The New Health Care Law: What a Difference a Year Makes

When President Obama signed the Patient Protection and Affordable Care Act into law on March 23, 2010, few would have predicted what happened in the following year. Opposition to the law has led to Republican gains in Congress, a House vote to repeal it, and two federal courts striking down part or all of the law as unconstitutional. At a half-day Cato Institute conference, held one year after the House of Representatives passed the law, Kavita Patel, M.D., managing director of delivery-system reform at the Engelberg Center for Health Care Reform at the Brookings Institution; Michael F. Cannon, director of health policy studies at the Cato Institute; Ron Pollack, executive director of Families USA; and Douglas Holtz-Eakin, former director of the Congressional Budget Office, debated how the law has already affected America's health care sector, labor markets, and the federal budget, and what impact it will have in the future.

KAVITA PATEL: My background is in primary care as an internal medicine physician, and that's where we often talk about quality, delivery-system reforms, and some of the actual transformations in the Affordable Care Act. We're seeing some of those changes right now—in medical homes, patient care coordination, transitions in care—by virtue of the fact that one of the things we tried to do in the ACA was show that those are the promising areas for the next decades.

A lot of us working on the health care law knew that there were mechanisms—bureaucratic, statutory, and otherwise—preventing the Centers for Medicare and Medicaid Services from rewarding places doing "innovative" things. Out of that was born the Centers for Medicare and Medicaid Innovation, with $10 billion for projects, research, and evaluation. One of the first things out the gate from that $10 billion—over 10 years—was the promotion of primary care and medical homes at the state level. This is a population for which innovation is desperately needed.

In terms of quality, we've known now for the last seven or eight years that the quality of care in our country has been, at most—on average—"good" about half the time. If you're in Las Vegas, that may be decent odds. If you're dealing with health care, that's unacceptable. So, in an effort to make sure that we understand the gap—but also so that we can do something about it—we really need to understand what works. That means not just putting money into data on websites, but actually investing in effectiveness, in comparing research that looks at treatments and processes of care—as well as establishing guidelines on how our evidence is used by clinicians.

Streamlining and coordinating what the government does was something that all of us thought were broken and dysfunctional. One year later we've already seen agencies coordinating and making their data accessible—agencies that had not spoken to each other before and historically had not necessarily even traded data or had their data accessible to the public.

Looking forward, the key changes are not spelled out in much minutiae in the law, offering an opportunity for not only interpretation, but also for action and decision-making on behalf of health care providers. Those changes impact accountable-care organizations, medical homes, value-based purchasing, a lot of the insurance design benefits that we're hoping that we will see in Medicare, as well as some of the state-based Medicaid contracts. That's exactly where the promise of not only cost containment and bending the cost curve will come from, but also the true promise of delivering the right care, at the right time, in the right place.

MICHAEL CANNON: ObamaCare is no more going to improve the quality of health care than its consumer protections are going to protect patients. Most of the provisions that are supposed to improve the way we deliver health care were not specified in the law. Basically what happened, we created a Center for Medicare and Medicaid Innovation to run pilot programs and experiment with different ways of setting prices and different financial incentives—different terms of exchange—to see if providers will deliver care that is more coordinated.

The problem with these pilot programs—and this approach for reforming health care—is that we have tried it and it has never worked. Medicare has been trying pilot programs for its entire existence, and either those pilot programs fail or, if they succeed in either improving the quality of care or reducing the cost of care, are blocked by the corners of the health care industry whose income streams those innovations threaten: the low-quality providers or high-cost providers who will see Medicare revenues delivered someplace else. Under lobbying pressure, these pilot programs are eliminated. There's an article in the most recent issue in the journal *Health Affairs* that polled physicians in Switzerland and asked them, "What would it take for you to provide more coor-

dinated care than what you're providing right now?"—to join into the sort of accountable-care organizations that are discussed in this law? The Swiss doctors said they would want a 40 percent raise before they took these steps to improve the quality of care. That's the sort of resistance that you're going to see to these pilot programs.

