Inside, Outside, All Around PPACA:

We won't know for sure whether or not it might work until 2014, but its fate will be determined in 2012

By Robert E. Hertzka, M.D.

Dr. Robert E. Hertzka, clinical anesthesiologist, CSA member, and past president of the California Medical Association (CMA), has been a longtime observer, participant and teacher of the political process. He has involved himself for decades in medical politics, including leading the effort that produced many of the CMA's current policies on health care access. Dr. Hertzka currently serves on the American Medical Association (AMA) Council on Medical Service, which "recommends AMA policies and actions for consideration by the AMA House of Delegates on the socioeconomic factors that influence the practice of medicine." He has been a passionate advocate for improved access to health care, chairing San Diegans for Health Care Coverage (California's largest bipartisan coalition supporting increased health care access). Familiarity with the process and the details of the Patient Protection and Affordable Care Act (PPACA) is "right in his wheelhouse."

PPACA as Another Unfunded Mandate

Not since the enactment of Medicare and Medicaid in 1965 has there been a piece of health care legislation that is as stunning in its breadth and sweep as is PPACA. Any physician who renders clinical care will be significantly affected by how well—or how poorly—this program rolls out.

First, consider that those of us who have been involved in the health reform efforts of the past 20 years or so appreciate that certain basic principles must be followed to expand health care access successfully. Chief among them is financial soundness: Does the program pencil out? Government programs that are "overpromised" but underfunded are not sustainable, and they burden physicians in particular because we are obliged to pick up the pieces when these programs fall short.

If you ponder government entitlements in health care that already exist, you will see that this is not just theory. Medicare payments to physicians have been essentially frozen for 10 years, while ever-increasing and now ominous cuts are threatened—the latest being in the 30 percent range at the end of 2011. Medicaid payments in California (Medi-Cal) have also remained static for everyone other than obstetricians and pediatricians for 25 years. Meanwhile, eligibility, enrollment, and the benefit package associated with both of these programs have expanded. It is much the same for military dependents; when I started in practice, what was then CHAMPUS was a good payer, but now the new version (TRICARE) is linked directly to Medicare.

Second, consider the PPACA provisions that purport to expand access to health care for 32 million people. At first blush, access for 32 million additional people by 2014 seems just wonderful. However, the reality beneath that "32 million newly covered" statistic is emblematic of the underlying problem. As proposed and touted, approximately half of those newly covered will be in an expanded Medicaid program, and the other half will obtain coverage from the new health exchanges in the context of an individual mandate. Even putting aside the very serious constitutional issues that have been raised about both the Medicaid expansion and the individual mandate, both of these access expansions, as currently structured, are at best highly problematic.

Examine the Medicaid expansion first. It is not widely known that Medicaid, which was originally designed in 1965 to cover all low-income people, has actually evolved into a program largely for low-income pregnant women, low-income children, AIDS patients, and a smattering of other eligibility categories, including low-income parents in some states. Contrary to popular belief, there is no inherent eligibility for nonelderly, childless adults—and as many as 32 million of the currently 50 million uninsured are in fact such childless adults.

Although some low-income adults do get some kind of "coverage" (in California through a County Medical Services program), they find themselves enrolled in a program that pays at abysmal Medicaid rates. So while they are "covered," their access is actually limited to a smattering of primary care doctors and community clinics; access to specialists for Medi-Cal patients is virtually zero. Combining this limited access with the nature of very low-income adults produces a subpopulation that frequents the emergency room at a rate far in excess of otherwise uninsured individuals.

It is important to note that this demographic belies the public's belief that it is the uninsured who are the ones who crowd our emergency rooms. In fact, many of the uninsured shun the emergency room—the waits are long and the

bills are huge. However, once very low-income individuals are given Medicaid eligibility and realize that they are essentially immune from being billed for any health care expense, study after study shows that relatively few establish any kind of steady, cost-effective primary care access; rather they tend to seek episodic care in expensive emergency rooms at a rate two to three times that of the uninsured.

Effective January 1, 2014, PPACA declares that all those below 133 percent of the federal poverty level (FPL, currently $11,000 for an individual, $14,000 for a couple, and $22,000 for a family of four) are immediately eligible for Medicaid. There are as many as 16 million people (half of the 32 million to which PPACA refers) at or below that income level, and this group makes up a large proportion of the uninsured.

