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ObamaCare: Rocky Politics, Stable Coverage

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Abstract: The Affordable Care Act (ACA) and Medicare Part D had the same rocky start. Both were criticized as unworkable and unsustainable. Yet both have similar structures. They offer individuals a choice of competing health plans, provide subsidies to make coverage affordable, and impose penalties for late enrollment. Medicare Part D's success in creating stable coverage of prescriptions drugs for Medicare beneficiaries shows how the ACA may stabilize health insurance coverage for working-age Americans. The comparison with Part D also reveals two potential sources of instability for the ACA: a narrow subsidy structure and benefit mandates. The biggest source of instability for the ACA and all other forms of health care coverage is rising health care costs. That threat, which can lead to higher taxes or benefit cuts, could stimulate bipartisan action. There are a series of opportunities that start small and work up to major action: the repeal of Medicare's Sustainable Growth Rate, sequestration replacement, state gain-sharing, and tax reform. A focus by policy makers on rising costs as a common enemy can help move the health care debate beyond the rocky politics over the ACA.

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At its start, this program had a 23 percent approval rating (Kliff, 2013). Call centers were overwhelmed as enrollment began (Hoadley et al., 2013). Members of Congress called it a budget-busting entitlement that would fail. For example, see Burton (2003). That may sound like the Affordable Care Act (ACA), but in fact it was Medicare Part D. Enacted in 2003 to expand prescription drugs for Medicare beneficiaries, it is now one of the most successful government programs.

Part D's underlying structure has enabled it to succeed despite initial doubts and opposition. It offers beneficiaries a choice of coverage among competing health plans. The competition among plans has restrained premiums. Beneficiaries have grown increasingly satisfied with their coverage.

The ACA and Medicare Part D share the same basic structure. The exchanges under the ACA offer individuals a choice of competing health plans. Both programs offer subsidies to make coverage affordable and both programs impose penalties for late enrollment.

Does the ACA's similarity to Part D guarantee success? No, but experience with Part D does suggest a similar path for the ACA. Supporters of the ACA can take solace in Part D's ultimate triumph. Opponents can look to Part D for constructive ways to address the policy challenges posed by the ACA.

This paper examines the potential for the ACA to stabilize health care coverage in light of the achievements of Part D. It examines how the programs' similarities lead to stable coverage. It shows how the differences are sources of instability. Lastly, this paper identifies opportunities for addressing the biggest source of instability: rising health care costs.

The Path Toward Stability

The ACA and Medicare Part D are like twins separated at birth. They inherited a common policy structure, but have been nurtured by different parents at different times. To understand how their policy heritage leads to stable coverage, it is important to know their background.

¹¹ All views expressed are the author's.

Medicare Part D: A Market that Did Not Exist in Nature

During the debate over Medicare Part D, the Bush Administration's Director of the Centers for Medicare and Medicaid Services, Tom Scully, raised concern about the idea of standalone prescription drug coverage, saying such coverage "does not exist in nature" (Pear, 2003). Indeed, standalone prescription drug benefit plans did not exist as a consumer product at the time of Part D's enactment. Although Medicare beneficiaries could choose a supplemental Medigap policy with limited drug coverage, it would not protect them from large drug costs that could potentially bankrupt them. Pharmacy benefit managers and private health plans were providing drug coverage as part of a comprehensive package of benefits, but none were offering it alone on a retail basis.

Medicare Part D was enacted as a bold experiment that sprang from years of debate and negotiation in Congress. In the 2000 election, both presidential candidates supported a prescription drug benefit to offer coverage to Medicare beneficiaries. Vice President Al Gore proposed a drug benefit for low-income beneficiaries and subsidized coverage for most drug expenses including all catastrophic expenses (New York Times News Service, 2000). Then-Texas Governor George W. Bush proposed coverage for low-income beneficiaries through private insurers (Oliver et al., 2004). After the election, President Bush's proposal evolved from a block grant to states for low-income drug coverage, to subsidies to privately managed care plans that would offer additional coverage including prescription drugs (Oliver et al., 2004). After a failed effort in the 107th Congress and a protracted debate in the 108th Congress, which included an unprecedented, nearly three-hour vote in the House of Representatives, a Republican-controlled House and Senate and President Bush finally won enactment on December 8, 2003 (Oliver et al., 2004).

The result was Medicare Part D that provides coverage through three sources: standalone private drug plans, Medicare Advantage private health plans, and employer or union-sponsored retiree health plans through a subsidy for their drug coverage. Beneficiaries in every area of the nation have at least 23 options from which to choose (MedPAC, 2013). Prior to Part D's enactment, 75 percent of Medicare's beneficiaries had some sort of prescription coverage; today, it is 90 percent (MedPAC, 2013).

