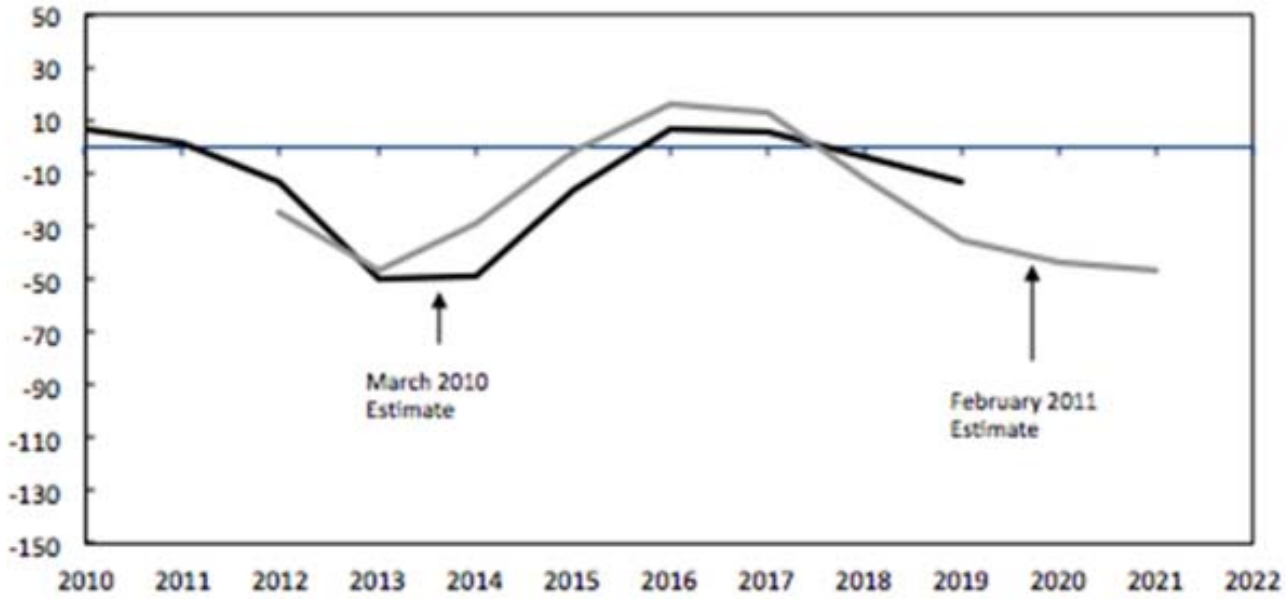
Notes: Projections (P/dotted lines) include the impact of the Affordable Care Act. The projected 2013 slowdown in Medicare spending is the result of two policy actions: a 30.9% cut to physician payment rates mandated by Medicare's sustainable growth rate formula and a provision of the Budget Control Act of 2011, which requires an estimated 2% cut to Medicare payments between 2013 and 2022. Not shown: Other Public Health Insurance, Other Payers.

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release. See Appendix B for detail on payer projections.

With the implementation of health reform in 2014, many people are expected to gain insurance, especially through Medicaid. Accordingly, Medicaid spending is projected to increase the most of all payers — 18%, up from 7% the prior year. Out-of-pocket spending is expected to fall as many uninsured people gain coverage.

Comparison of CBO's 2010 and 2011 Estimates of the Net Budgetary Impact of All Provisions of the Affordable Care Act

(Billions of dollars, by fiscal year)



Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: Negative numbers imply a reduction in budget deficits

The Affordable Care Act (ACA) is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

The March 2010 estimate, which covers 2010 to 2019, comes from CBO's cost estimate for the ACA in March 2010. The February 2011 estimate, based on a cost estimate covering 2012 to 2021, was produced using CBO's baseline projections of revenues and outlays available in early 2011.

http://en.wikipedia.org/wiki/File:CBO_-_Budget_Impact_of_Affordable_Care_Act_-_March_2012.png

Will implementation of Health Insurance Exchanges work as proponents predict?

