The Affordable Care Act: A New Health Insurance Paradigm?
November 5, 2010
The Size of the So-Called Problem
Health Care Spending as Percent of GDP in Selected OECD Countries, 2007

- United States
- United Kingdom
- Sweden
- Norway
- Japan
- Italy
- Germany
- France
- Canada
- Australia
Health Care as % of GDP

health care growth continues at current rate

Calendar Year

% GDP

Total

Other Health

Medicare

Medicaid

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What Do We Get For Our Money?
MRI’s Per Million in 2007

- United States: 25
- United Kingdom: 8
- France: 6
- Canada: 6
- Australia: 5
Do We Spend More and Get Less?

- In the U.S. health care is 16% of GDP and in Japan 8% of GDP.
- Japanese life expectancy is greater than in the U.S.
  - 79.1 versus 75.2 for males
  - 86.4 versus 80.6 for females
- But, in the U.S. Japanese-Americans have a female life expectancy of 88.0 and a male life expectancy of 82.5.
Some Further Comparisons

I. Canada has 6.7 MRIs per million citizens while the U.S. has 25.9 MRIs per million citizens.

II. Canadians pay for care with time and not money. The median waiting time for procedures:
   a) For radiation treatment for breast cancer in province of Ontario: 8 weeks
   b) For angioplasty in the province of British Columbia: 12 weeks
   c) For radiation treatment for prostate cancer in province of Quebec: 12 weeks
   d) For cataract removal in the province of Ontario: 20 weeks.
   e) For cataract removal in the province of Saskatchewan: 52 weeks.
   f) For a tonsillectomy in the province of Saskatchewan: 80 weeks.

III. For Europe the Five-year cancer survival rates show the impact of rationing:
   a) For leukemia, the American survival rate is almost 50 percent; the European rate is just 35 percent.
   b) For esophageal carcinoma: 12 percent survival in the United States, 6 percent in Europe.
   c) For prostate cancer is 81.2 percent survival in the United States, 61.7 percent in France and down to 44.3 percent in England.
The Uninsured: Who and Why
Health Insurance Coverage

- Percentage of Total Population

- 1999: 90%
- 2000: 88%
- 2001: 86%
- 2002: 84%
- 2003: 82%
- 2004: 80%
- 2005: 78%
- 2006: 76%

- Red line: private and government
- Green line: not covered
Why Be Uninsured?

• You are young and healthy
• You have a “free” care alternative
• The tax breaks only apply to firm sponsored plans
• There is an absence of competition in health insurance when purchased outside a firm
Composition of the Uninsured Population in 2008

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Percent Change in the Number of Uninsured Americans by Income (1998 - 2007)

-21%  -2%  27%  65%
<$25K  $25K-$50K  $50-$75K  $75K+

The Entitlement Tsunami
Medicare and Medicaid Funding Shortfalls

Percent of Federal Income Taxes

Source: CBO “The Long-Term Budget Outlook,” June 2009 and author’s estimates.
Federal Income Taxes are estimated to be 10.7% of GDP, the 50-year average.
Let The Workers Pay
Payroll Tax Required to Pay for Projected Medicare and Social Security Deficits

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Let the Elderly Pay
Medicare Premiums as a Share of Projected Medium Earner Social Security Benefits

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What Has Been Done:

The Patient Protection and Affordable Care Act
Some Immediate Results of Health Care Reform

- New taxes on medical equipment and drugs that will raise prices for services.
- Allow "children" to age 26 to stay on their parents coverage. Since the young are healthy in a real market their coverage less expensive.
- Mandatory first dollar coverage for preventive services.
- Minimum loss ratios of 80% for small groups and individual coverage, and 85% for larger groups.
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- Mandatory first dollar coverage for preventive services.
- Minimum loss ratios of 80% for small groups and individual coverage, and 85% for larger groups.
- Accept all applicants, regardless of medical history.
- No dollar cap on coverage.
- Offer dental and vision care for children.
- Mental health and substance abuse services.
- No copayments for routine care.
- Coverage of adult children up to age 26 on parents' plans.
Effect of PPACA, as Amended, on 2019 Enrollment by Insurance Coverage
(in millions)

Prior Law
PPACA

Medicare
Medicaid and CHIP
Employer
Individual
Uninsured

60.5
63.5
83.9
165.9
164.5
25.7
41.6
56.9
23.1
Total Health Care Expenditures: Prior Law and PPACA

% GDP


PPACA  Prior Law

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The Uninsured After Reform
2019

Undocumented: 5
Choice: 18
Let The States Pay
The States Share of Medicaid Expenditures: 2010 and 2019
Projected Effect on Medicare Advantage by 2019

Current Law: 14.8

PPACA: 7.4
Two “Pie in The Sky” Provisions
The Independent Payment Advisory Board: Can it Reduce the Cost of Medicare?

• Charged with preventing per-beneficiary Medicare cost from increasing faster than the average of the CPI.
• Reasons for Rising Per-Beneficiary Costs of Medicare
  – Health care price growth.
  – Increasing utilization.
  – Increasing complexity of health care services.
• The past attempts at such cost control indicate that these changes will not and cannot happen.
  – Over the last 25 years the average increase in the target growth rate has been 0.33 percent below the average increase in per capita GDP, approximately the target level of the physician growth rate (SGR) payment system.
  – Congress has overridden the SGR-based payment reductions for each of the last 7 years and for the first 5 months of 2010.
Payment Updates

Payment updates will be adjusted downward by the increase in productivity experienced in the economy overall.