This law will not improve the cost of medical care or health insurance, either. The individual mandate, portions of which began taking effect on September 23, 2010, is already increasing the cost of health insurance for millions of Americans. One insurance company reported those provisions were forcing it to increase premiums on some customers by up to 30 percent.

Another reason for the backlash is that many believe the law is overkill. If you look at the preexisting-condition insurance plans that the law has set up in each state, they've attracted just 12,000 enrollees at last count, or three percent of the 375,000 projected to enroll. Since the primary motivation of the law was to protect people with preexisting conditions, that suggests that it wasn't necessary to conscript 200 million Americans into a compulsory health insurance scheme to solve that problem. The projections that ObamaCare will permanently eliminate 800,000 jobs—not to mention any temporary job losses—is striking fear in those battered by the recession.

Finally, many Americans are taking this law personally. The president promised to put an end to the game playing, but then made backroom deals with the drug lobby and Walmart, while Senate Democrats who drafted this law used tax dollars to buy votes in support for it. Americans watched Kathleen Sebelius repeatedly censor insurers who disagreed with her. They saw their tax dollars buy ads where Andy Griffith used "weasel words"—those aren't my words, those are from FactCheck.org—to mislead seniors about how this law will affect their coverage. They hear the president continue to say things that they know are untrue, that his own advisers in some cases—and nonpartisan observers in others—have discredited: for instance, ObamaCare will allow Americans to keep their coverage, reduce costs, and reduce the deficit. We heard that the individual mandate was a tax. Then the president told us that it was not a tax. Then his Justice Department went into court to argue that, in fact, it is a tax. At a certain point, people start to feel insulted.

Newt Gingrich predicted that this law would be repealed by April 2013. I don't know if anyone can know if that's true, but I'm struck by two things. The first is that if Congress doesn't repeal this law, we'll be back here on the second anniversary of ObamaCare, the fifth anniversary of ObamaCare, the 10th anniversary of ObamaCare—having conferences like this one, in rooms like this one, in Washington, D.C., and elsewhere in the country. We'll be asking why health care spending is still rising out of control, why we still don't have coordinated care, accountable-care organizations, comparative-effectiveness research that helps us to improve the quality of care, and health information technologies; and we'll be questioning why insurers are being rewarded by ObamaCare's price controls for avoiding or mistreating the sick. The second thing that I'm struck by is just how plausible Gingrich's prediction is. It's certainly far more plausible than anyone thought one year ago today.

Kavita Patel

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RON POLLACK: We have already seen significant and helpful changes due to the Affordable Care Act. So far, much of the conversation about the Act has focused on matters that go into effect in 2014. But there are a number of things that have already gone into effect, and they are very significant and helpful. Let me pick out the more salient ones. In no particular order they include:

Young adults—who turn out to be the age most likely to be uninsured—now can continue to stay on their parents' policy until their 26th birthday. I don't know how many young adults have already availed themselves of such coverage, but they can now get coverage through their parents. (There's a moral here: Be good to your parents.)

Second, with respect to seniors, some have already seen the benefit of this legislation in two different respects. One of them is helpful to those who currently fall into the huge prescription drug gap in coverage, the so-called "doughnut hole,"—where, after seniors and people with disabilities in Medicare have spent a certain amount of money, they fall into a no-coverage zone. In today's dollars, once a senior has spent $2,840 in drugs during the year, the gap in coverage begins, and it doesn't end until they've spent $6,484—a gap of $3,644 dollars. With each passing year that gap is supposed to get larger. Last year, people who fell in the doughnut hole received a modest $250 check. This year, anyone falling into the doughnut hole can purchase brand-name drugs with a 50 percent discount. In other words, somebody who falls into the doughnut hole can receive a $1,822 benefit to help them afford their drugs. Seniors also receive the benefit of free preventive care, so that Medicare becomes more of a preventive and primary care system, not just a sickness care system.

A third group aided is small business owners. They can receive a tax credit of up to 35 percent of the costs of covering their

workers if they have fewer than 25 workers. I don't yet know how many have availed themselves of this tax-credit benefit, but there are over 4 million who qualify for it.

Children are another group already helped. They are the first to receive the benefit of insurance-related protections such that they cannot be denied coverage due to a preexisting condition. An insurance company can't deny coverage just because a child has asthma or diabetes. This important protection is extended to adults in 2014.

