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The Past, Present and Future of U.S. Health Care Reform

Jonathan Gruber

Abstract: The beginning of the most important elements of the Patient Protection and Affordable Care Act of 2010 (ACA) is an opportune time to review the history of health care reform in the United States, the issues involved in the development of the ACA and its prospects. Efforts for reform trace back to President Teddy Roosevelt and have moved forward since then. The ACA is the culmination of years of debate and discussion at the federal level, but the Massachusetts Health Care Reform Plan adopted in 2006, Romneycare, was the most tangible forerunner and experiment confirming the design, possibilities and success of the ACA. Obamacare is Romneycare. Based on the success of Romneycare, Obamacare will be successful. This paper develops the fundamental challenges of reform and the approaches taken by the ACA to solve those potential problems, especially improving access to health care, improving affordability and avoiding increased federal budget deficits. It also outlines steps developed in the ACA to achieve significant future cost control in health care without sacrificing the trend productivity gains in health care observed in the past and that can further improve access and affordability. This paper is based on a presentation at the Networks Financial Institute's forum on health care reform, "The Big Bang for the Affordable care Act: The End of Health Care Financing as We Know It?" held October 18, 2013 at the Columbia Club in Indianapolis, Indiana.

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There are strong feelings about the Patient Protection and Affordable Care Act (ACA), a lot of controversy. This is a law which is misunderstood, and, and I would like to explain what it's about. I'm obviously biased because of my advisory role in its development. I'm not going to try to deny that, but I want to provide factual evidence. If you want more information, I also have written a comic book to try to explain health care reform. It's called a graphic novel, but it is a comic book, ambitiously titled Health Care Reform.¹ You can get it for about eight dollars on Amazon.com. It also tries to lay out clearly what the law is about and how it works. I will try to do that here.

U.S. Health Care Reform: The Past

We have to take a step back if we're going to understand the health care law. How did we get where we are? We have to recognize that The United States has been trying to reform health care for about 100 years. Teddy Roosevelt made the first attempt at fundamental health care reform. Since then we have been stuck between two extremes. One extreme has been the left, which has said, look, we should have a single government-run plan. According to the left, there are two fundamental problems we have in health care in America. First, we have a high and rising number of uninsured individuals, now amounting to about 18% of the non-elderly population. Second, we have high and rising health care costs. Health care costs were about 4% of the GDP in 1950. They are about 18% today. They are projected to rise to 40% by 2080. So, these are clearly problems. The latter is clearly unsustainable. A single payer health care plan would solve them: everyone's insured from birth, and the government just imposes a cap on what society is going to spend on health care. We are done. Now, the problem with that approach is that it has proven politically unrealistic, clearly unrealistic, for two reasons. The first reason is actually very nicely laid out in a book by Paul Starr.² It is the history of U.S. health care reform. Starr points out that as health reform failed, the public built up a partial system that now works for most Americans. Most Americans are pretty happy with their health insurance arrangements. They wish it was cheaper, but they are pretty happy with it, and you do not get very far in American politics by taking away something most people are happy with to give them something they do not know about. So it is simply not

¹Jonathan Gruber, with H.P. Newquist, *Health Care Reform: What It Is, Why It's Necessary, How It Works*. (New York: Hill and Wang, December 20, 2011).

² See Paul Starr, *Remedy and Reaction*. (New Haven: Yale University Press, 2011, revised 2013).

going to happen that we are going to convert the whole system. Second, we have an \$850 billion a year private health insurance industry. The industry is not going away. There is just no way that the government is going to nationalize an \$850 billion a year industry, so the notion of one government-run insurance plan is simply not going to happen.

On the other extreme, there is the right, which argues that the system basically works. Maybe to help cover rising health insurance expenses for the uninsured the government can give out some tax credits, but otherwise let's let the private insurance industry run its business as usual and tinker with the wonderful private system we have today. The problem with that argument is that it is wrong. The system doesn't work for a substantial minority of Americans. In America today, if you do not have health insurance from your employer or from the government, you are fundamentally uninsured. Now, some might argue that there is another option. There is an individual insurance market where you can go buy insurance on your own. Well, that is not insurance. Insurance is defined as allowing participants to join in something which is a pool where, in the case of health care, both the healthy and the sick are pooled, and the sick people are covered for their illness. That doesn't happen in this market. In this market, you're excluded if you're sick or you can be denied coverage all together, or your price can be many, many multiples of what healthy people pay. That's not insurance.

