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The ACA—Two Policy Experts' Perspectives

With Kurt Wrobel

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With the upcoming deployment of the most important aspects of health care reform, we are fortunate to have two well-known policy experts respond to our questions on the legislation. Grace-Marie Turner and David Cutler participated in a debate at the SOA health conference in 2010 and this interview serves as an extension to that initial debate. While they have different views, they each provide a very articulate support of their policy positions.

As we enter into the most important phase of the Affordable Care Act (ACA), have you been surprised by any particular aspects of its implementation?

Grace-Marie: Unfortunately, the ACA is unfolding with the implementation problems, delays, economic distortions and rising costs that my colleagues and I had predicted.

What has surprised me is the determination of the law's supporters to continue to press forward in spite of the harm it clearly is doing to the most vulnerable Americans. A few examples: People with lower incomes are finding their hours slashed to part time by employers threatened with fines for not complying with the ACA's temporarily postponed employer mandate. Seniors without retiree supplemental insurance or the means to purchase Medi-Gap insurance are at risk of losing access to Medicare Advantage health plans that provide them with comprehensive health benefits. People on Medicaid today will be forced to compete with millions more people being added to the program for appointments with the limited number of doctors who can afford to treat Medicaid recipients. People with pre-existing conditions have been shut out of the ACA's temporary high-risk insurance program because of cost overruns. Families risk losing their health plans at work because of a glitch in the law that allows employers to escape penalties if they provide coverage that is affordable only to the employee. It would seem to me that the administration would do more than it has to protect those who are most at risk of being harmed by the law.

David: I am surprised by how smoothly things have gone overall. The programs that were supposed to start have started, exchanges are being set up, and there have been more favorable surprises than negative ones.

All new programs come with unforeseen challenges and benefits. At one point, Part D was considered a troubled program because of implementation glitches. But Part D is now seen as a major success. The same will be true of the ACA.

The glitches are well known, and the administration did not handle some of them well. But look at the successes: state exchanges are being set up, half the states are expanding Medicaid, average premiums are coming in below expected costs, local groups are gearing up for outreach, and medical cost trends are below forecast.

The issue of the reduced rate of cost increases is particularly interesting to me. Recall one of the conservative arguments about Obamacare—that it would increase medical spending and explode the deficit. Alas, the reverse has happened. So, conservatives need a new argument. Their new argument is, "it started before Obama so it couldn't have been the ACA". It is true that the cost slowdown started in the mid-2000s. But if one looks at the data, as I did, the relative slowdown in the mid-2000s is somewhat easy to explain by income growth. The one that is harder to explain is the post-ACA slowdown as the economy has been recovering.

Looking at the data shows that the ACA is a big part of this. Remember the hospital payment increase reductions that were going to ruin care for Medicare beneficiaries? They happened, with no apparent adverse effects. Recall the Medicare Advantage payment reductions that were going to toss people out of Medicare Advantage? They happened too, and Medicare Advantage enrollment continued to increase. Those two factors together are about 10 percent of the cost slowdown. In addition, there are savings from the reduction in hospital-acquired conditions and reduction in readmission rates—driven by ACA-enacted policies penalizing those events—that have materially affected the Medicare bottom line. At this point, Obamacare deniers have the feel of climate change deniers: lone voices arguing against a sea of science.

One calculation is fascinating. The actuaries in the Centers for Medicare and Medicaid Services have continually reduced their forecast of future medical spending since the Affordable Care Act was enacted. Their latest estimate shows that medical costs will be sufficiently lower in 2016 (after the recovery has entirely occurred) that the typical family will pay $2,500 less for health care every year. That is exactly what the President has promised people.

Considering both the short and long term, what aspects of ACA will have the greatest benefit? What aspects have the potential to be damaging?

Grace-Marie: There is no question that there were serious problems in our health sector that needed to be addressed before the ACA was enacted in 2010. But the ACA is a complex, interacting system and it is not possible to pick and choose good and bad aspects of the law. It is a Rube Goldberg contraption that cannot be saved and will likely be dismantled piece by piece.