But, more importantly, in the context of no real effort to improve primary care access other than (a) a two-year increase in primary care payment rates in 2013 and 2014 (really only one year because the eligibility increase does not occur until 2014); and (b) a series of proposals to deputize nurse practitioners as primary care providers equivalent to physicians, it is predictable that we will see a flood of new emergency room visits and very little new comprehensive care.

Bottom line: A major new adult Medicaid expansion (unlike pediatrics, which has adapted and adjusted to Medicaid over decades) does not represent true health care access, yet it is fully half of what PPACA purports to provide.

Joining in the Insurance Exchanges or Paying the Penalty

Moreover, access for the other half of the 32 million looks problematic as well. Unlike the dubious optimism that went into the proposed Medicaid expansion, the underlying principles here seem logical and coherent. The idea is to give uninsured individuals above 133 percent of FPL purchasing power by letting them buy partially subsidized private insurance through an insurance exchange, much like 5 million federal workers currently do. These millions of people will enjoy the purchasing power of a large group and cannot be discriminated against for any pre-existing conditions.

This looks great in theory—combining the "carrot" of subsidized health care premiums with the "stick" of a penalty if insurance is not purchased—but, as can be seen in Figure 1, the choices that people will probably make are likely to be different from what the Obama administration leads us to believe.

FIGURE 1

Penalties and Premiums for the Individual

	PENALTY: 2014/2016	PREMIUM
$16,000 (150% FPL)	$160/$400	$640 (4% of income)
$28,000 (250% FPL)	$280/$700	$2,254 (8.05% of income)
$44,000 (400% FPL)	$440/$1,100	$4,180 (9.5% of income)
$45,000(>400% FPL)	$0/$0	Market Rate

Penalties and Premiums for the Family of Four

	PENALTY: 2014/2016	PREMIUM
$33,000 (150% FPL)	$330/$825	$1,320 (4% of income)
$55,000 (250% FPL)	$550/$1,375	$4,400 (8.05% of income)
$88,000 (400% FPL)	$880/$2,085 (max)	$8,360 (9.5% of income)
$90,000 (>400% FPL)	$0/$0	Market Rate

Insurance subsidies will lower the cost of insurance for very low-income people to just 4 percent of income, but only to 8.05–9.5 percent for low to moderate incomes, and not at all for those above 400 percent of FPL (currently $44,000 for an individual and $88,000 for a family of four). Meanwhile, the penalties paid by individuals will only be 1 percent of income when this rolls out in 2014, rising to 2.5 percent of income by 2016. This may sound substantial, but it is in fact far below the levels seen in the successful individual mandate models of the Swiss and the Dutch, where the penalties for not obtaining health insurance *exceed* the cost of the subsidized premium. Furthermore, under PPACA, those who do not purchase insurance and then become ill can buy the same subsidized insurance at that time.

Ask yourself the following: will an uninsured individual scraping by on $16,000 a year really pay $640 for health insurance if the penalty for not doing so is only $160, and they can get the insurance later if they need it? Better yet, they could just work a bit less or report less income and get into the newly expanded Medicaid for free. How about an uninsured individual living on $44,000 a year? Will that individual really pay $4,180 for health insurance if the penalty for not doing so is only $440 and they can get the insurance later if they need it? Why would they?

Protections for Individuals and Incentives for Employers

Next, consider the working insured, those who now buy insurance in the individual market and who are captive to the well-publicized abuses of individual underwriting. The authors of PPACA were so focused on improving the lot of this subpopulation and how they might or might not respond to various incentives and penalties that they seem to have forgotten everyone else, namely the 170 million currently insured through their employers, the vast majority of whom are in a secure albeit increasingly expensive situation.