So, fundamentally in America, you do not have insurance unless you get it from your employer or the government and giving somebody \$2000 isn't going to solve that. My wife is a breast cancer survivor. If I did not have insurance from MIT, she would be uninsurable, full stop. So basically, we have got this problem that the right didn't solve. And moving forward we have these two extremes that the nation has been stuck between for years. Into this abyss, came the hero of our story, let's call him Mitt Romney. Mitt Romney was Governor of Massachusetts and as Governor of Massachusetts, he devised a real, but elusive third way, something I like to call "incremental universalism." It sounds like a new religion, but it's not. What I mean by that is incremental, borrowing from the right, meaning let's build on what works, and universal, borrowing from the left, meaning let's get to universal coverage. How did he do it? He did it by building what amounts to a three-legged stool. The first leg was insurance market reform. Do not allow insurers to discriminate against the sick. Insurers have to guarantee insurance to anybody who applies and pays for it. They have to guarantee renewability to anybody who has insurance, and they cannot charge sick people more than healthy people. It can vary a bit by age, but you cannot vary pricing by health.

Now, in fact, this wasn't original to Governor Romney. In fact, Massachusetts was one of seven well-meaning states in the mid-1990's that passed these "community rating reforms." What happened was exactly what an economist would tell you would happen, which is that they destroyed the insurance market. Now, to think about why, we have to

understand that insurers are fundamentally like bookies. The way sports bookies work is there's a spread on a game, and people bet on one side or another, and sports bookies' goal is to just balance the bets on either side so they can take their spread off the top. Well, that's what insurers do, too. They just want a nice predictable distribution of risk so they know what they're going to pay out, and they can take their profit off the top.

That works as long as they have a predictable distribution of risk, but if you tell sports bookies: by the way, at halftime, you're going to have to take bets at the pre-game odds no matter what's happening, well, the sports bookies would go out of business because everyone would bet on the team that's winning, and they would usually lose all their money. Likewise, if you tell insurers you have to offer insurance to everyone at the same price regardless of how sick they are, but we're going to let people wait until they are sick to buy it, then the insurers go out of business, and that's what happened. In all these states, the insurance market collapsed because insurers said, wait a second, you're going to force us to charge the sick and the healthy the same, but people aren't going to buy until they're sick. We're going to lose money. That is why Romney realized he needed a second leg of the stool, which was the individual mandate. If you're going to force insurers to charge everyone the same price, the only way to make that work is to force every prospective customer to participate in the insurer's market. With the second leg of the stool, insurers can price fairly, then everyone is betting at the pre-game odds, and if every insurer can price fairly, then they can more easily stay in business.

The problem with the individual mandate is that you cannot mandate something that people cannot afford. That's why you need the third leg of the stool, which is the individual subsidy. We then designed a program that subsidized individual insurance quite heavily up to three times the poverty line or about \$66,000 for a family. We make insurance much cheaper. These three legs of the stool began in early 2006 and were the basis for Massachusetts' health care reform. Has it worked? If you look at the objective facts, it has worked pretty well. Massachusetts has covered 2/3 of its previously uninsured residents. The uninsured rate now in Massachusetts is 3% compared to 18% nationally, and we fixed a broken insurance market. Premiums in our individual insurance market fell by 50% when we passed this reform. We've done so with broad public support, consistently between 60 percent and 70 percent, according to public polling of support for this law.

As a result of this success, despite what Presidential candidate Mitt Romney might have told us, it became the basis for the Obamacare. Obamacare is Romneycare. It is the same approach, the same three-legged stool done at the federal level. Once again, first of all, it fixed broken insurance markets. This is the fundamental accomplishment of the Affordable Care Act—it ends the fact that the United States is the only nation in the developed world that allows insurers to discriminate against the sick, the last people to become medically bankrupt because once they're sick, they can't get insurance coverage.

No other country does that. We are now going to suddenly join the league of developed nations in ensuring that people can get insurance when they're sick, which is the whole idea of insurance in the first place.

