

RHETORIC AND REALITY
The Obamacare
Evaluation Project: Cost

Paul Howard
Senior Fellow, Manhattan Institute

Yevgeniy Feyman
Research Associate, Manhattan Institute

President Barack Obama's first term was defined by the battle over, and the passage of, the Patient Protection and Affordable Care Act, the landmark health-reform legislation known popularly as Obamacare. Along the way, Obama, the law's supporters, and independent analysts such as the Congressional Budget Office (CBO) made specific claims or projections about how the law would affect consumers, patients, and businesses.

Now, three years after Obamacare's passage, many key provisions of the legislation are beginning to be implemented. Whether implementation succeeds or fails will be strongly influenced by the reactions of states, providers, insurers, businesses, and consumers to the law's provisions and to the thousands of pages of new health-care regulations.

Rhetoric and Reality is a project of the Manhattan Institute's Center for Medical Progress designed to offer an ongoing, objective, and accessible perspective on the law's performance in light of key claims or projections made about it. Our project will examine the law's effect on Americans in five overarching areas: health-care costs, insurance coverage, employment, access to care, and consumer-driven health plans. Additional topics may be added.

Each evaluation will be based on the best available data and will be revised as new or more authoritative data become available. Each evaluation will come with a letter "grade" on the law's performance, using the following scale:

A = Very strong likelihood that the reforms will achieve their intended goals

B = Moderate evidence that the reforms will achieve their intended goals but a need for future analysis

C = Weak evidence that reforms will achieve their intended goals or growing evidence of unintended consequences

D = Little or no evidence that the reforms will achieve their intended goals and significant evidence of unintended consequences

F = Undeniable evidence that the reforms will produce effects contrary to their intended goals

I (Incomplete) = Insufficient evidence to support a final judgment on the effects of the reforms

ABOUT THE AUTHORS

PAUL HOWARD is a Manhattan Institute senior fellow and director of the Institute's Center for Medical Progress. He is also the managing editor of *Medical Progress Today*, a web magazine devoted to chronicling the relationship between private sector investment, biomedical innovation, market-friendly public policies, and improved health. Howard writes on a wide variety of health policy issues, including medical malpractice, reform of the Food and Drug Administration, and Medicare initiatives. He is often quoted on health-care issues, and his columns have appeared in national publications, including the *New York Post*, *Dallas Morning News*, *Investor's Business Daily*, and *WashingtonPost.com*. He is also a member of the Manhattan Institute's Project FDA, a committee of physician-scientists, economists, medical ethicists, and policy experts whose purpose is to show how twenty-first century technologies can help improve FDA regulations and accelerate the drug-development and drug-approval process without sacrificing safety. Howard received a Ph.D. in political science from Fordham University in New York City in 2003, and holds a bachelor's degree from the College of the Holy Cross in Worcester, Massachusetts.

YEVGENIY FEYMAN is a Manhattan Institute research associate providing research and analysis on health care and energy policy. He blogs on health care and entitlement reform at *MedicalProgressToday.com*, and has written for *National Review Online*, *The Washington Times*, and *FOXNews.com*. Feyman holds a degree in economics and political science from Hunter College.

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THE OBAMACARE EVALUATION PROJECT: COST

Paul Howard and Yevgeniy Feyman

The Patient Protection and Affordable Care Act (aka Obamacare) was described to the American public not only as a means of expanding coverage but as a way of holding down spending on health care. As President Obama told the *Washington Post* in 2009, “I think it’s important for us to make sure that 46 million people who don’t have health insurance get it. And I think it’s important for us to bend the cost curve, separate and apart from coverage issues, just because the system we have right now is unsustainable and hugely inefficient and uncompetitive.”¹

As of this writing, important parts of the law have not gone into effect (in particular, the coverage provision). The administration has nonetheless remained adamant (based on CBO estimates dating back to 2009) that the law will create substantial savings in the health-care system. Examining some preliminary data that include projections by independent, nonpartisan experts allows us to test the president’s claims that Obamacare will lower U.S. health-care costs. Based on analysis of the available data, we project that Obamacare will increase U.S. health-care spending and will not lower health-care costs.