When my colleagues and I wrote our book, *Why ObamaCare Is Wrong for America* (Broadside/HarperCollins, 2011), we anticipated many of the disruptions that have unfolded in the three-plus years since the law was enacted—the rise in costs for health insurance, the dislocations in the labor market, doctors leaving and selling their practices, and the extraordinary difficulty of creating the massive bureaucracies needed to redesign one-sixth of the economy, for starters. We also anticipated that the law would become more unpopular as it neared implementation with individuals facing the individual mandate and with businesses facing the employer mandate and its onerous reporting requirements. The administration recently has acknowledged by its actions that many of these warnings were valid. For example, the administration has delayed for a year (in contradiction to the language in the statute) the reporting requirements and fines associated with the employer mandate.

And in a 606-page regulation issued late on July 5, the administration announced that income and employment verification in the state-run exchanges in 2014 will be waived. This announcement is another indication of the difficulty, and perhaps impossibility, of such a massive bureaucratic undertaking. The administration acknowledged the difficulty of getting verification systems up and running, saying "large amount of systems development on both the federal and state side … cannot occur in time for October 1, 2013." Therefore, income verification "is not feasible for implementation for the first year of operations." The administration will, instead, rely on an honor system for reporting.

Meanwhile, public support for the law is dropping, leading Congress to begin action to delay the most unpopular features of the law, including the individual mandate that requires most Americans to obtain qualified health insurance or pay a "tax."

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David: The success of health reform hinges almost entirely on two issues: (1) do people get coverage early next year; and (2) what happens to cost trends in health care?

If people get coverage, the cost of insurance in the exchanges will be affordable, subsidies will be modest, and the economic benefits of insurance coverage—reduced job lock, fewer people applying for disability insurance as a means to get health insurance, reduced presenteeism and absenteeism—will be substantial. I wrote extensively about this on the New York Times Economix blog page, where I relay the economic benefits of having greater coverage. For these benefits to occur, we do not need everyone to be covered, but we need most people to be covered most of the time.

The second aspect of success is a continued moderation of health cost increases. As health costs increase, wages of middle income families stagnate, employers seek to leave more workers uninsured, and governments either run deficits or cut essential services. Over time, the most important aspect of health care is whether we make it more efficient or not—which means cutting spending and improving the quality of care.

Some people have argued that additional social subsidies could impact the incentive for people to work while others have argued that because workers will not be locked into their jobs through employer sponsored health care that they will have a greater opportunity to leave and either start new businesses or take more satisfying jobs. How do you think ACA will impact the incentives in the labor market?

Grace-Marie: The subsidies for the portable health insurance provided through the ACA exchanges are not free: they come from higher taxes and larger deficit spending. Spending therefore is shifted from the private to the public sector. As a result, there will be fewer opportunities in the private sector and fewer opportunities to start new businesses until the economy recovers more strongly.

Chris Conover of Duke University explains that "every dollar going into the U.S. Treasury to finance this expansion is a dollar taken out of the private economy." And he adds that "Every additional dollar of new taxes shrinks the economy.… That dollar would have been spent (i.e., 'created' or supported jobs) anyway: the [ACA] expansion simply transfers the decision about how to spend that money to Washington, D.C."

But the impact is not neutral. "Currently every added dollar of federal taxes essentially shrinks the economy by 44 cents," Conover adds. "Thus, if we convert this to jobs, we will lose 144 jobs for every 100 health sector-related jobs that are induced by expansion."

Young people have been hit particularly hard by the faltering labor market, at least partially induced by the ACA. Most young people need jobs even more than they need health insurance, yet the law provides strong incentives for employers to refrain from hiring entry-level and lower-skilled workers, to put full-time employees on part time, and even to release full-time workers to keep their total workforce under 50 so as not to trigger the employer mandate.

A recent Gallup poll had found that 41 percent of small businesses surveyed had frozen hiring because of the health law. One in five said they already have reduced the number of employees in their business "as a specific result of the Affordable Care Act." Large employers are also carefully navigating the complexities and ongoing uncertainties of "Obamacare."

Even though the reporting requirements and fines for the employer mandate have been delayed until 2015, that will not change the hiring practices of employers. The ACA will continue to exert downward pressure on job creation until the employer mandate is repealed entirely.

An extension of the delay of the employer mandate is likely, since the 2014 congressional elections would come at a time that the current delay will be set to expire, putting members who voted for the law at risk with voters.

David: I have analyzed the economics of the Affordable Care Act in some detail: *http://economix.blogs.nytimes.com/2013/08/07/the-economics-of-the-affordable-care-act/?_r=0*. Let me make several points about it.

