What will “Obamacare” (a.k.a. PPACA or ACA) mean?
What will and won’t change?

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Objective:

• Provide broad overview of US system for financing health care.
  - How much do we spend on health care?
  - Why do we need health insurance?
  - Sources and uses of funds.

• Describe key provisions of Obamacare.
  - Discuss impact, focus on expansion.

Caveat: Non-technical presentation for a general audience. Should not be viewed as personal financial or health/medical advice.
Health spending in broad terms:

• About $9,000 per person per year for an annual total of over $2,800,000,000,000.
• Approximately 18% or one sixth of US income.
• Historical comparisons:
  <5% of income in 1955;
  >13% of income in 1993.
• International comparisons:
  OECD average <10% of income;
  Approximately 12% of income for next highest spenders (e.g., CA, FR, SW).
How is the money spent?

(percentages based on National Health Projections)

- Hospital: 32%
- Physician: 19%
- Dentistry: 4%
- Nursing Home: 5%
- Home Health: 3%
- Drugs: 10%
- Public Health: 3%
- Products: 3%
- Construction: 4%
- Administrative costs: 7%
- Research: 2%
- Other: 8%
- Public Health: 3%
- Research: 2%
- Administrative costs: 7%
Sources of funding (and a bit of background):

- Employer Ins.: 31%
- Medicare: 20%
- Medicaid: 16%
- VA & DOD: 3%
- Other govt: 11%
- Self-pay: 12%
- Other: 7%
- Medicare: 20%
- Other govt: 11%
Why don’t we just pay out-of-pocket for health care?

• Big difference between average costs vs. realized costs for individuals
  -skewed cost distribution:
  Majority of people have minimal health expenditures in a given year (< $600).
  **But**—Expenditures for the 1% most expensive patients average approximately $200,000.
  Expenditures for the 10% most expensive patients average over $50,000.
Health Insurance is a mechanism for pooling funds.

• Much of a modern health care system can’t function effectively without pooling—many life-saving treatments would be unaffordable to all but a tiny minority (and would probably not be developed for the tiny minority).

• Pooling provides access and protection from the potentially catastrophic consequences of serious illness.
Pooling (continued)...

- Risk pools face pressures that can cause them to split:
  -- low-cost individuals have an incentive to leave.
  -- insurers have incentives to exclude high-cost patients.

=> The most expensive patients are currently either heavily subsidized or excluded from insurance. Obamacare extends pool.
Health Insurance in the US:

- Employment (incl. dependents) — 55%
- Other Private — 7%
- Medicare — 13%
- Medicaid — 16%
- DOD — 3%

=> More than 80% have insurance: major reason why reform to provide coverage to the uninsured has been so contentious.
Main provisions of Obamacare: PPACA or ACA (2010)

• Young adult coverage under parents’ plan (implemented).
• Medical loss ratios (implemented).
• Preventive care and wellness visit added to Medicare (implemented)
• Close Medicare part D “donut hole” $2,700-$6,175 in 2009 (gradual phase-in by 2020).
Main provisions (continued)

- Insurance expansion implemented through state “exchanges”. Feds step in for states that do not create exchanges. Nondiscrimination (3x by age; 1.5x tobac.; location; fam. size)
- Individual mandate.
- Comprehensive benefits.
- Income-based limits on deductibles; OOP max.
- Income-based subsidies for premium payments.
Main provisions (continued):

• Medicaid Expansion (SC decision made state participation optional; 26 states not participating).

• Employer mandate; small business tax credit.

• “Cadillac tax”: 40% tax on cost over $10,200 for individual and $27,500 for family coverage. (beginning 2018, indexed to inflation, not to inflation in health services).
Insurance exchanges:

• Applies to individuals and families w/incomes over 138% of FPL.
  --Medicaid expansion was supposed to cover people up to 138% of FPL.

• 16 states and DC running own exchanges. Feds running exchanges for 34 states.
  (more on these in a moment)
Fiscal impact (from CBO sources):

- Gross spending 1% of GDP per year from 2016 (Gross spending about $1.7 trillion to 2023).
- Spending net of penalties, offsets, “Cadillac tax” about $1.2 trillion to 2023.
- Other provisions reduce spending (esp. payments to Medicare providers) by $700 billion to 2023.
- Higher payroll taxes on high earners, fees/taxes on manufacturers/insurers: $600 billion to 2023.
- Net effect: relatively modest deficit reduction.
- CF Medicare-D: 0.33% of GDP, $50 billion in 2008.
Likely effects on coverage (CBO, 05/13):

• 25 million people covered by 2017:
  --coverage increases from 81% to 92%.
  --24 million through exchanges, 12 million through Medicaid/CHIP.
  --6 million fewer people to have employer coverage, 4 million fewer in non-group/oth
Back to insurance exchanges:

- Intended to permit easy comparison between private insurance plans.
- Plans must cover preventive, maternity, etc.
- Subsidies for coverage and OOP based on cost of second cheapest silver plan:
  - $300/yr (2% income); $2,000 OOP at 138% FPL.
  - $4,300/yr (9.5% income); $4,000 OOP at 400% FPL.
  - $6,000 OOP max for all individuals.
Insurance exchanges (continued)...

- Bronze (60% of actuarial costs).
- Silver (70% of actuarial costs).
- Gold (80% of actuarial costs).
- Platinum (90% of actuarial costs).
- Understanding the difference between actuarial costs and individual (realized) costs is very important for individuals and families.
- Premiums in exchanges have been 18% lower than CBO used in fiscal impact calculations => costs to government will be lower.