Since the provision of health services tends to be labor-intensive and is often customized to match individuals’ specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large.

Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services.

Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.
75-Year Medicare Unfunded Liability
2009-2010
Long-Run Medicare Unfunded Liability
2009-2010

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Relative Costs Assuming PPACA Provisions
Projected Medicare Expenditures

% GDP

Calendar year

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Comparing the Annual Flows
Medicare Spending from the 2010 Trustees Report as a Percent of Spending from the 2009 Trustees Report

Sources: Table III.A2. 2009 and 2010 Medicare Trustees Reports. Percents reflect the 2010 Report’s shares of GDP as percents of the 2009 estimates.

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Does the Patient Protection and Affordable Care Act
“Bend the Curve?”
National Health Expenditures (NHE) as a Percent of GDP

National Health Expenditures (NHE) per capita


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Bending the Medicare “Curve”
Medicare per Beneficiary

Long-Run Comparison
Reduction in Medicare Benefits Per Beneficiary

Sources: Medicare benefits are net of premiums and premiums of 25 percent of Part B and D spending are assumed. 2009 Medicare benefits are from and May 12, 2009, Office of the Actuary memorandum and 2010 benefits are from 2010 Medicare Trustees Report.
Percent of Social Security Income Required to Cover the Reduction in Medicare Benefits

Sources: Table III.A2. and A3. 2009 and 2010 Medicare Trustees Reports, Tables VI. F6 and F10 from 2009 and 2010 Social Security Trustees Reports, and May 12, 2009, Office of the Actuary memorandum. Social Security income is the income for average new retirees in each year.

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Implications of Spending Reductions
Medicare Prices as a Percent of Other Payers

Source: Derived from Office of the Actuary Memorandum, August 5, 2010, Figure 1.
Percent of Facilities with Negative Total Margins After the Passage of the Affordable Care Act

I encourage readers to review the “illustrative alternative” projections that are based on more sustainable assumptions for physician and other Medicare price updates.

Richard S. Foster
Chief Actuary, Centers for Medicare and Medicaid Services, 2010 Medicare Trustees Report
Comparing Medicare’s Total General Revenue Funding Requirements as Percents of Federal Income Taxes

Sources: Table III.A2. 2009 and 2010 Medicare Trustees Reports. Table VI.F4. 2009 and 2010 Social Security Trustees Reports. 2009 Alternative from May 12, 2009 Office of the Actuary Memorandum, Table 4. 2010 Alternative from August 5, 2010 Office of the Actuary Memorandum, Tables 4 & 5. Part B and D Premiums assumed to be 25 percent of spending. Federal individual and corporate income taxes assumed to be 10.6% of GDP, the 50 year average for 1960 to 2009.
A Lesson From the Past
The Medicare Catastrophic Coverage Act

- Passed June 1988 and heralded by the Reagan White House and both parties of Congress.
- Provided new health care benefits for the elderly
- Some provisions of the bill
  - Placed a ceiling on hospital and doctor bills
  - Expanded payments for nursing home care
  - Expanded payments for prescription drugs
- The new benefits were to be budget neutral
  - Increased Medicare premiums
  - Introduced a surtax for those over 65 with incomes greater than $35,000, $64,000 in 2009$
The Congressional Budget Office estimated that the average Medicare beneficiary would pay Medicare $145 for benefits available in the private market for $62.

A still existing and powerful advocacy group, The National committee to Preserve Social Security and Medicare attacked the bill.

The term “Catastrophic” implied that long-term care was to be covered – which was not the case.

Because of these shortcomings and the protest of the elderly the bill was repealed in 1989.

Is there a lesson here? Who knows.

Is Speaker Pelosi’s statement that we have to pass this bill to find out what is it, prophetic?
Is It the Level or the Rate of Growth?: Can or Do We Even Want to Bend the Curve?
Can Waste Elimination be a Major Part of the Solution?

- The former Director of OMB, Peter Orszag argues that health spending could be reduced by as much as 30 percent, or $700 billion a year, without compromising the quality of care, if more doctors and hospitals practiced like those in low-cost areas.

- Orszag argues further that the supply of hospitals, medical specialists and high-tech equipment “appears to generate its own demand.”

- Are all those mammograms and MRIs really necessary?
Unnecessary Medical Visits

- Physician Visit: 25%
- General Medical Care: 30%
- Emergency Room Visit: 55%
- Annual Physical: 100%

The Source of the Problem?
The Real Answer

Using the Power of Markets
Cosmetic Surgery versus General Health Care Inflation
Parts of the Solution

- Repeal community-rating and guaranteed-issue laws.
- Remove the penalty on the use of unspent Health Savings Accounts so that the funds are identical to other income.
- Approve Health Savings Accounts for the individual-insurance market.
- Allow individuals to shop for health-insurance across state lines.
- Allow insurers to offer plans with all levels of coverage.
If You Could Choose

- In Idaho there are only 13 mandated benefits.
- In Iowa there are 26 mandated benefits.
- Missouri, Ohio and South Carolina have 29 mandated benefits.
- In contrast, Rhode Island has 70 mandated benefits.
- Not surprisingly, health insurance costs follow mandated benefits.
Why Does Health Cost so Much?

A. Customers Don’t Care About Price.
B. Payment Restrictions on Suppliers.
C. For Most of Medicine Prices are Fiction.
Why Don’t Doctors Return Your Telephone Calls When Lawyers Do?

Why Can’t You e-mail Your Doctor and Get a Response When You Can email your Lawyer and Get a response?
Medical Tourism: Where Prices Matter
Price Lists When Prices Are Real

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