HEALTH-CARE PREMIUMS

Monthly health-insurance premiums are calculated based on actuarial predictions of an individual's risk of requiring medical care. For instance, all other things being equal, premiums—the amounts charged for insurance coverage—will be higher for the elderly than for the young, as the elderly tend to have more health problems than do the young. Premiums are effectively the canary in the health-care coal mine because they take into account not just the actual cost of care but also state and federal taxes, politically mandated coverage requirements, and how many sick or healthy people purchase insurance. As these underlying costs change, insurance premiums change with them.

The American health-care system is dominated by so-called third-party payers (i.e., an organization other than the patient or a health-care provider that actually pays for health-care services when they are rendered). Usually, the third party is an insurance company or the government. As a result, individuals often conflate the cost of their insurance premiums with the cost of their health care—that is, as a person's premiums rise, so will his perception that his health

care is becoming more expensive and vice versa (regardless of whether that is true). Because of this, we focus first on premiums paid *directly* by households, not on premiums paid by either an employer or by the government.

As it turns out, since the passage of Obamacare, household premiums have increased by a full 11.3 percent. Moreover, this increase even outpaced the rate of the medical services consumer price index (CPI), which netted a mere 6.8 percent increase over the three years that we measure.³ The CPI is the commonly used measure of inflation; the medical services CPI measures the growth in prices of medical services.

Independent analysis also suggests that this trend will not slow down anytime soon. In 2012, the CBO and Joint Committee on Taxation estimated that by 2016, employer-based family coverage will cost \$20,000, with varying amounts of minimum required contribution based on family size and income.⁴ This will be an increase of \$4,255 from 2012's total family premium of roughly \$15,745—a 27 percent jump.⁵

Looking further down the road, per-enrollee household private health-insurance premiums are projected

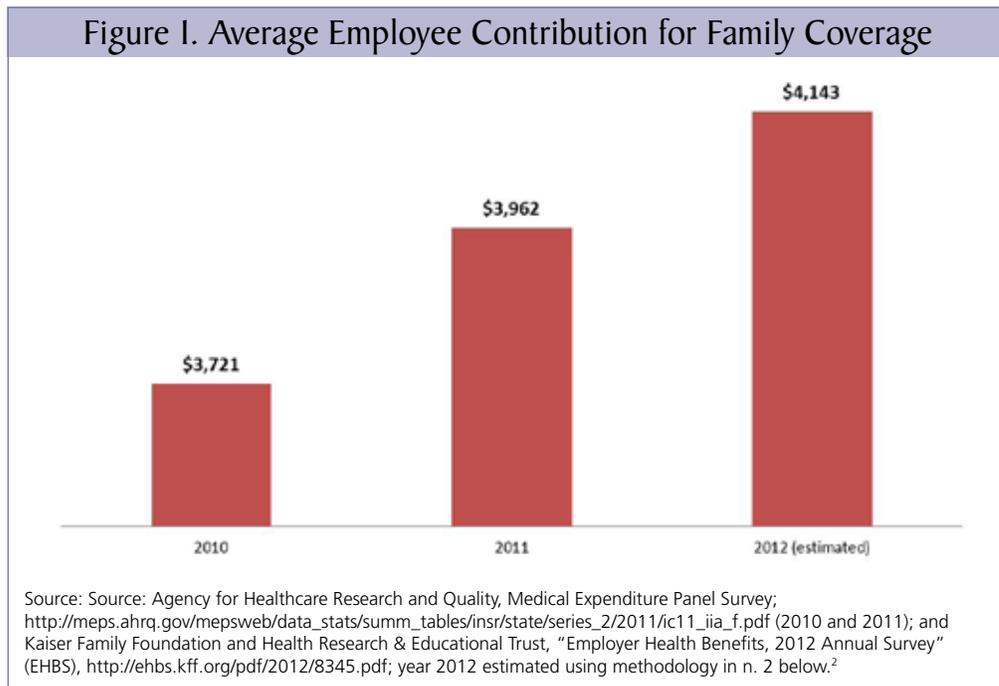
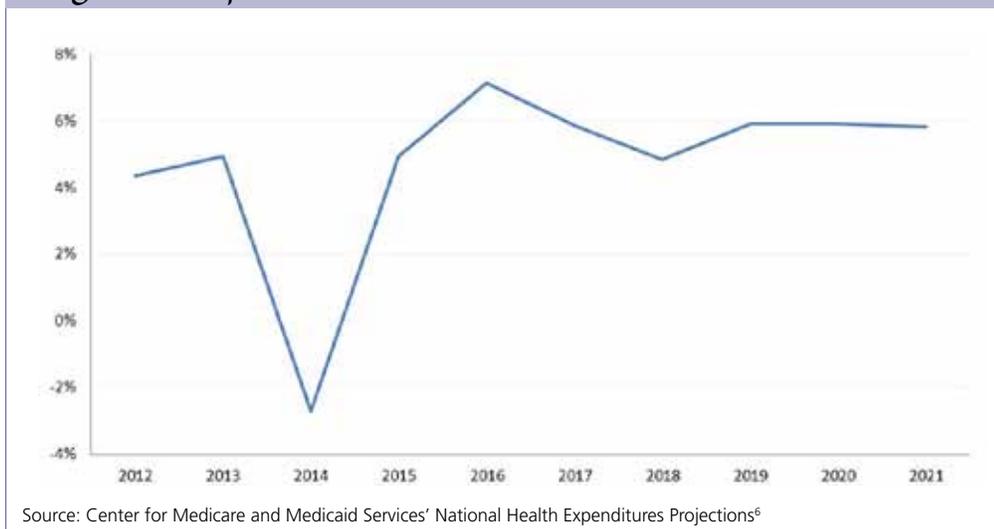


