

VITAL SPEECHES

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THE BEST THOUGHTS OF THE BEST MINDS ON CURRENT NATIONAL QUESTIONS

IMPARTIAL · CONSTRUCTIVE · AUTHENTIC

Putting Health Care on a Sustainable Path

FLAWS IN THE NEW HEALTH CARE REFORM LAW, AND SOLUTIONS

Testimony by JOHN C. GOODMAN, President and CEO, National Center for Policy Analysis
*Delivered to the House Energy and Commerce Subcommittee on Health, U.S. House of Representatives,
Washington, D.C., Mar. 9, 2011*

There are major structural flaws in the Patient Protection and Affordable Care Act (PPACA), what some call Obama Care. Each is so potentially damaging, Congress will have to resort to major corrective action even if critics of the new health care law are not part of it. Further, each must be addressed in any new attempt to create workable health care reform.

An Ever-More-Costly Mandate

Health costs per capita have been rising at twice the rate of per capita income for the past 40 years. This is not a uniquely American problem. On the average, the same trend is in place for the entire developed world. But here is the bottom line: If you have to buy something at a cost which is rising at twice the rate of growth of your income, that mandated purchase will consume more and more of your disposable income with each passing year.

Fortunately, there is a better way to achieve the same desirable end: 1) Repeal the individual and employer mandates, 2) offer a generous tax subsidy to people to obtain insurance, but 3) allow them the freedom and flexibility to adjust their benefits and cost-sharing in order to control costs.

A Bizarre System of Subsidies

One problem with the PPACA is that it offers radically different subsidies to people at the same income level, depending on where they obtain their health insurance—at work, through an exchange or through Medicaid. The subsidies (and the accompanying mandates) will cause millions of employees to lose their employer plans and may cause them to lose their jobs as well. At a minimum, these subsidies will cause a huge, uneconomical restructuring of American industry.

Look at it from the employee's point of view. The new law says that an employee must have insurance costing, say, \$15,000 for family coverage in 2016. Remembering that employee benefits are a dollar-for-dollar substitute for wages, that implies that a previously uninsured \$30,000-a-year worker will get a 50% cut in pay. Further, the only help this worker will get from Uncle Sam will be the ability of the employer to pay the premiums with pretax dollars. That's worth about \$2,298. (See the chart.) On the other hand, if this worker can get the same insurance through the newly created health insurance exchange, the federal government will pay almost all the premium and reimburse most out-of-pocket expenses. That's a total net subsidy worth more than \$16,000.

It follows that every worker at this income level is going to want to work for a firm that does not offer health insurance and pays cash wages instead. Yes, this employer will have to pay a \$2,000 fine. But the fine is well worth the opportunity to obtain a net benefit of more than \$13,000.

As family income rises, the subsidy in the health insurance exchange falls. A family earning \$42,000 would qualify for an exchange subsidy of \$12,512; but the same coverage through work would result in a tax subsidy of \$5,536. At \$60,000 the exchange subsidy would only be worth \$6,805 while the subsidy at work would be worth \$3,545.

Now consider a \$100,000-a-year worker (not shown in the chart). This employee will get no subsidy in the exchange. But insurance premiums paid by the employee will avoid a 15.3% payroll (FICA) tax, a 25% federal income tax and, say, a 5% state and local income tax. So at work, the federal government is prepared to pay almost half the cost of this employee's health insurance. It follows that any worker at this income level will want to work for a company that does offer health insurance.

In competition for labor, therefore, companies and entire industries will reorganize. Low-income workers will congregate in companies that do not provide insurance; high-income employees will work for firms that do provide it. Firms that ignore these worker preferences will not survive.

This implies two bad results: 1) much higher burdens for taxpayers as millions more take advantage of the subsidies than the Congressional Budget Office (CBO) has predicted and 2) an entire economy whose structure is based not on sound economics, but on gaming an irrational subsidy system. Again, there is a better way: Offer people the same tax relief for health insurance, regardless of where it is obtained or purchased—preferably in the form of a lump-sum, refundable tax credit.

Perverse Incentives for Insurers

We have heard much from the White House and congressional leaders about how insurance companies are abusing people. You haven't seen anything yet. Inside the health insurance exchange, no insurer will be able to charge a sick person more or a healthy person less. So insurers will try to attract the healthy and avoid the sick—even more than they do today!

Furthermore, after enrollment the perverse incentives will not end. Health plans will tend to over-provide to the healthy (to keep the ones they have and attract more) and under-provide to the sick (to discourage the arrival of new ones and encourage the departure of the ones they already have). Of course, there are countervailing forces: professional ethics, malpractice law, regulatory agencies. But ask yourself this question: Would you want to eat at a restaurant that you know does not want your business? You should think the same way about health plans.

The alternative: Instead of requiring insurers to ignore the fact that some people are sicker and more costly to

insure than others, we should adopt a system that compensates them for the higher expected costs—ideally making a high-cost enrollee just as attractive to an insurer as a low-cost enrollee.

Perverse Incentives for Individuals

The PPACA allows individuals to remain uninsured while they are healthy (paying a small fine or no fine at all) and to enroll in a health plan after they get sick (paying the same premium everyone else is paying). No insurance pool can survive the gaming of the system that is likely to ensue.

A poorly reported development in Massachusetts, for example, is the growing number of people who are gaming the system. People remain uninsured while they are healthy and get insurance after they get sick. Then, after they receive care and their medical bills are paid, they drop their coverage again. This behavior is more likely the lower the penalty for being uninsured and more weakly the individual mandate is enforced.