The ACA: Public Subsidies for Private Coverage

While the scope of ACA is larger than Part D, it tapped more established forms of coverage to achieve its ends. Exchange-like coverage has existed in several places throughout the country for decades. States like California and Wisconsin have exchange-like models for state employees. The federal

government has a similar system for federal employees, the Federal Employees Health Benefits Program (FEHB).

These established individual choice systems, however, involve a defined group of employees with a well-worn path to enrolling in coverage. The ACA exchanges must reach out to anyone who is uninsured regardless of their work or health status. Like Part D, the exchanges must take all individuals.

Enacted in 2009, the ACA also had a long road to enactment and a rocky legislative debate. Throughout the 20th century, several major attempts at enacting health care reform failed, including President Bill Clinton's 1993-94 effort. Most of those efforts involved a high degree of government control of health care markets. Barack Obama ran for President promising a health care reform modeled after a market-based model, the FEHB with subsidies for coverage, albeit with a public plan option modeled after traditional fee-for-service Medicare (Sack et al., 2008). He won enactment of the ACA in his second year in office despite the Democrats' loss of a filibuster proof majority in the Senate when Republican Scott Brown was elected following the death of Senator Ted Kennedy. It also survived a constitutional challenge except for the mandatory state expansion of Medicaid.

The ACA exchanges offer multiple health plan choices in the vast majority of states. The Congressional Budget Office (CBO) projects that the ACA will increase coverage among lawful U.S. residents from 82 percent in 2013 to 92 percent in 2017 (CBO, May 2013). It estimates the number of uninsured will drop by 25 million people.

The Conditions for Stable Coverage

Since World War II, Americans have found stable health care coverage through the workplace. Half of the U.S. population gets coverage from employment-based coverage. Most American workers have been able to hold onto their health benefits even as premium growth has exceeded wage growth. Coverage through large employers has been especially stable. Similarly, Medicare has provided stable coverage for retirees and the disabled following its 1965 enactment.

Less stable has been coverage for individuals and employees of small businesses. Many small employers do not offer coverage. Many individuals with pre-existing conditions cannot get coverage.

Stability also requires sustained political support. The policy bulwark of employment-based coverage – the Employee Retirement Income Security Act (ERISA) and the tax exclusion for job-based coverage – have never been under a

serious threat. Republicans have made periodic attempts at market-basket reforms of Medicare, but have never tried to repeal it.

The most recent example of stable coverage is Medicare Part D. Ninety-four percent of beneficiaries are satisfied with their coverage (MedPAC, 2013). Its cost has come in under budget (Elmendorf, 2013). Seniors with financially devastating prescription drug costs (exceeding \$5,000 in a year) fell from 14 percent in 2003 to seven percent in 2010 (HHS, 2012).

Part D enjoys bipartisan support. After enactment under GOP leadership, Democrats pushed to fill the donut hole gap in coverage through the ACA, thereby giving them a sense of ownership in the program.

The policy framework for Part D has created stable coverage by blending regulation and markets in a practical way that promotes efficiency and fairness. It is these core features that Part D and the ACA share as the chart below shows.

| Shared Policy Features | Medicare Part D | ACA |
|--|---|---|
| Guaranteed issue | Yes | Yes |
| Community rating | Yes, not age-adjusted | Yes, age-adjusted |
| Risk-adjusted payments to health plans | Yes | Yes, through exchanges |
| Individual choice of plan | Yes | Yes, through exchanges |
| Subsidies | Yes, for all, plus additional low-income subsidy | Yes, sliding scale up to 400 percent of poverty |
| Penalty for not having coverage | Yes, premium increases every year beneficiaries go without coverage | Yes, tax penalty for not having coverage |
| Entitlement financing | Yes | Yes |

This combination of features allows the retail health plan market to flourish as proposed in managed competition theory (Ellwood et al., 1992). Guaranteed issue, which prevents people with pre-existing conditions from being denied coverage, allows individuals to switch plans without medical underwriting. The subsidies encourage broad participation of the population in the health plan marketplace. The risk-adjusted payments to health plans ensure that plans that attract relatively sicker patients are not punished financially. Community-rated health insurance premiums provide a clear price to consumers rather than the opaque pricing that occurs under medical underwriting. The penalty for not having coverage helps prevent people from waiting until they need care to obtain coverage.

