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2013 POLICY RECOMMENDATIONS FOR THE OBAMA ADMINISTRATION

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Implementing the Affordable Care Act: Recommendations for Realizing Legislative Goals

by Vivian Ho, Ph.D.

Overview

Successful implementation of the Affordable Care Act (ACA) is a crucial challenge that the administration of Barack Obama faces in its second term. The administration will be judged by whether the legislation lives up to its name: making health care in the United States affordable to more Americans. To do so, the country must see substantial increases in rates of health insurance coverage in 2014 and 2015, while slowing the rate of growth in health insurance premiums for those with private insurance. To achieve these goals, we recommend that the administration focus on the following tasks:

- **Recommendation 1:** Use any possible policy levers to encourage states to undertake the Medicaid expansion offered in the Affordable Care Act.
- **Recommendation 2:** Structure health insurance exchanges that facilitate active purchasing in those states that have failed to create their own exchanges.
- **Recommendation 3:** Alter Centers for Medicare & Medicaid Services (CMS) coverage decisions so that only cost-effective technologies are covered.

Background

Rapid and persistent growth in publicly financed health care spending is the most serious threat to the long-term financial strength of the U.S. economy. Total Medicare expenditures reached \$549 billion in 2011, and the program's hospital insurance trust fund is projected to be bankrupt in 2024.¹ The Medicare Trustees Board projects that, under current law, program expenditures will increase in future years at a faster pace than either aggregate workers' earnings or the economy overall. Growth in the public sector is mirrored by rapid increases in private health spending, which is making health insurance unaffordable to many Americans. The average health insurance premium for a family of four is now \$15,745 per year.²

The growth in private medical spending is driven in part by the structure of the Medicare program. Medicare is the single largest purchaser of medical care in the United States. The majority of hospitals and physicians are reimbursed by fee-for-service, which creates incentives for health care providers to provide higher quantities of services, regardless of whether these services provide substantial or insignificant improvement to a patient's health. Even though most privately insured patients received care through some type

of managed care organization, most physician and hospital services continue to be reimbursed under a fee-for-service system as well. Therefore, the provider mentality of performing more services in order to earn greater revenues drives up spending in both the public and private sector.

The Affordable Care Act of 2010 was passed in order to increase access to medical care, which has become prohibitively expensive to a significant portion of the population. Substantial subsidies in the legislation increase access to public and private health insurance; individuals are required to obtain coverage beginning in 2014, and businesses with 50 or more full-time workers will pay penalties if they do not offer their workers affordable insurance coverage. However, the Supreme Court decided in June 2012 that the mandate for states to expand Medicaid under the legislation is unconstitutional. In addition, states have been slow to implement state-based health insurance exchanges, which are meant to be the primary source of health insurance for large numbers of currently uninsured individuals. The legislation takes inadequate steps to reduce the rate of growth in health care spending. Even if the ACA succeeds in the short term in improving access to health insurance, its long-term future will be doomed if expenditure growth is not contained. We recommend that the administration focus on expanding both public and private access to health insurance, while taking additional legislative steps to restrain cost growth.

Recommendation 1: Use any possible policy levers to encourage states to undertake the Medicaid expansion offered in the Affordable Care Act.

The Congressional Budget Office estimates that the Supreme Court's decision to allow states to individually choose whether to elect the Medicaid expansion will reduce the number of newly insured individuals under Medicaid and the Children's Health Insurance Program (CHIP) from 13 million to seven million in 2012.³ Some of the individuals who would have newly entered Medicaid are expected to obtain private health insurance through the exchanges instead. However, voluntary participation by states in Medicaid and CHIP is expected to lead to four million fewer individuals gaining health insurance coverage.

The administration should aim to encourage all states to elect the Medicaid expansion. The four million people who are at risk of not gaining Medicaid coverage are low-income individuals. Low income is associated with worse health status, so that both poor children and adults need significant medical care for a range of acute and chronic conditions. Most of these individuals cannot afford to pay out-of-pocket for medical care, so they frequently seek care from hospital emergency rooms, where federal regulations (e.g., the Emergency Medical Treatment and Active Labor Act) require that these patients be examined and receive stabilizing treatment if necessary. This care represents an extraordinary financial burden on hospitals, most of which is financed by local, state, and federal taxpayer dollars. Obtaining Medicaid coverage for these individuals would facilitate their ability to obtain care from medical clinics and outpatient facilities. Doing

so would lead to more coordinated care, which would improve the health of the patient and reduce inefficient expenditures in the health care system.