Economics of Health Insurance Exchanges: The Individual Mandate

- Insurers were willing to accept these constraints on pricing, capping, and enrollment because the individual mandate spreads the financial risk of newly insured people with pre-existing conditions among a larger pool of individuals.
- Estimated that the 99th percentile of financial risk represented 3.95X the average risk (mean)[23]. Figures from the House Committee on Energy and Commerce indicate that ~1 million high-risk individuals will pursue insurance in the Exchanges. Congress has estimated that 22 million people will be newly insured .
- Thus high-risk individuals do not number in high enough quantities to increase the net risk per person from previous practice. It is thus theoretically profitable to accept the individual mandate in exchange for the requirements presented in the ACA.
- Only 19 states and Washington, DC, have taken steps toward creating the Exchanges which launch 1/1/2014. The federal government will set up exchanges for those states not doing it themselves.

Concerns

- However, **adverse selection** is a concern for insurers. This means that only sick individuals will enroll when they need care, and others will wait to enroll until they also need care.
- The result of this potential phenomenon would be an influx of high-risk individuals without the corresponding pool of healthy individuals over which to distribute risk.
- State insurance exchanges in Texas and elsewhere failed due to this problem.
- MA solved this problem through an individual mandate requirement in the law known as "RomneyCare" signed by Gov. Romney in 2006.

http://en.wikipedia.org/wiki/Health_insurance_exchange
http://en.wikipedia.org/wiki/Massachusetts_2006_Health_Reform_Statute

What does candidate Romney propose?

- Mr. Romney has vowed to **"repeal and replace"** the law. Whether he could actually do so is debatable.
  - He would probably offer states waivers from the law (some would not accept), then try to repeal the law in its entirety.
  - Democrats would surely filibuster attempts at repeal. Mr Romney may try to scuttle parts of the law through "reconciliation", a process usually reserved for budget measures, which requires a simple majority vote.
- Even if Mr Romney were to repeal the law, it is unclear what he would replace it with—or if Congress would have the appetite to replace it at all. Mr Romney's governing philosophy is that Washington's role should shrink, with states and the private sector leading reform instead.
- Like congressional Republicans, he favors letting insurers sell products across state lines. He wants tax breaks for individuals who buy insurance on their own.
- Turning his back on everything he did in Massachusetts, Mr. Romney has few plans to expand coverage.
- He would gut Mr. Obama's Medicaid provisions, the state exchanges and their accompanying subsidies. Mr. Romney would instead give states a set amount of money for their Medicaid patients, to contain spending.
- Confusingly, in September he said he would keep parts of Mr. Obama's law, such as guaranteed coverage for the sick. He did not explain that the guarantee would be only for those previously insured.

Economist Oct6-12 Election Special; http://www.economist.com/node/21563954

What does candidate Romney propose for Medicare?

- Romney / Ryan plan would give the elderly (starting in 10 years) vouchers to spend on insurance.
- Beginning in 2022, beneficiaries could buy insurance on a new "Medicare Exchange".
  - They would keep the savings if a plan cost less than their voucher and pay the extra if a plan cost more. Competition would supposedly contain costs.