Stable government financing is secured through entitlement spending that is not subject to the annual Congressional appropriations process. A

government shut-down does not affect coverage through Part D or the ACA. A shut-down does not affect federal tax-based financing for job-based coverage or Medicare.

Both the ACA and Part D have incentives for consumers to shop for lower-priced coverage. ACA and Part D participants receive subsidies in the form of a flat contribution. If they wish to purchase a more expensive plan, they must pay the full additional cost themselves. In contrast, the tax break for employees with coverage at work obscures the additional costs of a more expensive plan because the additional cost is tax-free, which reduces the actual extra cost by around 30 percent. This flat form of subsidy helps keep costs stable.

Potential Instability for the ACA

Despite the many similarities, the ACA and Part D are different in two areas: the subsidy structure and benefit coverage requirements. Part D has a broad-based subsidy available to nearly everyone regardless of the source of their coverage. The ACA offers a sliding scale subsidy targeted to those who lack coverage today. The ACA subsidy does not extend to employees with coverage through the workplace.

The difference in the benefit design area is that Part D has some very specific benefit coverage requirements for certain drug classes. Specifically, Part D plans must cover virtually all drugs for diseases like depression, cancer, HIV, and AIDS. The ACA requires plans to follow the benefit coverage standards established in the marketplace.

But before examining those two potential threats to the ACA's stability, let's look at the biggest potential source of instability: rapidly rising health care costs.

Rising Health Care Costs

Although health cost growth has been muted during the recession, few health care economists expect that the problem is resolved. The CBO projects that growth in health care costs will exceed inflation for decades to come.

The challenge of rising costs for the ACA can be summed up as follows: If health insurance premiums spiral upwards, federal subsidies for coverage would also increase, causing fiscal pressure to reduce benefits. Rising premiums would also lower the value of coverage to younger participants who are less likely to need health care services. Fewer younger participants would put additional pressure on rising premiums, thereby adding more fiscal pressure. Increasing the penalty on young adults and all individuals not having coverage

could offset some of that pressure. But given the political resistance to the individual mandate, it is not clear how effective such a tool would be.

Rising costs also affect the stability of other forms of coverage. With rising per capita costs and an aging population, Medicare is not sustainable. The Medicare Part A trust fund will be insolvent by 2026. Medicaid will also continue to grow as the population ages. Employer-sponsored coverage will slowly continue to erode, due in part to rising costs.

The pressure on public budgets from health care costs will thus increase. Even before the ACA enactment, the federal, state and local government's share of health care spending had reached nearly 60 percent when the tax exclusion for job-based coverage is considered (Conover, 2011). For governmental budgets, the consequence of rising costs will provoke higher taxes or deficits, benefit cuts, or new measures to restrain costs. The least objectionable solution for both Democrats and Republicans is to adopt cost restraint measures instead of raising taxes or cutting benefits. In other words, cost restraint could well become the path of least resistance.

Unstable Subsidies

Coverage under the ACA will shift around more than under Part D as employers position themselves to take advantage of the subsidies offered through the exchanges. In the ACA, subsidies for individuals to buy coverage are available only through the exchange. Small employers who offer coverage and have mostly low- and moderate-income workers may in fact benefit their employees by dropping their coverage, thereby giving them access to subsidized coverage through the exchange. In contrast, Part D extends subsidies to Medicare beneficiaries across multiple types of coverage (e.g., stand alone coverage, retiree coverage and Medicare Advantage plans). That means Medicare Part D beneficiaries do not need to change their coverage in order to receive a subsidy.

The downside of the Part D approach of providing widespread subsidies is that it costs the government more money. Widespread public subsidies often replace private coverage payments that people are already making. Some health policy analysts refer to this problem in negative terms as crowd-out. But it is not necessarily bad because some amount of crowd-out is necessary to prevent disruption of coverage.

It is not clear how fast the consequences of the ACA's uneven treatment of employees of small employers will play out. One mitigating factor is the small employer tax credit that is available through the Small Business Health Options Program (SHOP) exchange. It is worth up to 50 percent of an employer's contribution to the coverage of low and moderate-income employees. Employers and employees will be sizing up their options over the

next few years and making changes accordingly as they see how well the exchanges perform.

Such disruption is far from a fatal flaw, however. The ACA can support—and was designed to sustain—a fair amount of disruption. The CBO's projections for the ACA include reductions in employment-based coverage due to such disruption.

Benefit Mandates

Conservative analysts often point to the problems of benefits mandates as the reason to oppose any kind of compulsory insurance model. By definition, any purchase requirement must specify *some* benefits that a person is required to purchase. In addition, subsidies for coverage must define qualifying coverage. That can lead to benefit mandates that are unwanted or unneeded, like coverage for infertility treatment in insurance policies paid for by older couples. Some wasteful mandates have been enacted by state legislatures.