So, that is the first leg of the stool, but to make that work, you need the second leg of the stool. You need the individual mandate. In my graphic novel, I had this image of the mandate as being the spinach we have to eat to get the dessert that is fair insurance pricing. You have to have the mandate if you are going to have fair insurance pricing, but then to make the mandate feasible, you have to have subsidies. The ACA expands the Medicaid program, more on that later, but notionally the Medicaid program has been expanded to our lowest income citizens and for incomes between 133 and 400% of the poverty line, or up to about \$88,000 for a family, there are tax credits to offset the cost of health insurance that you buy in private health insurance exchanges. So that's the basic structure, and according to the nonpartisan Congressional Budget Office (CBO), it will work pretty well. The CBO estimated that about 30 million Americans would get coverage. That was about 58% of the uninsured. That's less than in Massachusetts, partly because the law doesn't apply to illegal immigrants, and we don't have many of them in Massachusetts, but they are a large number of the uninsured in Texas and Florida. The ACA alone would be less successful than the reforms in Massachusetts, but it will still cover well more than half the uninsured. That is all well and good. But the story can't stop there because the ACA had to be more ambitious than reform was in Massachusetts in two important ways.

The first way is a bit of a dirty secret about Massachusetts reform that people were not admitting. The reason Massachusetts reform worked was because the federal government paid for it. For this to happen, Massachusetts needed a pretty powerful Senator who you may have heard of named Ted Kennedy. Ted Kennedy devised the mechanism. It was not unique to Massachusetts. Senator Kennedy was just very good at it; he was essentially ripping off the federal government for about \$400 million a year in Medicaid subsidies. George Bush said why am I sending this Democrat \$400 million a year in Medicaid subsidies? I'm going to cut them off. Mitt Romney to his credit went to the Bush Administration and said wait a second. What if we rededicated this money and used it to cover the uninsured, and the Bush Administration to their credit said yes, and that became the seed money that made our health reform possible.

The Affordable Care Act

At the federal level, we don't have the seed money that Massachusetts had. No one is paying our subsidies, foreigners are not going to come forward and pay the cost of U.S. health care reform. The American public has to pay for it, and President Obama made it

very clear from day one that this would be a deficit-reducing bill. That was a fundamental principle, perhaps the President's number one principle. This would not increase the deficit, and it has not and why is that? It does not increase the deficit because there are both spending reductions and tax increases associated with the ACA, and those are controversial. That is why this law was a lot harder to pass, I think, than in Massachusetts, but it does reduce the deficit. According to the CBO, it reduced the deficit by about \$100 billion over the first decade and by more than \$1 trillion over the next decade. It does it with spending reductions and tax subsidies. In each case, I want to highlight two components, the two biggest, and in each case I want to discuss one that should not be so controversial and one component that perhaps is controversial.

On the spending side, there are two major spending cuts. One spending cut is a reduction in the overpayments to private Health Maintenance Organizations (HMOs) that insure the nation's seniors. Elders today have a choice between Fee for Service Medicare, and Medicare Advantage Plans, which are offered by HMOs that insure them on behalf of Medicare. This was set up very wisely in the 1980's as an alternative to help bring managed care into Medicare and to lower costs. The problem is that through a history of political maneuvering, by 2008, these plans were being paid 118 percent of what Medicare has paid. It's hard to save money when you're paying the alternative 118%, so what the law did was cut that, not below 100, but down to 100, varying between 100 and 115%, but at least varying it down to 100 in some cases. So that is bad for no one except the stockholders of these insurance companies, but that was just a giveaway to the insurance companies. It is ending and that finances about a quarter of the law.

The spending cut that perhaps should be a little more controversial is a reduction in the growth rate of reimbursements to hospitals. Medicare is the single biggest payer of hospitals in the United States. It grows by a certain amount every year. That growth rate has been reduced by between half a percent and a full percent per year. In the near term, that's not much. In the longer term, it could be. In the longer term, if that continues and hospitals do not find a way to become more productive, then that could start to really hit their bottom lines and matter, and so that is something that must be watched closely.

On the tax increase side, once again one component should not be controversial, but it gets all of the press. This is an increase in excise taxes on the sectors that benefit from health care reform. Particularly, there has been a lot of press around the medical device sector. This law is covering 30 million people with new health insurance. That is a huge boom in business for the pharma sector, for the medical device sector, for the insurance industry. What the law does is ask those industries to kick back a little bit to help pay for it. It's kind of like saying here's a \$100 bill, oh, by the way, can we have five dollars of that back to help pay for the law that allowed you to get this \$100 bill? Now that is still a pretty good deal for these industries. Now, that doesn't mean that I do not have every right to complain about the five dollars that I have to pay back, but let's be clear, this is

not a job killer for the medical device industry or the insurance industry or the drug industry. This is a job creator. This is a boom for those industries, and sure, they would prefer not to pay \$30 billion in taxes, but the notion that in some sense this law is bad for them is simply incorrect, factually incorrect. That should not be controversial, although it is.