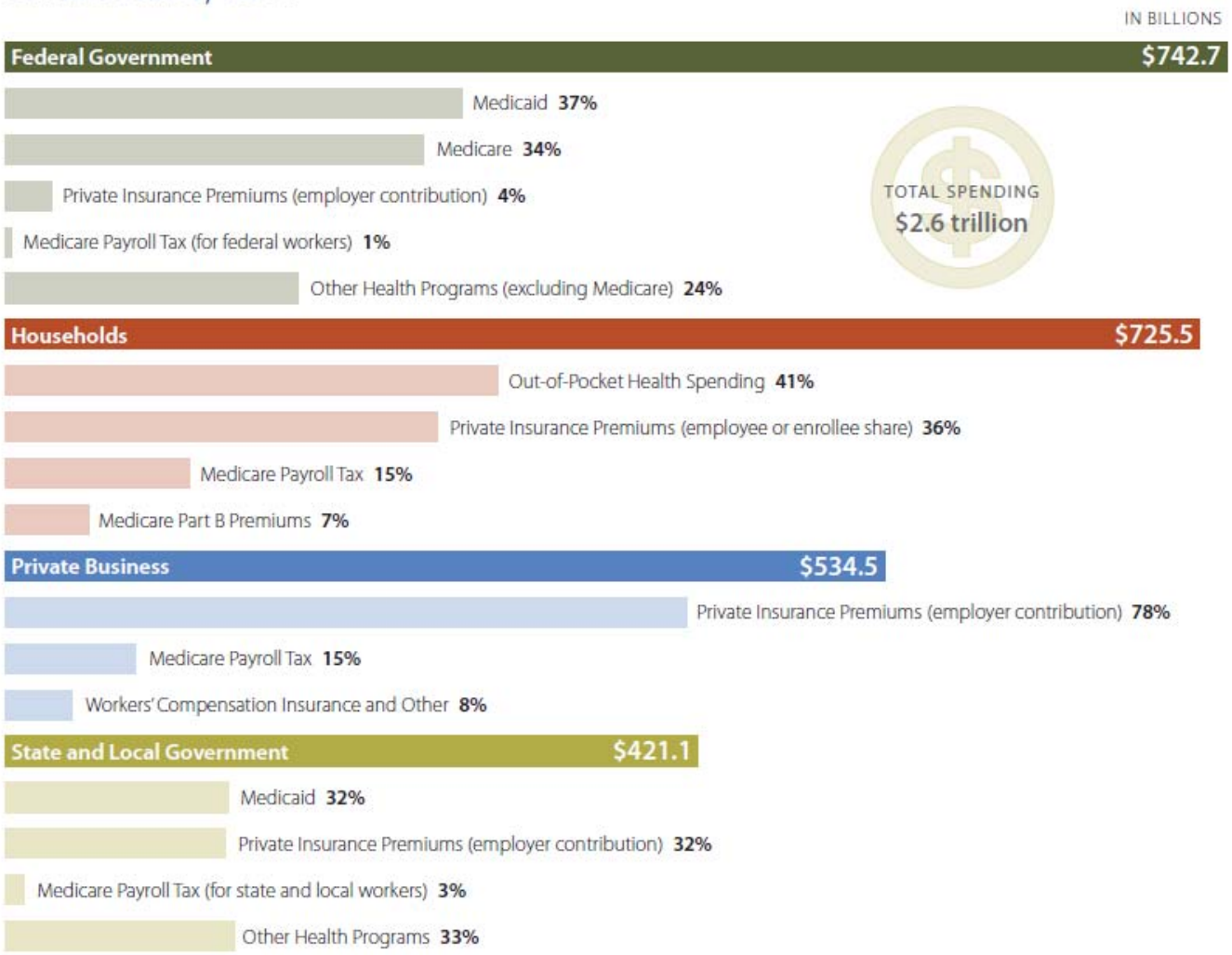
Ironically, Romney/ Ryan and Obama plan each favor health exchanges, but Obama plan rejects the idea for the elderly and Romney/Ryan would scrap the idea for the rest.

Economist Oct6-12 Election Special; http://www.economist.com/node/21563954

Appendix

Health Spending Distribution, Contributor Detail

United States, 2010



Notes: Health spending refers to National Health Expenditures. Not shown: Other Private Revenues ($169.9 billion), which includes philanthropy, privately funded structures and equipment, and investment income. Medicaid buy-in premiums for Medicare are reflected under Medicaid. Figures may not add due to rounding. CMS refers to contributors as "sponsors."

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

Health Care Costs 101
Contributors

The majority (77%) of private business spending on health care consisted of employer contributions to insurance premiums for workers. Household spending consisted largely of contributions to private insurance premiums and out-of-pocket spending on copays, coinsurance, and items not covered by insurance.

http://www.chcf.org/publications/2012/08/health-care-costs-101