So far, the ACA has avoided getting mired in such controversy. It is relying on established health plans by state small group markets to serve as the standard for essential benefits. Another curb is that the federal government would have to pay for any mandated benefits because the cost of subsidies would increase as a result of the extent of a mandate. States must also pay for any increases in federal subsidy costs if they mandate benefits.

The capacity to distinguish between good and bad benefit requirements will improve with the increasingly sophisticated analysis of the efficiency and equity of mandates. Some states are supporting the development of economic analysis in order to balance against purely political concerns in setting mandates. Federal level analysis by organizations like CBO will also be necessary as proposals for federally mandated benefits inevitably emerge.

The debate over benefit mandates preceded the ACA and would continue without the ACA. But the ACA does amplify the consequences for mandates benefits that are inefficient and unfair as more Americans will have coverage under the ACA and will thus be subject to the requirements. It will simply take more effort to get it right. And it further underscores the need to make cost restraint in general a higher national priority.

The Opportunity for Stable Health Care Politics

The opportunity for stable health care politics will come as both parties see a common enemy in wasteful health care spending. For over 20 years, the Dartmouth Atlas Project has documented regional variation in Medicare spending that is not explained by the demographic or health status

characteristics of people in each region. As much as 30 percent of Medicare spending does nothing to improve the health of beneficiaries (Skinner and Fisher, 2010). A recent report from the Institute of Medicine confirms that such geographic variation also occurs in the commercial, non-Medicare marketplace and also finds similar variation within progressively smaller units of analysis, from hospital referral areas down to individual practitioners. The report urges policymakers to eliminate wasteful variation by focusing on local decision-making about care in hospitals, group practices, health care organizations, individual practitioners and patients.

Eliminating wasteful health care spending is a rallying cry that can bring the two parties together even for different reasons. Republicans want to avoid tax increases to pay for additional spending, and Democrats want to avoid cutting benefits. Although strong fiscal reasons can push the two parties to work together, politics will still get in the way. Bipartisanship will be easier by starting with small steps. Here is a series of opportunities that start small and work up to major action.

The Sustainable Growth Rate Repeal

Medicare's Sustainable Growth Rate (SGR) links updates to the physician fee-for-service payments to the growth in the economy, which is usually less than the growth in health care spending. Also known as the "doc fix," delaying the impact of the SGR has become a beltway ritual performed annually or sometimes even more often. Without Congressional action this year, physician payments will be automatically cut by 24.4 percent in 2014 (CMS, 2013). The House of Representatives is considering bipartisan legislation that would permanently repeal the SGR and make several changes to the current fee-for-service payment system that head towards a payment that rewards performance, not just the volume of care provided (U.S. Congress, 2013). This legislation builds on the payment innovation demonstrations included in the ACA.

Although these initial steps are modest, the legislation would set up a process to develop alternative payment models that could complement or replace the current fee-for-service payment system. A more aggressive approach could produce savings to offset the cost, which is \$175 billion over 10 years, due to the repeal of the SGR and the cost of an additional increase in physician payments (CBO, 2013). Alternative legislation calling for the adoption of specific new payment models like bundled payments (a package price for all the services needed for an episode of care) could produce budgetary savings (Kendall, 2013).

Sequestration Replacement

Under the Budget Control Act of 2011, payments to health care providers have been cut by two percent across the board since the so-called Congressional “super committee” failed. In addition, discretionary spending, which covers most of the basic functions of government like defense, law enforcement, and environmental protection, has been cut by about six percent. Such cuts will continue for the next 10 years unless Congress raises revenue or cuts spending in other ways.

Although relatively small, the two percent cuts will have an outsized impact. Providers are already subject to payment cuts under the ACA, and doctors in particular have been reeling from uncertainty over the SGR. Moreover, the impact of the across-the-board cuts is uneven (Brill and Leitner, 2011). For example, hospitals that find themselves at a point of low-liquidity due to investments will have a much tougher time adjusting to less cash flow (Brill and Leitner, 2011). Pressure to address the sequestration is even stronger coming from advocates for other parts of government hit even harder under sequestration. Research and general government spending would benefit from lower entitlement spending. With well-documented waste in health care, both parties could see it as a ripe target for more aggressive payment reforms over time that would avoid the arbitrary nature of across-the-board cuts.