The second tax component, which should be more controversial, is the ACA includes one of the most redistributive tax increases in our nation's history. There is an enormous tax increase on the wealthiest Americans. Americans making more than \$250,000 per year will face a sizable tax increase, particularly on their unearned income. How one feels about that depends upon their redistributive preferences. For a left of center guy, it is okay. For a right of center guy, it probably is not. Basically that is a little more controversial and a little more interesting to think about and see where it goes.

When you put all this together, the ACA is actually deficit reducing and growing more so over time. So that solved the first problem, the budget problem, but there was a second problem, which is even harder. Another dirty secret is that Americans don't actually care about the uninsured. If you poll people asking how much do you care about the uninsured, it is about eighteenth on their list. At the federal level we could not pass a law like the Massachusetts reform that was just about coverage. The ACA also had to tackle cost control or it would not have passed. The problem is it's really hard to tackle cost control and to see why, think about another image. In order to control health care costs in America, think of us having to climb up two hills. The first hill is scientific and do not let anyone tell you otherwise. We do not know how to control health care costs in America. We don't know. We could, for example, just say simply that society will not spend any more, but then people would die.

Two other facts help to highlight the issue. One, from 1950 until today, the United States has quadrupled what is spent on health care. It has been worth it. Health care was terrible in 1950. If you had a heart attack, you were four times likely to die in the year after. An infant was four times more likely to die in the first year of life. If you hurt your knee skiing, you were in the hospital for a week. You were on crutches for six weeks and could have had arthritis for the rest of your life. Now, you hurt your knee skiing or hurt your knee running or so on, you go in, you get scoped. You are back in business a week later. Health care is much better today, and it's been worth it. If you look at the improvement in our lives from improved health care, it's been worth it.

Second, the nation wastes a huge amount of what is spent on health care, by some estimates up to one-third. How are these two facts consistent? How can health care spending be worth it and one-third of what is spent is wasted? The answer is the other two-thirds are awesome. That the other two-thirds have been so good and so productive, has carried along this one-third that is wasted. The problem is that it is easy to look back

and say what the wasted one-third was. This would include Viagra and back surgery. It is hard to look forward and say what the waste will be in future. If health care reformers in 1950 had said, we are wasting one-third of what we're spending, so we are going to cap spending as a percentage of GDP, it would have been a terrible decision. Millions of Americans would have suffered. Millions of important medical improvements would not have happened. So policy makers need to figure out a way that is not a blunt cap. Instead it must be a smarter way to deal with that wasted one-third without limiting the two-thirds that has done so much to improve our lives.

Now you are getting up the scientific hill. You are learning. You are climbing. The science is advancing every day, and there are excellent health economists who are working on the implications of that. But, even once you get to the top of that hill, which you will, you will be panting, you will be out of breath. When you look up, you will see that there is a bigger hill in front of you, and this is the hill that you have to recognize and be realistic about, which is politics. The politics of cost control is unbelievably ugly. For example, you probably know the story of death panels. Republican Congressmen suggested that Medicare reimburse doctors for discussing with seniors their end-of-life options. This seems pretty sensible; it is an important issue for seniors. This was an early draft of the ACA. Some politicians got a hold of this. They started calling it death panels, they started saying the government is going to kill you, and then the drafters of the law had to pull it out. But, that's actually not the best example. The best example is actually mammograms. Recall that in November 2009, in the heat of the debate over the ACA, the Preventive Services Task Force, which is a nonpartisan board of expert physicians, came out with a recommendation that women in their 40's no longer get regular mammograms. They said that if you look at the cost of all the false-positives mammograms find compared with the benefits of early detection, which are shrinking because doctors are so good at treating breast cancers now, it's just not worth it. Women should not get them in their 40's anymore, and that was fine. I came home at the end of that day. My wife, who as a breast cancer survivor is attune to these things, said to me, "Jon, this could be a huge problem for you. People are going to be really upset about this. It's going to affect the law." I'm like, whatever. Don't worry about it. I went to bed. The next morning, of course, the evidence showed that she was right. She always is. The headlines read, "The Government Is Going to Take Away Your Mammograms." Now, this was not a government board. This was a group of private doctors making a recommendation that other doctors could or could not follow, but nonetheless, if you read the ACA, and I recommend you do not, but if you do read it you actually will see that "preventive services" are those services recommended by the Preventive Services Task Force before November, 2009. Congressmen were so afraid of the political backlash that they would not even allow these board of experts to be listened to in defining preventive services. That is not President Obama's fault. That's not Ted Cruz's fault. That's not any one politician's fault. That is the fault of the overall political system where it's so