Figure 2. Projected Increase in Private Health-Insurance Premiums



to rise steadily through the rest of Obamacare's implementation (2013–21), with the exception of a brief dip in 2014. (The dip is related to a one-time shift in costs from individuals to the government because people purchasing insurance on insurance exchanges will, on average, pay less of the cost because of federal premium subsidies. This drags down the average premium increase for households, but the costs will be borne by the federal government, i.e., taxpayers.)

A recent survey of insurance companies by the American Action Forum, a think tank, found that key Obamacare reforms will likely cause significant premium increases, particularly for young and healthy policyholders, and that much of these increases will be unrelated to the expansion of benefits under the law. Other elements in the law, including smaller rating bands (limits to how much more insurance companies can charge older enrollees than younger ones) and prohibitions on gender and health-status rating (sicker enrollees also cannot be charged more) contribute significantly to future projected premium increases.⁷ The projected increase in private health-insurance premiums is likely even to outstrip increases in medical inflation over ten years, further indicating that Obamacare is driving up insurance premiums beyond the price of individual health-care services. For instance, because Obamacare requires a richer benefit package in the individual and small-group markets

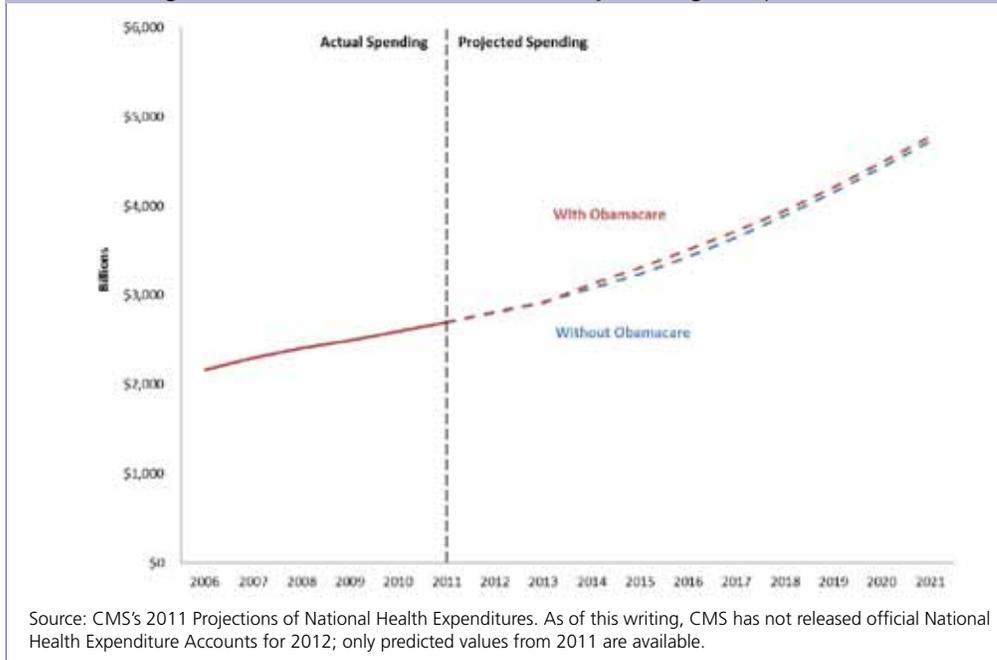
and adds new taxes on drugs, insurance companies, and medical devices, along with new subsidies for buying health insurance, Obamacare will, on average, place upward pressures on premium prices.⁸