Under the federal health reform law, the fines for being uninsured are low. When fully phased in, the fine is \$695 for individuals and \$2,085 for families, or up to 2.5% of income. Thus, those who do not pay thousands of dollars worth of premiums may face only a few hundred dollars in penalties—which is a bargain.

Individuals gaming the system could be the death knell for private insurance.

A better solution: People who remain continuously insured should not be penalized if they have to change insurers; however, people who are willfully uninsured should not be able to completely free-ride on others by gaming the system.

Impossible Expectations/A Tattered Safety Net

The PPACA aims to provide expanded coverage for most Americans who have insurance, and to insure as many as 34 million uninsured people. Economic studies suggest the newly insured will try to double their consumption of medical care. Yet the Act will not create the new doctors, nurses or paramedical personnel that will be required to provide health care to these newly insured patients. In fact, we can expect as many as 900,000 additional emergency room visits every year—mainly by new enrollees in Medicaid—and still, 23 million of these individuals are expected to remain uninsured. Yet, as was the case in Massachusetts, there no mechanism to ensure that funding will be there for safety net institutions that will shoulder the biggest burdens. Their “disproportionate share” funds are slated to be cut.

Again, there are better alternatives: 1) Liberate the supply side of the market by allowing nurses, paramedics and pharmacists to deliver care they are competent to deliver; 2) allow Medicare and Medicaid to cover walk-in clinics at shopping malls and other unconventional care—paying market prices; 3) free doctors to provide lower-cost, higher-quality services by allowing them to share in any savings they create from efficiencies in the delivery of that care; and 4) redirect

unclaimed health insurance tax credits (for people who elect to remain uninsured) to the safety net institutions in the areas where they live—to provide a source of funds in case they cannot pay their own medical bills.

Impossible Benefit Cuts for Seniors

The PPACA's cuts in Medicare are draconian:

- More than half the cost of health reform will be paid for by \$523 billion in reduced Medicare spending over the next 10 years.
- In general, these Medicare spending cuts exceed the new benefits by a factor of more than 10 to one.
- More than \$200 billion in spending cuts are directed at Medicare Advantage (MA) plans. By 2017, seniors in such cities as Dallas, Houston and San Antonio will lose one-third of their benefits.
- As a result, one of every two people expected to participate in Medicare Advantage over the next 10 years (7.4 million of 14 million) will lose their coverage entirely, according to Medicare's chief actuary; and those who retain their MA coverage will face steep cuts in benefits or hefty increases in premiums, or both.
- In addition to these direct costs there are indirect costs, including new taxes on drugs and medical devices—items that are disproportionately used by seniors and the disabled.

To make matters worse, the planned cuts in Medicare fees may cause some doctors to retire and force some hospitals out of business, according to Medicare's chief actuary. Moreover, as 100 million newly and more generously insured people try to increase their consumption of medical care, the elderly may find it increasingly difficult to obtain the care they need.

By 2020, regular fee-for-service Medicare nationwide will pay doctors and hospitals less than what Medicaid pays. And in succeeding years, reduced payments get really brutal. Seniors will be lined up behind Medicaid patients at community health centers and safety net hospitals unless this is changed. Either 1) these cuts were never a serious way to fund the PPACA, because Congress will cave and restore them, or 2) the elderly and the disabled will be in a separate (and inferior) health care system.

The PPACA reduces total Medicare spending. While lower Medicare spending means that premiums paid by the beneficiaries will be reduced, as will the taxes they have to pay to support Medicare, this reduced spending will surely result in reduced access and lower-quality care.

Among the solutions for seniors: In order to avoid a two-tier health care system, many of the cuts to Medicare required by the PPACA will have to be restored. However, Medicare cost increases can be slowed by empowering patients and allowing doctors to repackage and reprice their services in a way that encouraged them to compete for patients based on both price and quality of care.

The goal of these arrangements is not to save as much money as possible for Medicare. The goal is to encourage

a competitive market on the provider side—in which every doctor and every facility is encouraged to continuously search for ways to rebundle and reprice medical services in quality-enhancing, cost-reducing ways.

Once one hospital or doctor group implements an arrangement with better payment for better results, there will be competitive pressures on other providers to find new and innovative ways of raising quality and lowering costs. Plus, once Medicare takes these steps, private insurers can adopt similar payment systems more easily. Medicare and the private sector will be pushing in the same direction, for better care—not just more services.

Conclusion

Ideally, one hopes the two parties will work together to reform health care in a way that's good for doctors and patients. Congress should begin by voting to repeal the most politically unpopular features of health care reform. That means no individual mandates, no individual or employer fines, and no

regulations of the type that might cause an employer, such as McDonald's, to drop coverage for 30,000 low-wage employees and the 3M Corporation to drop coverage for all its retirees. Then Congress should come to the rescue of senior citizens.

If there is a budgetary cost for these measures, pay for them by pushing back the date when all the subsidies and mandates are supposed to kick in (Jan. 1, 2014). The short-term goal should be to push back the dates of these rate cuts by an election cycle or two. And in order to compensate for pushing back the rate cuts, push back the date of implementation as well. Just as the draconian cuts to Medicare provider fees get postponed year after year, the dates of other PPACA provisions should also be postponed year after year.

Let's hope Republicans and Democrats agree on Medicare reforms that will really control runaway entitlement spending. In the meantime, the approach should be to cancel cuts that are never going to be made anyway and pay for the cancellation by delaying the implementation of key provisions of the PPACA. ♦

VITAL SPEECHES — OF THE DAY —

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Editor

David Murray
vseditor@mcmurry.com

VP/Digital Business

Kyle Crafton

Art Director

Amy Wimmer

Associate General Manager

Jenny Makinde

Product Specialist

Jennifer Tanabe

Telephone 888-303-2373

Fax 602-395-5853

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