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The Patient Protection and Affordable Care Act A Summary Analysis Including the Reconciliation Act of 2010

Introduction

Any analysis of 3,000-pages of federal legislation (including the Reconciliation Act) that impacts every aspect of the economy and is being implemented over an 8-year period is an “informed guess” at best. There are too many variables and too many unknowns for it to be otherwise. Caution is therefore advised whether the analysis is provided by the Congressional Budget Office or any of the other interested parties that have undertaken the task in the wake of *The Patient Protection and Affordable Care Act’s* enactment.

The need for caution becomes even more necessary in a world already being buffeted by economic and political uncertainty. Much of what *The Patient Protection and Affordable Care Act* will do in the real world depends upon conditions in the broader economy. This legislation’s sweeping scope will have its own economic effect, potentially magnifying the impact of other factors. Unfortunately, community needs and operating requirements do not allow health care governing bodies and executives to defer decision-making until the final effects become clear.

Any attempt to project the real impact of legislation this massive must take into account both the literal language describing the Act’s individual components and the overall trajectory as determined by total content, policy preferences of the party in power, and historical patterns. In law and politics, the whole often does prove to be greater than the sum of its parts, particularly after the implementing regulations are written.

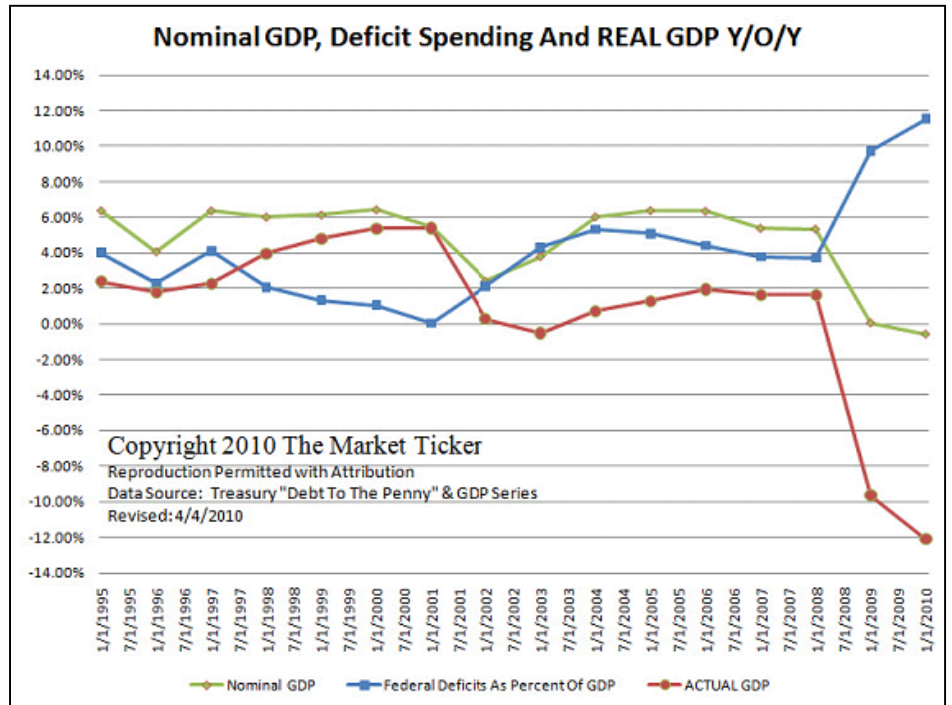
Some readers may feel that this document would be more accurately subtitled, “A Politically Incorrect Summary Analysis...” We most respectfully disagree. Politics had nothing to do with analysis content. However, in the interest of full disclosure, the reader should understand that the analysis was crafted from the following economic and systems theory perspectives:

- The Austrian school of economic thought (Rothbard, Von Mises, Hayek) is correct. The Keynesian school is incorrect and its errors lie at the heart of today’s economic problems.
- Static analysis of the type employed by the CBO will always understate costs and overstate positive financial impacts. As has been said to illustrate the point, “if you want more of something, subsidize it; if you want less of something, tax it.”

- The entropy principle applies. Large centrally controlled organizations are generally less productive than aggregations of smaller enterprises generating the same output because they consume proportionately more resources to maintain their structure. Resources consumed by organizational maintenance are not available to do the actual work of the organization.