1. The doom-and-gloom crowd has been proven wrong. Many of the adverse effects predicted of the ACA were also predicted for Massachusetts, when it passed its precursor to the ACA. In fact, every single one of these predictions have been proven wrong, as studies shown in the intervening years attest. Job growth has been robust in Massachusetts, full-time employment has increased, and employer-provided health insurance has risen.

2. The benefits of the Affordable Care Act are substantial and well documented. These benefits include reduced "job lock" (people locked into a job for health insurance, which they fear they cannot get elsewhere); fewer people applying for disability insurance as a way to get stable health insurance; and reduced rates of absenteeism/presenteeism as people receive better primary and preventive care. The latter effect alone has been estimated to cost the economy over $200 billion annually.

3. As noted earlier, the single biggest effect will be saving money for employers. A number of studies show that employment is sensitive to the rate of health care cost increases.

   Overall, while there is the potential for some adverse effects from the ACA, the benefits are so substantial as to outweigh any potential harm.

As actuaries, we get close to the details of the act and one that we have seen is the mandate to only allow a 3 to 1 rating differential based on a member's age. This rating restriction has the effect of increasing costs for young men and reducing the cost for older people. Do you think this rating restriction will have a significant impact on the potential for young men to purchase insurance?

Grace-Marie: About two-thirds of the uninsured are under age 40. Because they are generally healthier and are less likely to be major users of health services, their premium contributions are needed to help keep insurance costs down for everyone else.

Yet the incentive structures in the law work at cross-purposes with this goal and could well undermine its success. The former director of the Congressional Budget Office, Douglas Holtz-Eakin, found in a study published earlier this year for the American Action Forum that, "Across all markets, the ACA will dramatically increase the cost of insurance for the young and healthy individuals and small employers." He found that "the ACA regulations lead to a 149 percent average increase in the cost of insurance for this population."

The survey also showed that fewer than half of young people will sign up for insurance if premiums rise by 30 percent.

Ezekiel Emanuel, a key architect of the president's health plan, writes that he is worried that young people will be "bewildered," and they may "forgo purchasing health insurance and opt to pay a penalty instead."

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The fact that the administration has been working so hard to convince sports heroes to help promote enrollment in the ACA insurance shows the significant concern about reaching this group.

That certainly will be an attractive option for many since the penalty starts at just $95 the first year.

But if young people don't sign up, the insurance pools are likely to be composed primarily of people who have high health costs. This could cause a "death spiral" where many more older, sicker people are enrolled, causing health insurance premiums to rise to cover their medical costs, thereby driving even more young people out of the market.

And there is yet another disincentive for young people to enroll in coverage: Because of the guaranteed issue provision, they can wait to sign up for coverage until after they get sick or injured since the law requires health insurance companies to sell insurance to anyone who applies.

A study using a different survey method published this year by the American Academy of Actuaries' *Contingencies* magazine found that because of the 3-1 rating provision, "premiums for younger, healthier individuals could increase by more than 40 percent." The premium increase for young men will be much more than for young women because gender variations are not allowed.

The fact that the administration has been working so hard to convince sports heroes to help promote enrollment in the ACA insurance shows the significant concern about reaching this group.

David: I don't think it will have a huge impact because it will be offset by the subsidies. Many young men have relatively low incomes. Thus, the premium they face will not be the full amount, but rather the amount net of the subsidy. Put another way, the ACA has limits on the share of income that people will pay for health insurance. These limits are sufficiently low that the price will not be a prohibitive factor in determining whether to buy coverage or not.

David, you have suggested that we may have entered into a period of structural change in the health care delivery system. As suggested by your research, considering the impact of less expensive technology, better incentives among providers, and increased out-of-pocket expenditure, the trend rate for health insurance expenditure has decreased dramatically over the past three years. How do you think this spending slowdown will impact the success of ACA? What will happen to overall costs after the implementation of ACA?

David: The spending slowdown is fundamental to the ACA. If the implementation comes in under budget, it makes everything much easier. If it is over budget because of rising health costs, the reaction will be very severe.

The ACA will have several effects on spending. There will be a one-time bump in spending in 2014 as people get insurance. Insured people use more care than uninsured people (that's why we want them to have insurance). The bump will not be huge, but it will be noticeable.

Over time, I expect the growth of costs to continue to moderate. As cited earlier, I have explained my predictions in some detail, but can summarize them briefly. Between 1960 and 2011, real, per capita health care cost increases have exceeded the rate of GDP growth by about 2.5 percentage points annually. Much of this was the creation of Medicare

and Medicaid; take that out and the residual is 1.5 percentage points or so. Economists estimate that the technological component of this is about 1.0 percentage points, so many forecasts have medical care spending increasing by about 1.5 percentage points above GDP annually, declining to about 1.0 percentage points above GDP over time.