The Affordable Care Act is also providing reinsurance for early retirees between the ages of 55 and 64, and this enables more and more companies to continue providing coverage for their early retirees.

Already in effect is a prohibition on lifetime limits on insurance benefits. As a result, somebody with a catastrophic illness (such as cancer) or who gets into a bad accident will no longer be bankrupted because he or she has to spend money totally out of pocket once reaching a lifetime cap.

Under the Affordable Care Act, insurance companies can no longer take away your coverage once you get sick if you have paid your premiums all along. In the past, there have been a number of insurance companies that rescinded policies when people got sick. That no longer is lawful, and that is providing new, important protections.

In the longer run, the Affordable Care Act makes huge progress in expanding health coverage for people who are uninsured. It does so by providing direct help to people with incomes below 400 percent of the poverty level (which will help a family of three with approximately $75,000 in income or less). Additionally, the Act expands the safety-net Medicaid program to cover people and families with incomes below 133 percent of the federal poverty level. As a result largely of these two improvements, the Congressional Budget Office tells us about 34 million people who don't have coverage today will receive it. It is possible that even more than 34 million people will gain coverage, depending on how well enrollment and retention systems are established through regulations and state implementation. This coverage expansion is worthy of strong support.

DOUGLAS HOLTZ-EAKIN: One of the things that has been forgotten, in the course of the debate and the enactment, and now the anniversary, is that there was a time several years ago, beginning in 2009, when there was a bipartisan consensus that America needed sensible health care reforms that would control the growth of spending, improve the delivery system, and expand coverage. What actually happened was a highly partisan activity that has given me just one more piece of evidence that all partisan laws end up being bad policy. It is unwise in a democracy to push through large legislation on one party's votes. Those laws are never infused with the best ideas of both sides, and as a result they are not as good, and they immediately become objects for overturning. It doesn't serve our country—which needs a durable and functional health care system—to undertake this kind of activity, and so I expect us to be back again in the future, discussing either the demise of the Affordable Care Act or alternatives that build upon its shaky foundation.

Michael Cannon

> "If Congress doesn't repeal this law, we'll be back here on the 10th anniversary asking why health care spending is still rising out of control."

What are the problems with that foundation? Michael Cannon asked me to talk about the ACA from the perspective of budget, labor market, and economic policy, and there I think it is indeed a dramatically dangerous piece of legislation at the wrong point in our history. I hope it is now well understood that the federal government's budget is on the road to hell. There is no polite way to describe why the world's largest economy has placed itself on a trajectory that looks like a third-world debt crisis. It is for that reason mystifying to me when the very prosperity and freedom that has built our economy is put at a risk by taking a decisive step in the wrong direction, at a time when we already have deep problems.

There is no way you can pretend that the Affordable Care Act will improve the government's fiscal or budgetary condition. It sets up two new entitlement spending programs: insurance subsidies for those in the exchanges, and the so-called "Class Act," a long-term care insurance program—both of which the CBO estimates will grow at an average of eight percent per year annually as far as the eye can see. Tax revenues will not grow at eight percent a year annually as far as the eye can see; the economy will not grow at a rate eight percent a year annually as far as the eye can see; there will be no way either of those things will be able to keep up with those spending demands, and the budget will deteriorate, not improve. You can paper that over with a variety of budgetary gimmicks, as has been done with this legislation. You can count on savings that will never appear in the Medicare program, because we haven't reformed the Medicare program. Its business law remains the same, its costs will be the same, its providers will need the same money, or we just won't cover the beneficiaries. And I think when Congress is faced with that choice, it will cover the beneficiaries. You can't just simply pretend that the Class Act will collect money inside the budget window and not pay out benefits past the budget window. You cannot leave out the annual appropriations that are necessary to set up and run the program. You cannot do all the things that they did, and somehow trick people into believing this is a good step from a budgetary

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ority any time soon." And with India worried about the threat of its nuclear neighbors, China and Pakistan, "any commitments India is likely to make on nuclear force reductions will be linked to both of these states doing the same." Before the United States places disarmament at the center of its nuclear diplomacy, it needs to also be aware of the move's opportunity costs, for there is "the risk that the United States will offer much with respect to nuclear disarmament and get little in return."