easy to criticize when you want to make important decisions, but which might have consequences that are negative for some people. Nothing is more frustrating than when people say that Obamacare is a terrible option to control health care costs.

We do not know how and we could not do so if we did know. In my graphic novel, I have an image of a baby crawling. When you want a baby to walk, what do you do? You don't pen the baby up and then say walk. It does not work. You allow them crawl and then they learn to walk. That is what the ACA does in health care cost control. The law crawls. It takes little steps in many directions, hoping that we can move forward and hoping that some day we'll have a political environment where politicians are willing to take the bold steps you needed to more fundamentally control costs.

The ACA's New Directions in Cost Control: The Future

The ACA moves forward in five different ways to control health care costs. The first, especially important to any economist, is the so-called Cadillac tax. In the United States today, the tax system dictates that if your employer pays you in wages, you are taxed. If your employer pays you in health insurance, you are not. Economists call this the tax subsidy to employer-sponsored health insurance. For example, if MIT, my employer, comes to me and asks would you like \$1000 as a bonus, or would you like \$1000 in orthodontia benefits for your daughter, I would have to consider that with a \$1000 raise, I would take home only say 600 bucks, but with the \$1000 in orthodontia benefits, I get \$1000 in orthodontia benefits and my daughter gets these cool braces that spin and change colors. Most important, I come out \$400 ahead—my tax saving.

This tax break has three fundamental problems that make it one of the worst pieces of public policy in our nation. Problem one, it's incredibly expensive. If we taxed health insurance like we tax wages, as any economist would say that we should, we would raise \$250 billion per year more in taxes. That is twice what it would cost us to cover every uninsured American today, twice. Second, it is unfair because the richer you are, the bigger tax break you get because the tax break is proportional to how high your tax rate is. The richer you are, the higher tax rate you'll have, and the greater will be the tax savings from employer-provided health insurance. So it is unfair, it's what economists call a regressive tax break, and most importantly for this debate, it's inefficient.

As my daughter's braces example points out, it induces people to get extra health insurance and therefore to spend extra on health care. Economists for over 40 years have said that this subsidy this is a major driver of health care costs in our country. People are buying health insurance with 60-cent dollars, so that they are buying especially generous health insurance. When economists explain this, someone inevitably will raise their hand and say, you mean you want to tax our health insurance? And the economists will

answer, no you don't understand. There is an existing tax wedge between your health insurance and your wages, and I want to end that tax wedge, and the listener will say, you mean you want to tax our health insurance.

It is just impossible to get through this, so the ACA advisers early on settled on a compromise approach. If your health insurance is above a certain level, we'll tax the part above that level, so above that level, if it's above some high level, then the part above that level gets included in your wages, and you will not get a tax break on that anymore. Economists thought that was pretty good. We were very excited about it. It was a really great moment for economists. It was going to be used in an early draft to the bill, and the politicians got wind of it, and killed it. Economists, especially those advising on the ACA, were very upset, and thought that was the end of it until another Massachusetts hero, John Kerry, or more likely his staff, came up with a very clever alternative. They called it the Cadillac tax. They said instead of saying that on health insurance that costs more than a specified level, you lose your tax break--you lose your 40 percent tax break--what if we instead said that the insurance company selling health insurance for more than that specific level, will have to pay a 40% tax rate on the excess? You do not need a Ph.D. in economics to see that's the same thing because either way you raise the cost of insurance above the specified level by 40%. You do it by taxing the person or you can do it by taxing the firm, but either way, it's a 40% increase designed to offset the tax break. So the Cadillac tax was sort of a back door way of getting to the same goal, which is pretty neat, pretty clever, and politically palatable, so it passed. It got delayed until 2018, but starting 2018, the ACA will put in place this new system which will offset the existing tax break. It will undoubtedly increase the efficiency of our tax and health care insurance systems, reduce the use of expensive health insurance, and ultimately lower health care spending, so it is very exciting. That's point one.