Now consider how much waste there is in medical care. Consensus estimates suggest that the waste is about one-third of medical spending. Some think it is higher; others less high. But take one-third. The ACA puts us on a path to eliminate this waste. Imagine that we eliminate 20 percent of medical spending over the next decade. Note that this isn't a reduction of 20 percent of spending, but a slower growth rate that amounts to 20 percent lower spending than currently forecast. Reducing spending growth by 20 percent over 10 years is a reduction of about 2.0 percentage points annually. Allow for a somewhat longer transition and the reduction in growth is about 1.5 percentage points annually.

Note that the 1.5 percent growth reduction is about the same as the excess of medical care cost increases over GDP growth. So, my prediction is that the ACA will contribute to holding health care at the same percentage of GDP over the next 10 to 20 years. That would be a very substantial savings. I should note that the recent slowdown is consistent with this; since the recession ended, health spending has increased about the rate of GDP growth, right along the line of this forecast.

David, you have written about the potential for changing provider payment systems to improve their economic incentives to practice more efficient care, including a recent article on bundled payments. Among the programs in ACA, which program do you think has the greatest potential to improve provider incentives? Why?

David: There are many debates about this, and the truth is that we don't know. Remember—we don't need all of the programs to work, we just need some of them to. Put it another way: Success is defined by fostering a moderation in the growth of spending. Anything that promotes moderation is a winner. In my mind, I classify the programs in three groups. First are the ones that seek to make consumers more cost conscious. These include the creation of exchanges, where consumers can shop across plans, and the Cadillac tax, which will increase cost sharing for some people. Second are the ones that change provider payments. These include the Accountable Care Organization program, the bundled payment program, and the various other programs run through the Center for Medicare and Medicaid Innovation. Third are the provisions that seek to make the system more efficient. These include steps to reduce administrative expenses, sharing government data with the private sector, and reducing insurer administrative expenses. People argue strenuously about which of these programs is most important. The ACA adopts them all.

David, Grace-Marie Turner has written in the *Wall Street Journal* that implementation of ACA will require people to fill out complex and difficult to understand forms in order to purchase health insurance. Do you think this will become an issue in the implementation of ACA?

David: It was never an issue in Massachusetts. And recall that this was supposed to be a hindrance to Part D as well, where seniors were encouraged to go online and shop for prescription drug plans. Neither one was a fatal flaw.

The real question is whether people want health insurance, in which case this will be a minor inconvenience, or whether they do not, in which case this could be a big hassle. I find it ironic that people who trust individuals so much somehow think that people are incapable of working through a small hassle to get a product they want.

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Grace-Marie, considering the early reports on the state exchanges, do you have an early read on how competitive the markets will be on the exchange?

Grace-Marie: Fifteen states and the District of Columbia are planning to run their own health

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In New Hampshire, only one health plan, Anthem BlueCross BlueShield, is participating in the ACA exchange, giving applicants the choice only of different price points among standardized Bronze, Silver, Gold and Platinum plans.

exchanges. In some markets with developed managed care systems such as California, many choices will be available, although applicants may be surprised at the limited networks of physicians and hospitals available to them. But even there, Aetna, UnitedHealthcare and Cigna all have said they are leaving the state's exchange, called Covered California.

In New Hampshire, only one health plan, Anthem BlueCross BlueShield, is participating in the ACA exchange, giving applicants the choice only of different price points among standardized Bronze, Silver, Gold and Platinum plans. In Mississippi, two-thirds of counties will not have any health plans participating in the exchanges.

Connecticut, Maryland, Rhode Island and Washington state are examples of states that have been working exceptionally hard to create their own exchanges, but they are struggling. "It is highly complex, it's unprecedented and it's not going to be smooth," Kevin Counihan, chief executive of Connecticut's exchange, Access Health CT, said recently. Although states are promising to provide new marketplaces for individuals to compare and buy health insurance plans, most are being forced to scale back plans to meet the bare minimum of requirements to get certified to open enrollment. Even among those states trying hard to meet deadlines, some will fail, leaving the federal government little time to set up back-up federal exchanges.