Fannie and Freddie's Subprime Disaster

"By most accounts, the subprime mortgage market played a key role in the recent financial crisis. Yet there remains considerable debate over what drove that market," writes Mark Calabria, director of financial regulation studies at the Cato Institute, in **"Fannie, Freddie, and the Subprime Mortgage Market"** (Briefing Paper no. 120). But after carefully examining and presenting the evidence, he finds a clear culprit: "Fannie Mae and Freddie Mac were not only the largest players in the subprime mortgage market, they were drivers of that market." Nearly one-third of Fannie and Freddie's direct purchases were subprime, while during the height of the housing bubble, almost 40 percent of newly issued private-label subprime securities were purchased by Fannie Mae and Freddie Mac. Calabria argues that the failure of Fannie and Freddie and their precipitation of the housing crisis offer a strong rebuke to government attempts to engineer the housing market. "Ultimately taxpayers and the broader economy will only be protected from future bailouts by a full withdrawal of the federal government from housing policy," he writes. Calabria concludes, "Our financial system would become considerably more stable were Washington to abandon its attempts to direct capital to politically favored segments of the economy." ■

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ticularly in poor developing countries with questionable human-rights records.

An optional protocol on the right to property would also counterbalance the recently adopted optional protocol to the ICESCR, which allows individuals to complain that their ESC rights have been violated. That protocol is likely to result in decisions that further undermine property rights by reason of the so-called duty to fulfill, which, as discussed above, involves compulsory redistribution of property.

This development has potentially grave consequences for the right to private property around the world as NGOs, international organizations, governments, and courts are influenced by contemporary human-rights standards. Even in the United States, where the reference to international human-rights conventions is very limited at the federal court level, some courts in states such as New Hampshire, West Virginia, and California have referred to international human rights standards—including the ICESCR and the UDHR—when deciding claims related to adoption, education, and general relief.

An optional protocol affording private property human rights protection would create a line of defense against expropriations based on human-rights claims under the ICESCR. Moreover, the obligations arising out of the ICESCR are much less well defined than those under the ICCPR. The rights in the ICESCR have to be achieved progressively over time, and complaints generally have to show a "clear disadvantage" in order to be admissible. States have a wide margin of discretion in their implementation based on a standard of "reasonableness," taking into account a "range of possible policy measures." When it comes to the ICCPR, on the other hand, states are under an immediate obligation to "respect and to ensure" the rights therein, as well as provide an effective remedy for their violation. Taking into account the clear and immediate nature of the obligations under the ICCPR, it would be possible to argue that from the outset the right to property under ICCPR trumps claims involving the infringements of private property arising out of the ICESCR.

Mainstream human-rights thinking is increasingly hostile to the protection of private property and receptive to the ideas of ESC rights that often conflict with the right to property. Accordingly, those who believe that human rights are essential for freedom and prosperity and that the right to property is an essential human right should urgently focus their efforts on strengthening the protection of the right to property under international human rights law. ■

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point of view.

Another big risk is that we'll end up with more people in the exchanges—because employers can do arithmetic. They understand that there is so much taxpayer money on the table in those exchanges that it is entirely possible for them to drop their coverage, particularly for anyone under 300 percent of the federal poverty line. It is a no-brainer to drop the coverage, pay the penalty, give the worker a raise, and allow the worker to take the post-tax wage plus the subsidies and buy insurance at the exchanges that is just as good or better. If you take the population that's eligible for that kind of bargain, and assume that not even all of them do it, you can double the $1 trillion cost easily over the first 10 years, or triple it.

I would have loved to have stood here on the first anniversary of a bipartisan health care bill that took care of the costs problems and enhanced the prospect for coverage in the United States. Instead, we're celebrating the anniversary of something which represents another missed opportunity in health care reform in the United States, a dangerous step from an economic and budgetary policy point of view, and something that really cannot survive. And regardless of what we call it—repeal, replace, or simply throw up our hands and pray—it will not be this way in the future. ■