HEALTH-CARE SPENDING

It is often remarked that health-care spending in the United States is out of line with countries that have similar, advanced economies. This, coupled with reports of hundreds of billions of dollars in estimated annual waste, means that careful attention should be given to reforming the U.S.'s level of health-care spending and "bending the curve" of its growth rate.

Today, Americans spend well over \$2 trillion—close to 18 percent of GDP—on health care, and U.S. health-care costs have grown much faster than either income or GDP growth over the last several decades. However, despite the best intentions of its supporters, Obamacare will not make much of a dent in these trends. The Centers for Medicare and Medicaid Services (CMS) projects that between 2012 and 2021, America will spend \$36.8 trillion on health care. Absent Obamacare, CMS estimates that spending would be \$36.3 trillion—a difference of just \$500 billion over ten years. In other words, without Obamacare, Americans would spend *less* on health care.

Figure 3. National Health-Care-Spending Projections



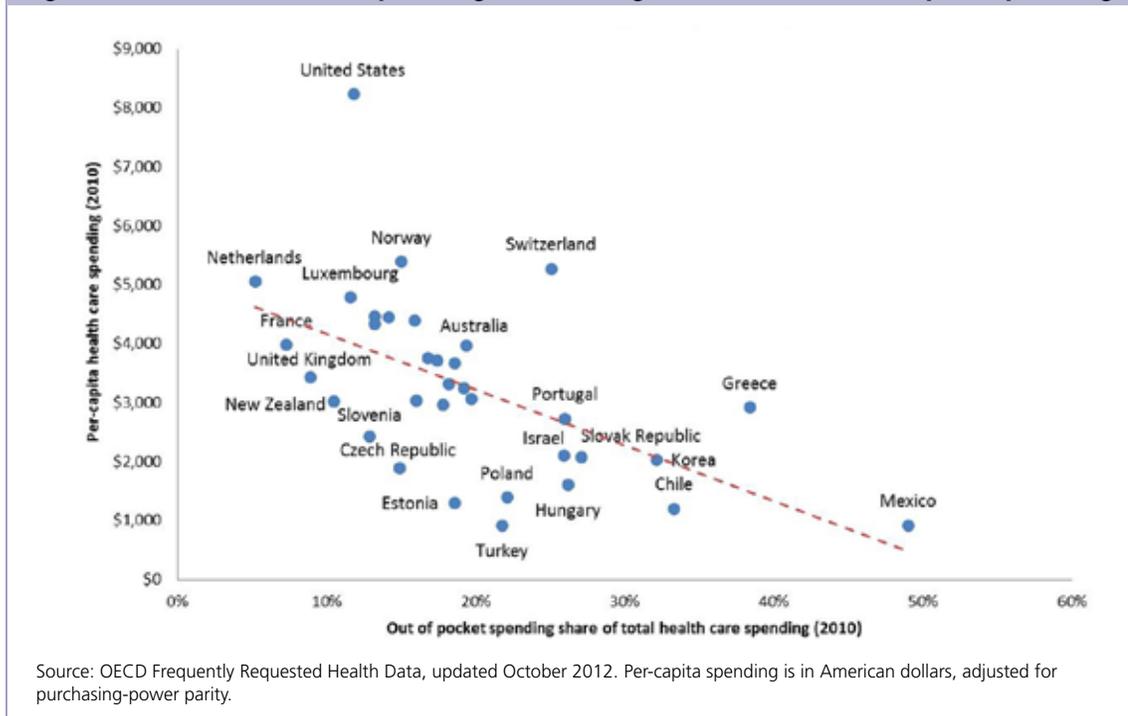
Obamacare does little to actually stem spending growth, aside from some relatively small pilot projects on reimbursement reform that have had disappointing results thus far, either producing some savings but also some cost increases, or increasing outright health-care spending. For instance, the implementation of electronic health records has, thus far, not only failed to decrease health-care spending but seems to have increased it by making it easier for providers to bill for additional services.

