Health care

Paul Krugman
Health spending is highly concentrated ...
So it has to be largely paid for by insurance
Insurance has two big problems:

1. Adverse selection

2. Moral hazard
Adverse selection: it can be limited, but it’s costly

Also, what happens to people with preexisting conditions?
Average Per Person Monthly Premiums in the Individual Market, 2010
Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)
Moral hazard: flat of the curve medicine

Excess spending on procedures?

![Graph showing health expenditure as % of GDP from 1960 to 2012](image-url)
Types of health care system, from least to most govt role:

1. Unregulated insurance market (e.g., California pre-ACA)

2. Regulated insurers (e.g. New York pre-ACA)

3. Regulated insurers + mandates + subsidies: Germany, ACA

4. Single-payer: Canada, Medicare, Medicaid

5. Public provision of care: UK, VHA

2.5? US system of employer-based coverage under ERISA
Note: PPP = purchasing power parity—an estimate of the exchange rate required to equalize the purchasing power of different currencies, given the price of goods and services in the countries concerned.
Source: OECD Health Data 2010 (Oct. 2010).
Exhibit 7. Drug Prices for 30 Most Commonly Prescribed Drugs, 2006–07
U.S. is set at 1.0

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<tr>
<th>Country</th>
<th>Price</th>
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<td>FR</td>
<td>0.44</td>
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<tr>
<td>NZ</td>
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US health reform: Patient Protection and Affordable Care Act (PPACA or ACA or Obamacare or ObamaRomneyCare)

Two goals:

1. Cover the uninsured

2. “Bend the curve” on health costs
Curve-bending measures:

Independent Payment Advisory Board (“death panels”)

Comparative effectiveness research

Bundling

Accountable care organizations

Excise tax on “gold-plated” employer plans
Second, the Affordable Care Act contains essentially every cost-containment provision policy analysts have considered effective in reducing the rate of medical spending. These provisions include:

- **Payment innovations** such as greater reimbursement for patient-centered primary care; bundled payments for hospital care, physician care, and other medical services provided for a single episode of care; shared savings approaches or capitation payments that reward accountable provider groups that assume responsibility for the continuum of a patient’s care; and pay-for-performance incentives for Medicare providers.

- **An Independent Payment Advisory Board** with authority to make recommendations to reduce cost growth and improve quality within both Medicare and the health system as a whole

- **A new Innovation Center within the Centers for Medicare and Medicaid Services** charged with streamlining the testing of demonstration and pilot projects in Medicare and rapidly expanding successful models across the program

- **Measures to inform patients and payers about the quality of medical care providers**, which provide relatively low-quality, high-cost providers financial incentives to improve their care

- **Increased funding for comparative effectiveness research**
Coverage:

A conservative plan in the non-political sense: “If you like your insurance, you can keep it” (actually not quite true) (why not? See mandate, below)

Also protects role of insurance industry

Three-legged stool:

- Community rating, so preexisting conditions don’t matter
- Mandate, so you don’t have adverse selection spiral
- Subsidies, so people can afford to obey the mandate
How it’s paid for:

Cuts in payment rates

Cuts in Medicare advantage overpayments

New taxes

**Net Investment Income Tax**
A new Net Investment Income Tax went into effect on Jan. 1, 2013. The 3.8 percent Net Investment Income Tax applies to individuals, estates and trusts that have certain investment income above certain threshold amounts. On Nov. 26, 2013, the IRS and the Treasury Department issued final regulations which provide guidance on the general application of the Net Investment Income Tax and the computation of Net Investment Income. In addition, on Nov. 26, 2013, the IRS and the Treasury Department issued proposed regulations on the computation of net investment income as it relates to certain specific types of property. Comments may be submitted electronically, by mail or hand delivered to the IRS. For additional information on the Net Investment Income Tax, see our questions and answers.

**Additional Medicare Tax**
A new Additional Medicare Tax went into effect on Jan. 1, 2013. The 0.9 percent Additional Medicare Tax applies to an individual’s wages, Railroad Retirement Tax Act compensation and self-employment income that exceeds a threshold amount based on the individual’s filing status. The threshold amounts are $250,000 for married taxpayers who file jointly, $125,000 for married taxpayers who file separately and $200,000 for all other taxpayers. An employer is responsible for
Single-payer

Low-income

High-income

Benefits

Taxes
Affordable Care Act (aka Obamacare) Enrollments
Compiled by Charles Gaba w/assistance from Olav Grinde & others
State-by-state breakdown with source dates & links available at:
http://ACASignups.net

Original CBO Enrollment Projection:
7,066,000 Private QHP Enrollments by 3/31/14

Enrollment Period Elapsed: 72.5%
CBO Projection Achieved: 44.9%
Last Updated: 02/10/14

Medicaid/CHIP Expansion:
between 2.40 Million and 7.60 Million to date
depending on which enrollments you include
NEW Enrollments Only
(3 types of enrollees: "Expansion Specific," "Out of the Woodwork" and "Normal Churn")
(Most 1/21 - 2/06 data missing)

Private Exchange QHP Enrollments:
appx. 3.05 Million to date
(Most 1/21 - 2/06 data missing)

Private QHP Enrollments (Exch, Direct & SHOP)
+ Medicaid/CHIP Expansion (Exch + Direct)
+ Sub-26ers on Parents' Plans
= Between 8.85 Million - 14.06 Million to date
depending on which NEW Medicaid enrollments are included

"Sub-26ers"
appr. 3.10 Million as of Dec. 2011
Young adults ages 16-26 on their parents' healthcare plan "specifically" due
to provisions in the Affordable Care Act
(this number was UP from 2.5 Million via similar study as of June 2011)
See http://acasignups.net/files-reports
for direct link to both HHS reports
Table B-1.

Effects on the Deficit of the Insurance Coverage Provisions of the Affordable Care Act

(Billions of dollars, by fiscal year)

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<td><strong>Net Cost of Coverage Provisions</strong></td>
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<td>151</td>
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<td>170</td>
<td>173</td>
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Memorandum:

Changes in Mandatory Spending | 37   | 103  | 156  | 186  | 196  | 207  | 217  | 229  | 241  | 254  | 267  | 2,056         |

Changes in Revenues | -4   | 15   | 29   | 44   | 45   | 55   | 61   | 68   | 75   | 84   | 94   | 570            |
### Table B-2.

**Effects of the Affordable Care Act on Health Insurance Coverage**

*(Millions of nonelderly people, by calendar year)*

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<tr>
<td>Medicaid and CHIP</td>
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<td>34</td>
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<td>34</td>
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<td>28</td>
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<td>Uninsured&lt;sup&gt;c&lt;/sup&gt;</td>
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<td><strong>Total</strong></td>
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**Change in Insurance Coverage Under the ACA**

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<td>Employment-based coverage&lt;sup&gt;d&lt;/sup&gt;</td>
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**Uninsured Under the ACA**

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<tr>
<td>Number of uninsured nonelderly people&lt;sup&gt;c&lt;/sup&gt;</td>
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<td>37</td>
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<td>Insured as a percentage of the nonelderly population</td>
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<tr>
<td>Including all U.S. residents</td>
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<td>Excluding unauthorized immigrants</td>
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