There has been even more uncertainty in the 34 states where the federal government is creating exchanges since the Department of Health and Human Services released little information in advance. There also is growing concern about security of the information that "Navigators" will be gathering to help people apply for subsidies—including home addresses, Social Security numbers, employers, income, names and ages of children, and even health status.

Grace-Marie, David Cutler has written about the potential for changing provider payment systems to improve their economic incentives to practice more efficient care, including a recent article on bundled payments. Among the programs in ACA, do you think a particular program has the promise to improve provider incentives?

Grace-Marie: There is no question that Medicare's current fee-for-service payment system encourages over-use of health services and that new incentives are needed to promote more efficient, economical care delivery. The ACA's accountable care organizations, medical homes and more comprehensive payment models are all very attractive in concept. But similar experiments over the past decade have failed to show measurable savings. The move toward "bundled payments" to encourage "hospitals, physicians, post-acute facilities, and other providers as applicable to work together to improve health outcomes and lower costs," according to the Centers for Medicare & Medicaid, is really a new name for managed care.

These experiments all will fail unless the one thing we haven't tried on a large scale is tested: consumer engagement. We must move away from tinkering with the byzantine payment regulations that dictate how Medicare pays hospitals, doctors and other providers of medical services and build a new system on the successful Part D model.

Part D works differently from traditional Medicare: It offers seniors a choice of plans that are competing with each other to offer the most comprehensive selection of drugs at the lowest price. Seniors have shown they are smart shoppers and have driven down the cost of the program. Overall, the cost of the Part D benefit to the federal government is 43 percent under budget projections.

Just after Congress created Part D in 2003, the Medicare trustees estimated that Medicare beneficiaries would pay an average of $61 a month for their drug benefit by 2013. Instead, the average premium has remained consistent at about $30—about where it was when the program began. During the same period of time, premiums for Medicare Part B, which covers doctors' visits and other outpatient care, have increased from an average of $89 in 2006 to $105 in 2013.

The difference is consumer choice, competition and market pricing. Medicare modernization plans have been introduced in Congress based on the Part D model, giving seniors a choice of competing plans and a guarantee that the Medicare subsidy will cover the full cost of a basic plan, while giving seniors the option of staying in traditional Medicare. This is a very different path forward than a rule-driven grab-bag of options in which the government is still in charge of doling out incentive subsidies.

Grace-Marie, David Cutler has suggested that we may have entered into a period of structural change in the health care delivery system. As suggested by his research, considering the impact of less expensive technology, better incentives among providers, and increased out-of-pocket expenditure, the trend rate for health insurance expenditure has decreased dramatically over the past three years. If you believe in this structural change, how do you think this spending slowdown will impact the success of ACA?

Grace-Marie: There is no question that the ACA has stimulated major structural changes in the health care delivery system. The industry is consolidating, hospitals are buying doctors' practices, and health insurers are trying to squeeze more generous health benefits into plans with tighter medical loss ratios.

The recent slowdown in the growth of national health expenditures has occurred before the major provisions of the ACA go into effect, and the slowdown began even before President Obama was elected. Therefore it is difficult for proponents of the ACA to claim a cause and effect.

Avik Roy of the Manhattan Institute explains two factors that are primarily responsible for the slowdown: "Whatever you think of Obamacare, however, there are two far more convincing reasons why health spending has slowed," he writes. "The first is the Great Recession, which has slowed health spending around the world. The second is that Americans are now much more responsible for their own health spending, a development that has made them more frugal."

Roy writes that, "Overall, growth in health spending in the developed world has declined since the onset of the Great Recession, and that's the most obvious explanation for why health spending growth has declined in the U.S. since 2008." He says that on a relative and absolute basis, "U.S. health spending growth rate has increased in 2010 and 2011, relative to 2009."

Prof. Cutler is correct that another likely factor in the spending slowdown is the fact that Americans are paying more directly for the cost of their own health care and coverage in the form of higher deductibles and premiums.

The real test of the ACA will be with the American people. Then-candidate Obama promised in 2008: "I will sign a universal health care bill into law by the end of my first term as President that will cover every American and cut the cost of a typical family's premium by up to $2,500 a year." Costs have soared by more than $3,000 instead, and the CBO estimates that approximately 30 million people will remain uninsured after the law takes full effect.

The ACA is trying to do too much, too fast, with too much bureaucracy and disruption. Major changes are likely so that health reform better comports with our market-based economy and consumers' desire for more and better choices of affordable coverage.