In fact, the largest components of estimated deficit savings in CBO projections related to Obamacare come from revenue *increases* rather than actual decreases in U.S. health-care spending. As noted earlier, the law shifts health-care costs from individuals to government, with the overarching goal of reducing the share of health-care spending borne by low- and middle-income uninsured consumers. The problem is that evidence strongly suggests that when out-of-pocket spending is lower, health-care spending actually rises.⁹ In fact, American consumers spend less on out-of-pocket costs than most of their advanced Organisation for Economic Co-operation and Development (OECD) competitors.

If we examine per-capita health-care spending across a number of OECD countries, we see a significant correlation between out-of-pocket spending as a share of total health-care spending and the level of per-capita health-care spending. This explains about 30 percent of cross-country variation in 2010, suggesting that in order to “bend the cost curve” of health-care spending, more out-of-pocket spending may be needed in the form of deductibles, co-pays, and cost-sharing for routine expenses. In other words, consumers must become more cost-conscious.

Critics may rightfully point out that Figure 4 is incomplete: if we compare *actual* out-of-pocket spending per capita (rather than the share of total) with total spending per capita (including the share covered by government and insurance companies), it appears as if more out-of-pocket spending is associated with higher, not lower, health-care costs. The issue with this approach is that the causal direction is not clear—that is, we already know that the U.S. spends more both overall and on a per-capita basis. Therefore, it is likely that an increase in actual per-capita spending will also increase actual out-of-pocket per-capita spending. The reverse is certainly

Figure 4. Out-of-Pocket Spending Is a Strong Predictor of Per-Capita Spending



possible—that increasing per-capita out-of-pocket spending will increase total per-capita spending—but intuitively, it seems unlikely. Many other studies, for instance, have found that increasing out-of-pocket costs reduces the use of health-care goods and services, serving as a check on spending.¹⁰

What we do know—again, from cross-country comparison (and this casts some doubt on the potential criticism earlier)—is that the out-of-pocket spending share of total health-care spending is strongly, and negatively, correlated with health-care spending as a share of GDP, a measure that is, in essence, the burden of health-care spending on the economy.