To garner votes they needed from more centrist Democrat House and Senate members, PPACA's authors limited the penalty on medium and large employers for failing to provide health insurance to only $2,000 per employee, far less than what most currently pay to provide it. This creates a substantial incentive for employers who currently provide insurance to stop doing so and just pay the fine, while sending their employees—by the millions—to the subsidized exchanges. For new and expanding companies, what is incentivized is never to provide health insurance in the first place. By 2014, many now believe that the number of people in the exchanges will not be just the 19 million projected by the Obama administration (the vast majority of whom will have been previously uninsured), but more like 55 million, *raising the cost of the necessary subsidies by an additional $1 trillion.*

C. Eugene Steuerle, a senior health policy analyst at the left-of-center Urban Institute, calls this arrangement "unworkable and unfair" (http://www.urban.org/publications/901386.html). What's more, two-term Tennessee Gov. Phil Bredesen, a Democrat, has published a detailed analysis of how Tennessee will be able to cut its health benefit costs for its state workers by as much as 40 percent. In this analysis, state workers are actually kept whole by having their state benefit costs replaced by some increase in wages but, most importantly, by access to the substantial federal subsidies.

Combining a projection of tens of millions of workers—many of whom will be low-wage workers—being directed to the exchanges together with the weak penalties for not obtaining insurance gives rise to a stunning scenario. A recent nonpartisan analysis by McKinsey and Co., an international consulting company whose Center for U.S. Health System Reform is headed by Bob Kocher, former special assistant to President Obama, suggested that after PPACA's implementation, we may still have as many as 40 million uninsured. This, together with as many as 20 million in a likely ineffective Medicaid expansion, gives us 60 million with little to no coverage—no better than where we are today—*and after spending as much as $2 trillion!*

Will PPACA Cost the Feds Less or More?

The Congressional Budget Office (CBO), a reputable source of information even if its director is chosen by political partisans, makes its projections based on assumptions that are provided to it. For projecting the costs of PPACA, the Democrats in Congress instructed the CBO to accept a long list of dubious assumptions, including: (a) Medicare physician payments would drop by 40 percent and stay there (actually making Medicare in the aggregate a worse payer than Medicaid); (b) $500 billion in cuts to other Medicare services, including $398 billion from hospitals, would be identified and successfully implemented; (c) the overall program costs would be estimated by using 10 years of taxation (some $500 billion) but only six years of subsidy payments. With this, the CBO projected $143 billion in "savings" over 10 years, and hence an even larger "cost" should PPACA be repealed.

By way of comparison, the truly nonpartisan Medicare actuary, an equally reputable source, quietly issued a report just a few weeks after PPACA became law in March 2010: PPACA would add to our overall national health expenditures by some $311 billion over 10 years. The report also stated that, if successful, the proposed cuts to hospitals could cause at least 15 percent of them to stop accepting Medicare patients in order to remain solvent.

So, we are left with two starkly different projections: (1) keeping PPACA in place will save us about $200 billion (CBO), versus (2) Medicare will likely not be able to cut physician payments by 40 percent, nor hospitals by $398 billion, and many millions of the currently insured will end up seeking care from the exchanges, ballooning the cost of the federal subsidies by an additional $1 trillion between 2014 and 2019 (Medicare actuary). The latter analysis suggests that repealing PPACA will actually *save* as much as $2 trillion over the next 10 years while leaving Medicare in better financial shape.

The Good in PPACA

Most of the various reforms to the private health insurance industry read like recommendations from a CMA policy manual. Conceptually, subsidized high-risk pools for people with pre-existing conditions, tax credits for small businesses to incentivize providing insurance to their employees, and additional relief for seniors with high drug costs all make perfect sense.

The caveat is that PPACA was written by politicians, not policy wonks, and so by design it front-loads as many "goodies" as possible to give its proponents political cover. Many of the "goodies" would likely be preserved in any form of an eventual "Repeal and Replace" effort. However, the core of the bill and its

$1 trillion cost (more like $2 trillion-plus if the critics are correct) is all about what begins in 2014. Even then, some may derive great benefit from the new health insurance exchanges, and some of the new Medicaid patients may find themselves in a better situation than they are today. Medicaid patients pay very little or nothing for their care, and therefore are at least protected financially.

Does the Public Favor Repeal?

The public knows little to nothing about the issues elucidated above, and yet polls show that upwards of 50 percent favor repeal now, a proportion that I predict would approach 60–70 percent if they did understand.

Beyond a growing distrust of government, many people seem to realize that there is probably not much in PPACA for them. The majority of people will actually end up paying more for the same, or less, coverage than they have now. Consider the various insurance reforms, most of which have been and remain quite popular. Having your uninsured children who still live at home stay on your policy until age 26 is a very reasonable idea, and it is projected to increase the cost of a family policy by a mere $135 a year. However, when you add in the ban on pre-existing conditions for children, the removal of lifetime payout limits on policies, the ban on rescissions, and all the other reforms, the cost of a family policy jumps by about $1,000 a year. This may be worth it, but my sense is that the 70 percent or more of the population currently insured believe that they will never derive much benefit from any of this.