Previous research by Rice University's Baker Institute for Public Policy has determined that insuring all children in America will yield substantial economic benefits.⁴ Universal coverage for children will increase health care expenditures, but by a relatively small amount. The cost of health insurance for children will be offset by the increased value of additional life years and improved health-related quality of life gained from improved health care. From a societal perspective, it is cost saving to cover the most low-income children with Medicaid as possible through a full Medicaid expansion.

Some state politicians are reluctant to participate in the expansion because they prefer to see less government involvement in the provision of health care and not more. These policymakers fail to understand that a completely free-market system for provision of health care to low-income persons leads to significant economic inefficiency. Inadequate financial support for the purchase of medical services by low-income persons places burdens on the entire health care system, exacerbates problems with adverse selection in health insurance markets, and produces inefficiencies in the labor market due to greater numbers of ill workers.

The administration should be aggressive in explaining to the public the financial benefits of state participation in the Medicaid expansion. In addition to explaining the previous points to the public, the federal government should emphasize the generous terms of the Medicaid expansion to the states. States will receive 100 percent federal funding for the expansion from 2014 through 2016. State contributions will increase after 2016, but the federal government will continue to pay for 90 percent of the expansion from 2020 onward. This federal funding is essential for local hospitals, which will be losing subsidies for disproportionate share payments under the Affordable Care Act. The additional federal dollars will yield substantial economic benefit for local economies through a multiplier effect on local spending. These points have been explained in an op-ed in the *Houston Chronicle* written by the Baker Institute,⁵ but the message requires greater visibility through Internet, television, radio, and print media.

The administration should also encourage the Department of Health and Human Services (HHS) to explore flexible alternatives that allow at least partial uptake of the Medicaid expansion where state leaders are reluctant to participate. For example, some large counties in Texas are exploring the possibility of approaching HHS to negotiate participation in the Medicaid expansion on a county-by-county basis.⁶ The federal government would need to waive the requirement that eligibility standards for Medicaid apply statewide, and the Texas Legislature's approval would also be required. But this approach may be politically feasible, particularly with the strong lobbying power of large hospital systems in the biggest cities in Texas.

Recommendation 2: Structure health insurance exchanges that facilitate active purchasing in those states that have failed to create their own exchanges.

The state-based health insurance exchanges legislated under the Affordable Care Act are designed to increase access to health insurance for individuals who are unable to purchase affordable insurance through their employer and small business purchasers. Establishment of these markets, along with federal provision of premium and cost-sharing subsidies, will foster competition among insurers that will improve quality and lower prices. Both Massachusetts and Utah have implemented health insurance exchanges, although they have different structures. Massachusetts' exchange is referred to as the "active purchaser" model, because it has taken a hands-on approach in determining the nature of the health insurance products that insurers may offer in the exchange. In contrast, Utah's exchange is referred to as the "open market model," where the state provides information that allows consumers to compare competing health insurance policies, but takes a hands-off approach regarding the types of health insurance policies being offered.

Comparisons of the Massachusetts and Utah models, as well as the challenges that states are facing in structuring their health insurance exchanges, have been described by other health policy researchers.^{7,8} Based on these studies, we recommend that the administration adopt the Massachusetts active purchaser model for states that have chosen not to implement their own exchange. The Massachusetts Connector model places greater weight on benefit standardization across health insurance plans, which simplifies the shopping decision for consumers and allows them to make better-informed purchasing decisions. Insurance carriers are only allowed to offer one Gold product, two Silver, and three Bronze products in the Connector, where the colors symbolize the amount of cost-sharing involved in each insurance plan. For example, a Gold benefit is priced so that the expected benefits are actuarially equivalent to 80 percent of full value, while a Bronze product is priced so that expected benefits are only 60 percent of full value.

Another advantage of plan standardization in the active purchaser model is that insurers have less ability to engage in risk selection, where they would attract healthy individuals to purchase their product, while discouraging sicker people from electing their plans. Unlimited variety enables insurers to structure multiple plans specifically targeted to specific portions along the spectrum of health risk, in order to reduce their future expected medical expenses.

One can attribute much of the Massachusetts Connector's success to the aggressive effort the state made to educate residents and small businesses on its availability and operations. The Department of Revenue sent mailings to all taxpayers and small businesses regarding the exchange. Paid advertising was undertaken on radio, television, and print media. Informational postures and brochures were distributed at the Registry of Motor Vehicles, and all new residents are sent mailings on the Connector. The state also spends \$3.5 million annually in grants to community-based organizations to provide application and renewal assistance.

Recommendation 3: Alter CMS coverage decisions so that only cost-effective technologies are covered.

