Transcending Obamacare

A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency

Avik S. A. Roy • Opinion Editor, *Forbes*
Senior Fellow, Manhattan Institute for Policy Research

aroy@manhattan-institute.org • @Avik

What Health Spending Slowdown?

- Health care remains the driver of the fiscal crisis
ACA Has Increased Govt. Spending

Federal Health Care Spending, 2011-2022 ($Billions)

- New Obamacare spending

NIHCM Capitol Hill Briefing
September 3, 2014
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Federal Health Care Spending, 2011-2022 ($Billions)

New Obamacare spending  Legacy health spending

NIHCM Capitol Hill Briefing
September 3, 2014
The Myth of ‘Free-Market’ U.S. Health Care

2012 Public Health Expenditure per Capita
(US$ purchasing power parity-adjusted)

Source: OECD, WHO

- In 2012, U.S. government (federal, state, local) spent more per person on health care than all but 2 other countries in the world
- Post-ACA, U.S will likely become #1

NIHCM Capitol Hill Briefing
September 3, 2014
Problems The ACA Didn’t Solve (Or Made Worse)
It’s The Prices, Stupid

- Despite lower average lengths of stay, per-diem hospital costs in the U.S. far exceed others

**Median Cost Per Hospital Day, USD**

- **Spain**: $476
- **Netherlands**: $731
- **France**: $853
- **New Zealand**: $979
- **Australia**: $1,472
- **UNITED STATES**: $4,287

*Source: International Federation of Health Plans*
Hospital Concentration Greatly Increased

Impact of M&A on Hospital Market Concentration, 1990-2012

Number of hospital M&As
Market concentration (HHI)

Highly concentrated (HHI > 2,500)
Moderately concentrated (HHI > 1,500)

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Health Insurance ≠ Health Care

- Much of the ACA’s coverage expansion relies on Medicaid
  - Medicaid and CHIP expansions, accounting for 11 million new insured, underpay physicians, resulting in poor access
  - 7 million Americans will lose higher-quality private coverage
  - Evidence is overwhelming that Medicaid has worse health outcomes vs. employer-sponsored and exchange-based insurance
ACA Exchange Plans: Individual Rates +41%

Percent Change in Individual-Market Premiums, Average of All Age Groups, Post- vs. Pre-ACA

Source: Avik Roy / Manhattan Institute
Is There A Better Way?
The Difficulties of ‘Repeal and Replace’

• Highly disruptive to existing insured
  – Caps/cuts employer tax exclusion (155MM in 2016)
  – By 2016, CBO estimates 24 million on ACA exchanges, 12 million covered via Medicaid expansion

**Millions on ACA-Sponsored Insurance, 2014-2018**

- 2014
- 2015
- 2016
- 2017
- 2018

![Bar chart showing millions on ACA-sponsored insurance from 2014 to 2018.](image-url)
Public Opposes Obamacare—And Repeal

What would you like to see Congress do when it comes to the health care law?

- **Keep the law as it is**: 10%
- **Keep the law in place and work to improve it**: 49%
- **Repeal the law and replace it with a Republican-sponsored alternative**: 11%
- **Repeal the law and not replace it**: 18%

**Total**

**Democrats**
- 16% Keep the law as it is
- 73% Keep the law in place and work to improve it
- 3% Repeal the law and replace it with a Republican-sponsored alternative
- 4% Repeal the law and not replace it

**Independents**
- 8% Keep the law as it is
- 44% Keep the law in place and work to improve it
- 9% Repeal the law and replace it with a Republican-sponsored alternative
- 23% Repeal the law and not replace it

**Republicans**
- 5% Keep the law as it is
- 26% Keep the law in place and work to improve it
- 27% Repeal the law and replace it with a Republican-sponsored alternative
- 31% Repeal the law and not replace it
The Myth of ‘Free-Market’ U.S. Health Care

Source: OECD, WHO

- In 2012, U.S. government (federal, state, local) spent more per person on health care than all but 2 other countries in the world.
- Post-ACA, U.S will likely become #1.
The ‘Switzapore’ Model for Health Reform

• Convergence of the ACA and Paul Ryan’s reforms
  – ACA uses Swiss-style regulated insurance exchanges with a sliding scale of subsidies to offer coverage to those between 100-138% and 400% of FPL
  – Paul Ryan uses Swiss-style regulated insurance exchanges to offer coverage to future Medicare beneficiaries

• The ACA can be transformed into a mechanism for system-wide entitlement reform
  – Opportunity for substantial coverage expansion and deficit reduction
Part One: Exchange Reform

- Modify ACA regulations in order to curb adverse selection and reduce underlying premiums
  - 6:1 age bands (subsidies protect low-income near-elderly)
  - More flexible benefit design (EHB reform)
  - Lower actuarial value tiers (e.g. “Copper”)
  - Benchmark plan would have higher deductible plus subsidized HSA; ACA cost-sharing subsidies (≤ 250% FPL) converted to additional HSA contributions
  - Repeal device, drug, premium taxes
  - Limited open enrollment period; no indiv. mandate
Part Two: Medicare Reform

• Increase Medicare eligibility age by four months each year, forever
  – Makes Part A trust fund permanently solvent
  – Allows future retirees to remain on exchanges or employer-sponsored coverage
  – Increases incentive to remain in work force (thereby increasing solvency of Social Security)
  – Net effect is means-tested benefits for future retirees

• Introduce other bipartisan Medicare reforms
  – Simpson-Bowles; Lieberman-Coburn
Part Three: Medicaid Reform

• Migrate Medicaid acute-care population onto reformed ACA exchanges
  – Cost-sharing protections just as with near-poverty population on exchanges
  – HSA deposits can accumulate, increasing *wealth* of low-income population & decreasing moral hazard
  – Potential for substantially improved health outcomes

• For fiscal neutrality, states assume full financial responsibility for Medicaid long-term care
  – Maintenance-of-effort to preserve spending trajectory
  – Exempt premiums, providers from state & local taxes
Part Four: Other Reforms

- Increase provider competition
  - Pricing reforms in concentrated markets
  - Increase funding for hospital anti-trust litigation
  - Allow VA hospitals to admit civilian patients
  - Facilitate medical tourism, reference pricing
- Repeal employer mandate
- Malpractice reform
- Increase funding for graduate medical education
- Offer veterans access to ACA exchanges
The Result: Higher Quality at Lower Cost

• Permanent stability and solvency of health-care entitlements
  – Deficit reduction of >$8 trillion over three decades
  – Reduction in net federal & state tax revenues
  – Medicare trust fund permanently solvent
  – Medicaid reform = improved state fiscal stability

• Expanded coverage above ACA levels
  – 12MM additional insured due to exchange reforms
  – Reduces single commercial premiums by 17%

• Improved health outcomes for the poor
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OBAMACARE

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aroym@manhattan-institute.org

Twitter: @Avik


Google: “Transcending Obamacare”