PPACA Increases the Cost of Private Insurance

PPACA provisions will increase the cost of existing private insurance—to a significant degree—in at least five different ways:

- The various cuts and freezes in Medicare and Medicaid will accelerate what has already been substantial cost-shifting by physician and hospital providers to private payers.
- The weak individual mandate, even if not struck down by the courts as constitutionally excessive, will boost private premiums as all of those with major medical conditions will buy insurance (no more discrimination against those with pre-existing conditions) while many millions of the healthy will wait until they get sick.
- As a perk for (high-propensity voting) seniors, some $80 billion in mandated price reductions for brand-name drugs will go toward shrinking Medicare Part D's so-called "donut hole." Great for seniors, but the rest of

us will all pay that through our private premiums as Big Pharma will just cost-shift that $80 billion over to private plans.

- Various new direct taxes on the health care industry are also part of PPACA, including a tax on health insurers ($14 billion per year by 2017), a tax on pharmaceutical companies ($4 billion per year by 2017), and a new 2.3 percent tax on all medical devices. All of these costs—more than $20 billion per year—will again just be cost-shifted to private plans.
- Finally, contrary to conventional wisdom, the proposed transition of the health care system to one based on so-called accountable care organizations may not save money, at least initially. There appears to be a rather frenzied consolidation within the health care world—hospital systems pumping up their sizes and physicians aligning with them, all trying to get bigger, trying to avoid being run over by some very powerful national forces. The problem is that there is plenty of evidence that the larger the health system, the harder bargain they drive in negotiating payments, particularly with private insurers. Once again, this raises the cost of private insurance.

At the end of the day, commercially insured Americans, 170 million of them, will likely see their annual premiums for family coverage go up $2,500 a year or more just from PPACA provisions. Notably, CBO does not "score" this because none of this is a government expense.

2012 Will Determine the Fate of PPACA

The Republican-dominated House of Representatives, bolstered by the votes of some House Democrats, repealed PPACA by a wide margin earlier this year. The Democratically controlled Senate then defeated repeal along party lines, 51–47, with 2 not voting. However, even though outright "repeal" has been stalled, putting into play dozens of PPACA's new boards, commissions, governmental units, and other entities has been made more difficult by a series of defunding votes by the House. This, in combination with at least 20 governors doing nothing to implement PPACA's various state-level programs, makes ultimate PPACA implementation quite problematic.

In addition, by next year the Supreme Court will likely decide two separate issues: the constitutionality of the mandated Medicaid expansion and the constitutionality of the individual mandate.

Should PPACA be upheld, the 2012 presidential election will then likely be decisive, with the Republican nominee running against President Obama on a

platform of "Repeal and Replace." Also, by that 2012 election, there will be a much more significant emphasis on the "Replace," as voters will want to keep several of PPACA's basic provisions, in particular the private insurance industry reforms.

Should Republicans re-take the White House in 2012, it seems almost certain that they would retain control of the House of Representatives, and likely could gain control of the Senate as well. If such a triple play were to come to pass, it would then become quite possible that PPACA could be replaced or significantly altered before the critical date of January 1, 2014—when the Medicaid expansion, the mandate to buy insurance, and the substantial subsidies are scheduled to begin.

One caveat for 2013 is that even in the most optimistic of Republican scenarios, they would not achieve a filibuster-proof 60 votes. However, most observers believe that if the Republicans take the White House and pick up five to 10 Senate seats, they would have done so at least partially on the basis of "repealing Obamacare," and therefore the large number of Democratic senators elected with the Obama wave of 2008 (and up for re-election in 2014) would in fact support a "Repeal and Replace" process, provided that the "Replace" represented meaningful reform.

Finally though, all this is moot if President Obama is re-elected in 2012. In that scenario, PPACA will stand, and we will all watch what happens in 2014: will PPACA surprise its detractors and work successfully, or will it be the poorly designed, underfunded program that its critics believe it to be—leaving us with a health care insurance system that is acutely destabilized and thus even more problematic than what we have now?

Stay tuned.

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