Medicare currently reimburses providers for medical treatments based only on effectiveness, not on value. As stated in congressional testimony in 2007 by Peter Orszag, Congressional Budget Office director, “the Medicare program has not taken costs into account in determining what services are covered and has made only limited use of comparative effectiveness data.” That is, Medicare is paying for some expensive technologies that “work,” but not very well.

An example of a technology covered by Medicare that is costly but of limited value is the left ventricular assist device (LVAD). LVADs are heart pumps for acute heart failure patients who are ineligible for a heart transplant. A recent study calculated that the cost per quality-adjusted life-year gained from using LVADs is £170,616. This figure represents the incremental costs of providing a patient with an LVAD, divided by the gain in life expectancy from the LVAD, adjusted for the fact that this increased life expectancy would not be spent in perfect health. Another U.S. study attempted to factor in future improvements in health technology and assumed that LVADs will be able to achieve a 15 percent reduction in mortality for heart failure patients by the year 2015.⁹ Even with this optimistic assumption, LVADs were predicted to cost \$511,962 (in 1999 dollars) per additional life-year gained. The additional cost of LVAD use to Medicare was predicted to reach \$10.1 billion in 2015.

Health economists tend to view medical technologies that cost \$100,000 per life-year saved or lower as cost-effective, and worth paying for. A recent study based on detailed economic modeling estimated that the value of a life-year peaks at \$350,000 at around age 50.¹⁰ Under either criteria, the price tag for the LVAD indicates that it does not provide sufficient value to the patient, relative to its costs. The additional cost per improvement in health status is just too high, and LVADs should not be covered by Medicare.

A second example of high-cost, low-value health care is treatments for back pain. A 2002 U.S. survey found that 26 percent of adults reported low back pain. Thus, the condition is widespread and accounts for a significant portion of health expenditures. Researchers estimated that the medical costs per patient of treating individuals with spine problems rose from \$4,695 in 1997 to \$6,096 in 2005.¹¹ Yet over this same time period, self-reported mental health, physical functioning, work/school limitations, and social limitations were all worse. In a span of eight years, this increase in expenditures was estimated to represent in \$85.9 billion in added costs to the health care system, but there was no demonstrated improvement in patient outcomes. Policymakers and clinicians must carefully review coverage decisions for back pain treatments, to determine whether any of these treatments are of value to patients.

In other cases, Medicare and private insurers reimburse health care providers for high-cost treatments that are provided to the wrong patient population. For example,

patients with stable coronary artery disease may benefit from an angioplasty to widen narrowed blood vessels. However, clinical guidelines state that patients must undergo a stress test before undergoing elective angioplasty in order to confirm the presence of restricted blood supply. However, a recent study determined that only 44.5 percent of Medicare patients underwent stress tests prior to angioplasty.¹² These figures suggest that a significant portion of angioplasties reimbursed by Medicare were unnecessary and needlessly placed patients at risk of complications from a complex medical procedure. More than 800,000 angioplasties are performed in the United States each year, and Medicare reimburses \$10,000 to \$15,000 per case. Therefore, there are significant savings to be achieved by requiring confirmation of the necessity of an angioplasty through a stress test.

Moving the Medicare system (and, in turn, the U.S. health care system) toward high quality, efficient health care requires the application of cost-effectiveness analysis when making coverage decisions for all costly medical treatments. These treatments may be costly because individual treatments are extremely expensive, or because the treatments are moderately costly and administered to substantial numbers of patients. In either case, policymakers and clinicians must determine whether each medical intervention yields health improvements to the patient that are worth the additional costs. The methodology for conducting such economic evaluations has matured over the last two decades, and we now have sufficient data and expertise for conducting these analyses.

One of the challenges of redirecting Medicare's focus to cost-effective technologies is shielding coverage decisions from the influence of health care providers and health technology manufacturers who are in danger of losing significant sources of revenue based on specific changes in reimbursement policy. For example, the Agency for Healthcare Research and Quality was in danger of elimination in the mid-1990s after issuing practice guidelines for back pain treatment that excluded existing forms of care for which physicians were receiving significant reimbursement. Whether CMS directly conducts cost-effectiveness analysis, or the task is assigned to a separate government agency, funding must not be linked to sources that can be influenced by political lobbying.

In addition, efforts must be made to educate the public on the intent of cost-effectiveness analysis. Patients are accustomed to believing that any treatment recommended by their physician must be highly effective. We must help patients understand that Medicare cannot and should not cover every possible medical treatment offered by the medical establishment. The government can dramatically improve its ability to identify technologies that are worth their additional costs and eliminate waste from the health care system. By reining in health care cost increases, the public will benefit from lower taxes to pay for Medicare, lower private health insurance premiums, and increasing rates of health insurance coverage.

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