That said, a consensus appears to be developing in some quarters that the U.S. has emerged from recession and that the worst is behind us. CBO scoring estimates employ that view concurrent with a static analysis that imagines increased taxes and business costs will have little economic impact. We believe this to be an incorrect reading. Once the real effect of federal spending is accounted for, a more realistic picture of “real” GDP emerges as shown in the graph at the right.

Although comprehensive review of the Act’s economic impact is beyond the scope of this analysis, the net impact is virtually certain to be profoundly negative, a stark reality that must be taken into account by any decision maker.



The Act’s Primary Effect on Hospitals and Physicians

There will be an initial increase in demand, particularly for certain outpatient, home health, long-term care and preventive care services. In the short term (during the calendar year 2010), Medicare payment protections are extended for small rural hospitals, including hospital outpatient services, lab services, and facilities that have a low-volume of Medicare patients. However, a net per capita reduction in Federally subsidized payment for mandated services will almost certainly occur on an accelerated basis over time.

Utilization of traditional private hospital and physician office services are gradually and increasingly targeted through a complex system of gradually implemented “financial disincentives” and regulatory changes over the eight-year implementation period.

- The Act’s financial incentives and regulatory controls promote the transfer of many primary care, dental care, counseling services, women's health, health promotion and education, podiatry, physiotherapy, case management, advocacy and intervention services away from traditional institutions and private practices funded by private insurance to a growing array of alternative delivery systems including the more than 4,000 “federally qualified” Community Health Centers and other subsidized or directly funded government programs. The funding of Community Health Centers, the number of Medicaid recipients, and the number of insured people with federal subsidies persons will all increase exponentially under the Act.

The Patient Protection and Affordable Care Act, An Analysis, Page 3

- The Act mandates the provision of grants for up to three years “to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics.” The funding period expands to five years beginning in 2011.
- The Act mandates the development of training programs that focus on primary care models such as medical homes¹, team management of chronic disease, and those that integrate physical and mental health services. Funds are to be appropriated for five years beginning in fiscal year 2010.

Congress is to determine physician payment levels for future Medicare participation sometime during the summer of 2010.

- From 2011 through 2016, primary care physicians will be eligible for a 10% bonus (to be calculated against yet-to-be-determined payment levels) in Medicare payments, provided that at least 60% of the physician’s total Medicare charges are comprised of office, nursing home, and home care visits.
- General surgeons who perform major procedures (with a 10- or 90-day global service period) in a federally defined health professional shortage area will be eligible for a 10 percent bonus payment for these services.

New Medicare regulations directly linked to physician payment will be implemented to “encourage” doctors to form “accountable care organizations” to “improve quality and efficiency” that will facilitate development of centralized mechanisms to control healthcare delivery.

The Act mandates that Medicare develop a physician payment program to reward quality of care rather than volume of services. Although the desire to reward “quality” is commendable, the incentives will work to the disadvantage of hard working private-practice physicians who now treat large numbers of Medicare patients and produce queues for service among the elderly ill.

A new federally created Patient-Centered Outcomes Research Institute will contract with appropriate federal agencies and private sector groups to conduct “comparative effectiveness research” (CER). Despite current disclaimers to the contrary (easily dispensed with by amendment whenever it becomes useful to do so) CER findings will ultimately define the boundaries of authorized medical practice which will be used to ration healthcare to the elderly ill by weighing the estimated cost of care against a patient’s statistically-determined years of remaining life.

The Act treats traditional U.S. healthcare institutions and practices as though they are *defacto* federal property and establishes a trajectory leading ineluctably to the total federalization of health care.

- It establishes a private, non-profit institute to “identify national priorities and provide for research to compare the effectiveness of health treatments and strategies.”
- It mandates creation of a national commission “to provide comprehensive, nonbiased information and recommendations to Congress and the Administration for *aligning federal health care workforce resources with national needs* [emphasis added].”

¹ The AAMC defines the medical home model as “a concept or model of care delivery that includes an ongoing relationship between a provider and patient, around-the-clock access to medical consultation, respect for a patient’s cultural and religious beliefs, and a comprehensive approach to care and coordination of care through providers and community services.” This is very close to what hospitals attempt to do today as a matter of mission. Badly implemented, the medical home model could develop into an additional layer of regulatory bureaucracy and gate keeping central control. The devil, as they say, is in the details.

- It establishes a “Graduate Medical Education” policy to redistribute “unused primary care training slots ... for purposes of increasing primary care training at other sites.” It is also to expand the size of the primary care nursing workforce by July 2011.