The second of the five new directions is the introduction of the exchanges. These exchanges will succeed; they have succeeded in Massachusetts. Never before in U.S. history has the Congress passed a law this broad and this important and actually been able to run the experiment first. The nation literally ran the experiment in Massachusetts. There were five years to see how it played out, and the exchange was incredibly successful. If you wish to see it, go on MAhealthconnector.org to see what a well-functioning exchange looks like. It's a terrific shopping experience, and importantly, it brings a competitive marketplace to a market that did not have one before and, therefore based on basic principles of economics, there will be more competition, more shopping, and lower insurance prices, though not everywhere. Several states, including Indiana, do not have very robust participation in the exchange. Eventually it will and other states will as well, and that is going to lower prices. That is the second feature.

The third feature is the IPAB, the Independent Payment Advisory Board. Medicare today has a broken payment model. Medicare is what is called a fee-for-service model, which

means basically whatever the doctor does to you, they get paid for it. Oscar Wilde referred to this arrangement as like saying the butcher gets to tell you how much red meat to eat. Basically the doctor just does as much as he wants and just gets paid even more and more and more. It's not a way to run health care. Health care should be run more along the model where doctors are reimbursed based on the value they deliver. The problem is getting from here to there is very hard politically because some doctors are going to lose. Uwe Reinhardt, a famous health care economist, has what he calls Reinhardt's Law, which is that health care costs equals health care income. If the United States is going to move from the system where doctors are paid no matter what they do to a system in which doctors are paid based on what a good job they do, there will be some doctors who do a bad job, but do a lot of stuff, who are going to be upset, and they are going to fight it, and they are going to be politically loud. Politically, this is why we have not been able to get there until now. The IPAB will be an apolitical body of appointed experts who will recommend a way of getting there that is subject to an up or down vote by Congress. It is like a base closing commission. It will basically come in and recommend a new higher value-added arrangement. This recommendation will get an up or down vote by Congress. If Congress votes it down, it will not happen. If Congress votes it up, it does. So the IPAB is not unelected bureaucrats running your health care. It is unelected bureaucrats recommending an alternative reimbursement, which we know we need, and that the Congress can then vote on.

The fourth new direction to cutting cost is comparative effectiveness. It is amazing that health care specialists actually have no idea what works. One might argue that this is not right. For example, there is the Food and Drug Administration (FDA). They approve and disapprove things, but they have no idea what works cost effectively. The FDA's job is to decide if a drug works or not. It's not to decide whether a drug is a good idea to have on the market. Does it actually work better than some other drug that costs one-tenth as much? People use health care all the time without this knowledge. We need to do research to understand what works better and at what comparative price. The ACA puts \$3 billion per year into this through the Patient Centered Outcomes Research Institute (PCORI), which is going to do this research. Now, once again, however, politics rears its ugly head because if you read the law, it says paraphrasing a bit, PCORI shall be set up and the research shall not be used. The ACA says that government insurance decisions are not allowed to be based on what PCORI finds because we're afraid that PCORI might tell us to do something differently. This is once again why cost control is super hard. The best hope is that PCORI does enough of this research and the results we ignore become blatant enough that politicians allow this research to be used, but right now it cannot.

Finally, the last thing, and the sort of vaguest, but potentially most important feature is the dozens and dozens of pilots and experiments of different ways of organizing and

reimbursing health care. One example is the Accountable Care Organization (ACO). An ACO is an ACA creation, which is trying to merge doctors and a hospital into one coordinated unit of care. There are now about 400 of these starting up around the country. It is an exciting development. Will they work and save money? No one knows for sure. The biggest problem with this health care debate is there is too much pretended certainty. We just do not know if we are going to save money. We do not know what is going to save money. So what should be done you in this situation? Try them. Experimenting with lots of different approaches, for example, changing the way hospitals who readmit a lot of patients are paid, or setting up ACO's, will show what works or does not. But not to try them is to step backwards. To end this law and say, well, we don't know what's going to work, so we're not going to do anything is to step backwards. We have to move forward. We have a long-term health care cost crisis. Now, we don't have to solve it tomorrow. We don't have to solve it next year. We don't have to solve it in five years, but we do have to solve it over the next 25 years. We cannot let this crisis continue for 25 years or more until health care spending is 30 to 35 percent of GDP. That's not acceptable.