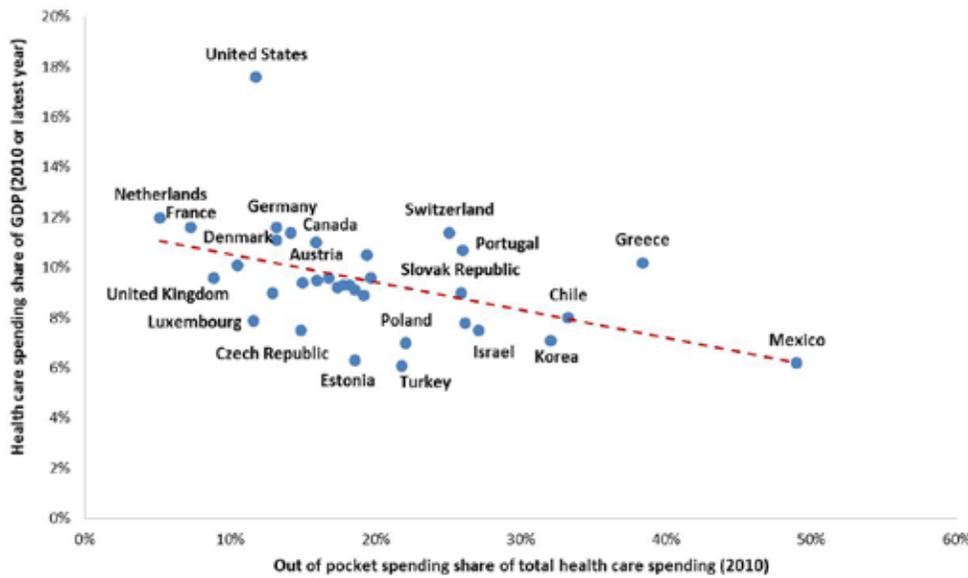
One may, however, criticize this approach on moral grounds by claiming that the poor and indigent should be protected from rising health-care costs. Of course, some means-tested subsidies, such as Obamacare’s premium subsidies, are desirable (and indeed, are used in countries such as Switzerland), but Obamacare provides these subsidies far above the poverty line—for families who make up to 400 percent of the Federal Poverty Level, or about \$94,000

for a family of four in 2014.¹¹ This means that the subsidies will be going to people who may not actually need them because they could easily afford to buy their own coverage.

When consumers are less cost-conscious (in this case, because they pay fewer direct medical costs), producers have greater freedom to raise prices while consumers have an incentive to utilize additional health-care services.

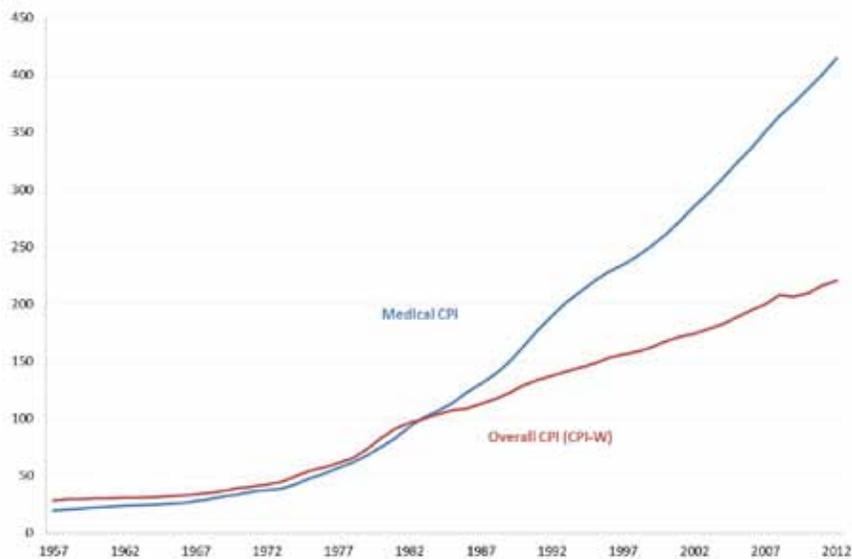
Consequently, increases in the costs of medical services have consistently been greater than cost increases in the rest of the economy. To combat this trend, policymakers should focus on finding ways of making most non-poor consumers more cost-conscious rather than less cost-conscious. By focusing on cutting out-of-pocket spending—which is projected to fall from around 11 percent of total health-care spending today, to 9.3 percent by 2021¹²—Obamacare does little to stem the growth in medical prices and may, in fact, accelerate some price increases by reducing price sensitivity and increasing demand for health services by bringing the newly insured population into the market.

Figure 5. Share of Out-of-Pocket Spending Is a Strong Predictor of Health-Care's Burden on Economy



Source: OECD Frequently Requested Health Data, updated October 2012

Figure 6. Medical CPI vs. Overall CPI



Source: U.S. Department of Labor: Bureau of Labor Statistics/FRED; CPI is indexed to 1982–84.