Of course, major changes in health care payment systems won’t happen overnight. That’s why a period of sustained fiscal pressure from sequestration may help encourage lawmakers commit to a process of change over time. An additional way to encourage long-term commitments is to allow the accrual of greater-than-projected savings in Medicare and Medicaid to offset future sequestration cuts. Such a measure could be enacted along with a broad set of payment reforms.

A package of reforms in this context could include not only provider payment reforms but also new ways for Medicare beneficiaries to shop and select high quality, lower cost health care coverage and services. For example, Medicare could offer incentives to supplemental Medigap insurance plans to offer beneficiaries lower copayments for high value providers like accountable care organizations.

State Gain-sharing

A longer term opportunity is to take advantage of the unique position of states in the panoply of health care cost factors. States have a mismatch between their responsibilities for much of the economic, legal and regulatory structure of health care and the rewards they receive for making cost-saving reforms. If they take on tough issues like scope of practice reforms that expand

the use of lower cost providers, they only receive a fraction of the reward through lower spending for their Medicaid and state employees' health benefits. Moreover, they are a logical testing ground for cost-saving innovations.

To encourage more leadership on the part of governors and state legislators, the federal government could share a portion of the savings with states that it would accrue from their leadership (Kendall and McConaghy, 2011). For example, states would share in the savings that would accrue to the federal government when defensive medicine declines due to tort system reform. Some states are pioneering multi-stakeholder initiatives that can save money for all payers.

States are also at the center of efforts to digitize medical records—a necessary precursor to enabling doctors to do a better job taking care of their patients. This is especially true for those patients with chronic conditions who need significant amounts of routine care. A key part of the national strategy for digitization has been state-based health information exchanges. As their federal funding comes to an end, states do not have a financially sustainable model for continuing data exchange efforts (Adler-Millstein et al., 2013). Sustainable models such as health record banks have been developed (HRBA, 2012). State gain-sharing could provide the upfront investments to launch and help capture system-wide savings.

State-based initiatives are naturally appealing to Republicans. For Democrats, state gain-sharing offers states a way to pay for Medicaid expansions. The 100 percent federal funding of Medicaid expansion plans in states that accept it will decline to a match rate of 95 percent in 2017, and to 90 percent in 2020 and onward. States will need a source of funding for their portion of the costs. A source of funding might also help encourage more states to adopt the Medicaid expansion.

Tax Reform

A final locus for cost-saving effort is tax reform. The tax exclusion for employer-based coverage is a major source of inefficiency. Because health benefits are tax-free, employees are shielded from the true cost of health care coverage. The so-called “Cadillac plan tax” in the ACA is a crucial first step toward ending this inefficiency. It effectively caps the tax exclusion by imposing an excise tax on plans with rich benefits and high costs.

The excise tax is 40 percent of the amount of premium that exceeds \$10,200 for individual coverage and \$27,500 for family coverage in 2018. Because those amounts are well above the average cost of coverage, many employees will still be shielded from the cost of inefficient health care.

Instead, the tax exclusion should be capped at the average cost of health plans. Employers and employees choosing more expensive health plans would pay the full additional cost without a tax subsidy. That would add appropriate economic pressure on health plans and providers to restrain costs generally. They would be constrained to offer more expensive services only when they are fully valued by consumers.

The revenue generated from the cap would be used to fund tax credits for all employees getting their coverage outside the exchange. This step would eliminate the incentive for employers to drop coverage in order to give their employees access to the subsidies through the exchange. The Cadillac plan tax would no longer be necessary.

A political deal to enact a tax cap would require employers, employees and unions to recognize they would be better off with a more stable source of financing for employment-based coverage. It would also require the exchanges to be successful in providing affordable, high-quality coverage. The subsidies for coverage through the exchanges will provide a clear test of the impact of limited subsidies for coverage. The exchange-based subsidies are limited to the second-lowest-cost “silver plan” in each exchange.

Conclusion

Despite its rocky politics, the ACA will expand and stabilize health care coverage in the United States. Like Medicare Part D, the ACA has several key elements that will lead to stable coverage. It will be more stable than coverage in the United States prior to the ACA enactment. The remaining sources of instability will require additional action. The most pressing problem is rising health care costs overall. That will push the politics of ACA opponents from “repeal and replace” to “mend it, not end it” by necessity and will ultimately realign the politics of health care insurance around the goal of stable coverage.

It will take time to move beyond the political rifts from the ACA and the process will likely take longer than with Medicare Part D. If Social Security is any indication, it could take more than one Presidential election. Indeed, Republican party platforms called for a repeal and replace approach to Social Security after its enactment in 1935 until the 1944 platform for New York Governor Thomas Dewey’s first run for president (Woolley and Peters, 2013).

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