So, we have got to continue to move the goals and accomplishments of the ACA forward, but in doing so, we have to do two things. We have to be humble and recognize that we do not know what to do yet, and we have to be patient and recognize we are not going to solve the affordability and access problems overnight. When we think of politicians, these two words, humble and patient, do not come to mind. It is the job of the expert community to remember and remind us that the fact that we did not solve the problem tomorrow doesn't mean it's not worth continuing to fight on.

Short-Term Implementation Issues

Let me conclude with what happens in the near future. The ACA had to overcome several hurdles. It had to overcome getting passed, had to overcome the Supreme Court, had to overcome the 2012 elections, and now it's got it's fourth and perhaps the most fundamental hurdle, implementation. There is an enormous amount of power within the states, and some of that power originated in the Supreme Court decision to deny the Federal mandate for Medicaid expansion. The fact that many states, given the choice, are not expanding Medicaid can only be described as preposterously stupid, it is the only word to describe that. The ACA says that if the State of Indiana, for example, wants to expand Medicaid to 400,000 uninsured Hoosiers, the 400,000 Hoosiers who are below the poverty line and uninsured, the federal government will pay the entire cost of doing so for the first three years and 90% of the cost of doing so thereafter. That means that the federal government is offering to ship Indiana billions of dollars in free money to provide health care for the lowest income citizens. Literally, there is not one person in Indiana

who is made worst off by this, not one. The uninsured get coverage. The state gets massive stimulus, which will boom the state economy. Now, it will cost tax dollars, but they are national tax dollars. Indiana is not more than 2 percent, maybe 2.5 percent of the nation's taxpayers. So the federal government would send a large amount of money to the state, boosting the economy here and along the way saving thousands of lives and helping hundreds of thousands of low-income people.

The situation in Indiana is much better than in most other states that are not expanding Medicaid because the Indiana Governor is willing to engage with the federal government, talking about an alternative way of structuring this, and that's cool. That's great. I think it's good they're doing that. I'm more upset at the states who are just point blank saying no, we won't do this. You know, to be honest, perhaps the reason I'm most upset is because it just makes no sense. It just doesn't make sense from any model that we could write down as scientists about the behavior of politicians. This makes no sense, so it is very frustrating, and I hope eventually will go away and eventually Medicaid will expand in all of the states.

The second issue is the problematic start of the exchanges. Now, states have the right to set up their own exchange or rely on a federal backup exchange. The states that have set up their own exchange are doing pretty well with initial registration and sign up for individual insurance. There have been some rocky starts, but by and large, the sign up is going well. The federal exchange isn't going so well. Now, we do not have to panic. There was an excellent Op-Ed in the *Boston Globe* on October 17, 2013 by my colleague, John McDonough, who noted that when we evaluate stocks, we will look every minute at how stocks are doing.³ The evaluation of the implementation of the individual exchange is not like that. Since Massachusetts passed their reform law, the state has reported every month on how it was doing. This is something which should be evaluated at that frequency, and it's going to go slowly. I mean, in Massachusetts, once again, we had something where we signed up about...all the ultimate set of people who signed up, about 5% signed up the first month and about 25% signed up the first three months. It took awhile to ramp up. The ACA is more complicated. It is going to take longer. Resolving the sign-up problem is going to take well into 2014, but we have to ask ourselves how do we evaluate success? Success does not mean it works for every single individual. Success means we will be better off than we are today, and my guess is that by the beginning of 2014, most people who want to get in these exchanges will be able to. Not everyone. There are still going to be glitches and in particular, lower income people looking for subsidies will encounter more glitches. That is going to be a problem, but it's going to be a solvable problem, and it's going to get solved throughout the course of 2014. In fact, I didn't realize until recently, that if you look at the public polling on Medicare Part D at about the same point in its roll-out, it was worse than the approval of

³³ John McDonough, "ACA's Reinsurance Program in the hot seat," *Boston Globe*, October 17, 2013.

the individual exchange roll out. After almost three weeks, the public polling on the Affordable Care Act had about 40 percent support. Public polling on Medicare Part D when it began to roll out showed 31% public support, lower than the ACA. Public support of Medicare Part D today is 90 percent. It just takes awhile for these things to get implemented. There's going to be some rocky spots, but it's going to happen. We just have to be a little patient.