Obamacare will also push about 12 million Americans into Medicaid. This joint federal-state health-insurance program for the poor is a huge and growing budget concern: it will spend some \$638 billion in federal dol-

lars over 11 years to expand coverage to the 12 million new beneficiaries. By 2023, the federal government will be spending \$572 billion annually on the program; state spending will bring the spending to about \$1

trillion. Because access to care in the program is spotty, it is questionable whether expanding it is worth the massive investment, given the growing share of the budget that the program makes up.¹³

Ultimately, all the existing evidence suggests that Obamacare will not reduce health-care costs, although it will certainly shift the cost burden to the government (which is ultimately the responsibility of taxpayers) as well as other, non-health-related industries. And while we don't address the costs of Medicaid spending in this report, the cost of expanding Medicaid—for state and federal budgets—is another important concern that policymakers should bear in mind.

Obamacare's Grade on Controlling Health-Care Costs: C

Since the mid-1980s, medical inflation has outpaced all other inflation by an ever-increasing margin. While many factors play into this phenomenon, Obamacare fails to address the drivers of excessive and continuous price increases for medical goods and services. By shifting costs to government and taxpayers and by increasing overall U.S. health-care spending, Obamacare will, by its own standards, fail to control health-care costs.

Proponents of the law have pointed to the CBO's February 2013 budget outlook as evidence that the law is already reducing costs, particularly for Medicare. In the updated outlook, the CBO did revise downward its estimated spending for Medicare from 2013 to 2022 by \$137 billion. However, 75 percent of that revision comes from Medicare's prescription drug benefit, Part D.¹⁴ There is no reason to think that the Part D savings stem from Obamacare. For one thing, actual Part D spending has been about 30 percent below CBO's original projections. More important, Obamacare actually expands the Part D benefit (and increases spending relative to what it would be otherwise) by requiring manufacturers

to issue rebates to cover branded drugs through the infamous "doughnut hole."

Obamacare does attempt several payment reforms and initiates a number of pilot programs.¹⁵ For instance, to deal with the disproportionately large share of Medicaid spending by dual-eligibles (those who qualify for both Medicaid and Medicare), CMS has started the Financial Alignment Initiative, which places dual-eligibles into a private managed-care program to improve care coordination and outcomes.

Other attempts at cost control include the implementation of payment reform projects designed to get doctors and hospitals focused on delivering health care more efficiently and improving health outcomes for patients, rather than simply maximizing payments for the services they provide. Specifically, Obamacare seeks to increase outcome-based care in Medicare through the use of Accountable Care Organizations (ACOs). ACOs allow providers who can offer better outcomes at lower costs to "share in the savings" with the federal government. The evidence on ACOs, however, is mixed—a CMS pilot project from 2005 to 2010 failed to consistently show significant savings.¹⁶ ACOs also present antitrust concerns as well; if they encourage greater hospital consolidation, which seems to be the case, then reduced competition may stymie any downward pressures on costs from bundled payments. Because we do not yet know how these programs and other initiatives will ultimately play out, there is a possibility that the ACA's efforts may yet result in modest savings; but at this juncture, that appears unlikely.

As such, we give Obamacare's cost-cutting efforts a grade:

C = *Weak evidence that reforms will achieve their intended goals or growing evidence of unintended consequence*

As these programs and other evidence develop on Obamacare's effect on health-care costs, we will update our findings appropriately.