In 2014 the income level for Medicaid eligibility will increase dramatically, creating an estimated 15 million new Medicaid patients and creating significant new financial pressures on the States. What this means for uncompensated care cannot be currently determined. However, it appears likely to increase significant new demand for hospital service by Medicaid patients in all regions which of necessity will produce a parallel increase in the percentage of care compensated at Medicaid rates.

Also starting in 2014, assuming it survives court challenges, a federal mandate will force all businesses employing more than 50 full-time employees to provide insurance, pay penalties or both. Penalties will be determined by the number of full-time employees (or equivalents) employed, whether or not the business provides health insurance at the “qualified” level of benefit, and whether or not one or more employees qualify for government subsidies toward the purchase of health insurance. Consider the downstream consequences of these mandated rules:

- If a business employs more than 50 full-time employees and does not offer insurance but one or more employees are receiving premium subsidies from the government, the penalty is \$2,000 per year per full-time employee, minus the first 30 employees.
- If a business employs more than 50 full-time employees, offers insurance, and one or more employees receiving premium subsidies, the penalty is the lesser of \$3,000 per subsidized employee or \$2,000 per full-time employee, minus the first 30 employees.
- If a business employs more than 50 full-time employees, offers insurance, and has no employees receiving premium subsidies, the business incurs no penalty.

This is sound policy only if the intent is to discourage small businesses from providing health insurance as an employee benefit. According to published survey data, the average corporate health benefit expenditure in 2009 was \$9,660 per employee. Inasmuch as the cost of providing or continuing the benefit will typically exceed the amount of potential fines by several orders of magnitude, the rational decision for many small businesses will be to continue not offering coverage (if it is not currently provided) or to discontinue existing coverage. This provision² will (1) decrease the number of privately insured individuals; (2) increase the number of people covered by tax supported and/or subsidized programs; (3) decrease premium revenue to insurance companies; and (4) increase revenue to the federal government from non-compliance fines.

² Although the Act’s effect on the general economy is beyond the scope of this analysis, the broader impact of this provision on job creation is worth thinking about. Consider the case of a small firm with 50 employees that does not now provide a health insurance benefit. Should the owner decide to hire that 51st employee, an additional hiring cost is now mandated. The owner must pay \$2,000 each year for that employee, plus \$2,000 per year each for the 31st through 50th employees. Therefore the total additional penalty cost of hiring that new employee is \$42,000 per year.

Primary Effects on Insurance Costs for Individuals

The requirement that insurance carriers provide coverage to all who apply for it will draw more people with higher-than-average medical expenses into the market. Independent actuaries project that by 2015 average annual medical claims will be between 50% and 60% higher than they are today, after inflation adjustments. The net effect will be a dramatic increase in average insurance prices for individuals.

Although CBO's estimate that currently uninsured persons are more healthy than the current total insured market is probably accurate, other data strongly suggest that currently uninsured persons will, after coverage, produce claims that averaging between 115% to 125% of those submitted by current individually insured persons.

The guaranteed issue provision provides increased access to insurance for high-risk people. However, its structure will almost certainly result in some people making the perfectly rational decision to buy insurance only when they perceive a need for it, a decision that will have the effect of increasing prices for everyone. Although participation is made mandatory for the estimated 30% of young adults who are without health insurance (many of them by choice), "undocumented workers" are exempt from the mandatory participation requirement. Because the average "fine" for non-purchase of insurance is \$750 per year, the Act's current enforcement measures are unlikely to persuasively change the decision to stay uninsured.

The elimination of health status ratings will inevitably result in younger, healthier individuals subsidizing the premium costs of less healthy and older people.

The requirement that all policies meet federally mandated minimum benefit levels guarantees an increase in total program costs. The potential premium cost for a family earning \$54,930 per year is \$5,218 or 9.5% of their income. This is an out-of-pocket cost. The amount remaining after all available federal subsidies have been applied.

Finally, as noted in the last section, the Act's provisions will force many people who are currently covered by employer-supplied benefit programs to purchase individual policies as businesses drop health insurance from their benefit packages.

Given the sheer size of the Act, the absence of implementing regulations, and the lack of clarity within the Act with respect to how certain titles are to interact, it is highly likely that important elements have not been covered in this analysis. We will make every effort to provide updates as they become available.

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