ENDNOTES

1. *Washington Post*, July 22, 2009.
2. A minor data issue concerns the combined use of MEPS and EHBS data. In recent years, EHBS data have shown higher absolute numbers for employee contributions but slower rates of increase. MEPS data have shown the reverse. We consider MEPS to be a more robust data source and one that is more nationally representative, given the state-by-state breakdowns; thus, where possible, we defer to MEPS data. Year 2012 data were projected for MEPS by using the ten-year average ratio (MEPS/EHBS) to project MEPS data for 2012 based on existing 2012 EHBS data.
3. U.S. Department of Labor: Bureau of Labor Statistics, and author's calculations, based on the urban CPI for medical care.
4. Congressional Budget Office, "CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance," March 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf.
5. Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits, 2012 Annual Survey," <http://ehbs.kff.org/pdf/2012/8345.pdf>. Using Kaiser's numbers gives a smaller potential increase than the results we would have seen using the estimating methodology from n. 2 above.
6. These numbers are not completely comparable with the numbers for average employee contributions, but they still represent an important element of rising health-care costs. They are calculated as household private health-insurance premiums divided by enrollment in employer-sponsored, other private health insurance, and exchanges. These numbers include Medicare supplemental coverage (which is less expensive than full insurance coverage) and thus may understate increases. Additionally, these numbers do not include out-of-pocket spending, such as deductibles. The drop in 2014 likely indicates a shift to premium subsidies for the exchanges.
7. Douglas Holtz-Eakin, "Insurance Premiums in 2014 and the Affordable Care Act: Survey Evidence," American Action Forum, January 2013, http://americanactionforum.org/sites/default/files/AAF_Premiums_and_ACA_Survey.pdf.
8. The ten-year (2003–12) historical difference between overall inflation (CPI) and medical inflation (Medical Care CPI) is 1.4 percentage points. The 2012 Medicare Trustees report assumes an average 2.8 percent CPI increase over ten years. CMS's projection for ten-year per-enrollee private health-insurance premiums is an average increase of 4.7 percent. If the historical difference holds, this means that medical inflation should increase at an annual average of 4.2 percent (over ten years). Thus, private insurance premiums should increase at an average of 0.5 percentage points greater than medical inflation ($4.7 - 4.2 = 0.5$). Note that this assumes that medical inflation will be greater than its ten-year historical average (2003–12) of 3.9 percent. Last, the CBO's latest projections estimate an annual CPI increase significantly less than 2.8 percent. By using a greater number for CPI (from Medicare's Trustees), we may understate the difference between medical inflation and insurance-premium-cost growth.

9. A recent study by the RAND Corporation looked at the impact of high-deductible health plans (HDHPs) on health-care spending. HDHPs increase the out-of-pocket share borne by consumers—the findings indicate that use of HDHPs results in lower health-care spending; see *American Journal of Managed Care* 17, no. 3 (March 2011): 222–30. Previous studies also confirmed that consumers are very price-sensitive when choosing health-insurance plans; see <http://www.nber.org/reporter/summer06/buchmueller.html>.
10. Gary Robbins, Aldona Robbins, and John Goodman, “Inefficiency in the U.S. Health-Care System: What Can We Do?,” April 1994, <http://www.ncpa.org/pdfs/st182.pdf>; and Rand Health Insurance Experiment, http://www.rand.org/pubs/research_briefs/RB9174/index1.html.
11. See <http://aspe.hhs.gov/poverty/13poverty.cfm>.
12. CMS’s National Health Expenditure Projections, Table 16, Household Out-of-Pocket Expenditures, <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf>.
13. Future Medicaid spending is somewhat difficult to gauge; according to CMS, the program’s per-enrollee costs are greater than those of private insurance. However, this includes the elderly and disabled, who utilize health services at a greater rate. Comparing per-enrollee costs for Medicaid with private insurance may indicate that Medicaid is more “efficient”; however, this efficiency comes at the cost of access to care, due to reduced reimbursements to providers.
14. See CBO, “March 2012 Medicare Baseline,” http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf; “February 2013 Medicare Baseline,” http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare2.pdf; and “The Budget and Economic Outlook: Fiscal Years 2013–2023,” <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf>.
15. Some pilot programs, such as the effort to increase efficiency by adopting electronic health records, have not been very successful.
16. Cola et al., “Spending Differences Associated with the Medicare Physician Group Practice Demonstration,” *Journal of the American Medical Association* (September 2012): 1015–23.

DIRECTOR
Paul Howard

FELLOWS
Peter W. Huber
Avik Roy

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