PPACA:
The Lay of the Land and What to Look for in the Future

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Basic Structure

	PPACA
Coverage	• "Individual Mandate" (ramped up penalties) • Employer penalties if workers in exchanges • Medicaid expansion to 133% of poverty • New insurance subsidies (to 400% of poverty) inside exchanges
State-Based Exchanges	• Insurance exchange system which pools individual and small group markets • Provides subsidies to lower and middle income people in the exchanges
Costs	• Medicare-led "delivery system reform" • "Cadillac" tax • Independent Payment Advisory Board (IPAB)
Financing	• Tax increases (insurers, devices, drug companies, Medicare payroll tax) • Medicare cuts (Medicare Advantage, payment updates)

Implementation Timeline of Selected Items

2010:
- High-Risk Pools
- $250 Medicare drug cost payment
- Medicare Advantage adjustments in anticipation of cuts
- "Tanning" tax
- Small employer (<25) tax credit

2011:
- CLASS Act (long-term care insurance)
- Drug manufacturer tax
- Cut Medicare provider "inflation" updates

2013:
- Medicare 0.9% payroll tax increase for $200/$250k +
- 3.8% tax on unearned income
- Tax on medical devices

2014:
- Individual mandate
- Employer mandate
- State-based exchanges
- Insurance reforms
- Medicaid expansion
- New premium credit and cost-sharing assistance programs
- Tax on health insurers

2015:
- IPAB enforcement of Medicare spending limit

2018:
- "Cadillac" tax

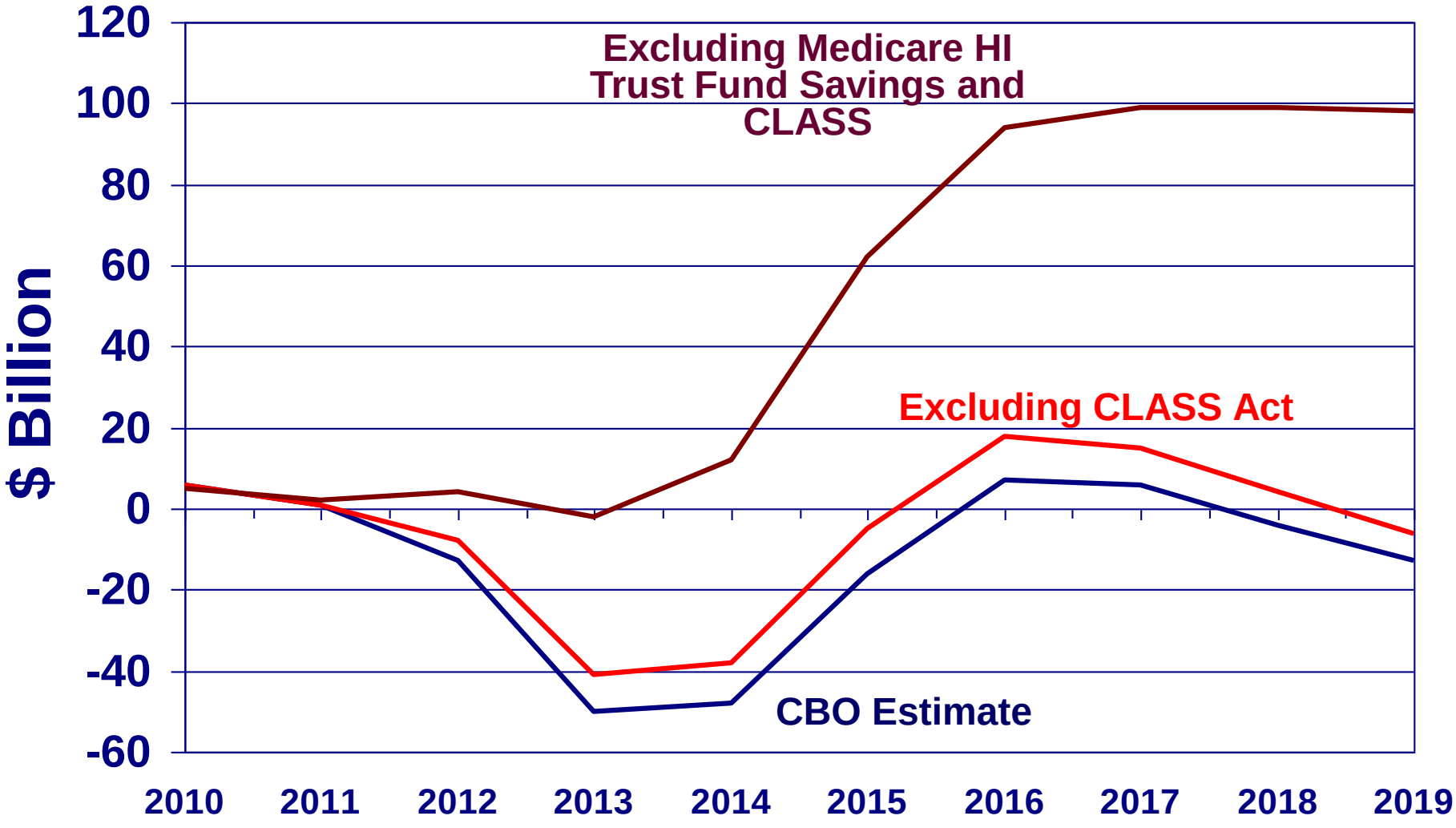
Final CBO Cost Estimate of PPACA

PPACA Effect on the Federal Budget Deficit*	$ Billions 2010-2019
Coverage Provisions (including tax credits)	936
Other Spending	30
Medicare/Medicaid Cuts	-455
CLASS Act	-70
Tax Increases	-563
Net Effect on Federal Budget Deficit	-124

*Excludes the effect of the legislation's student loan provisions.

Source: CBO Letter to House Speaker Nancy Pelosi, March 20, 2010

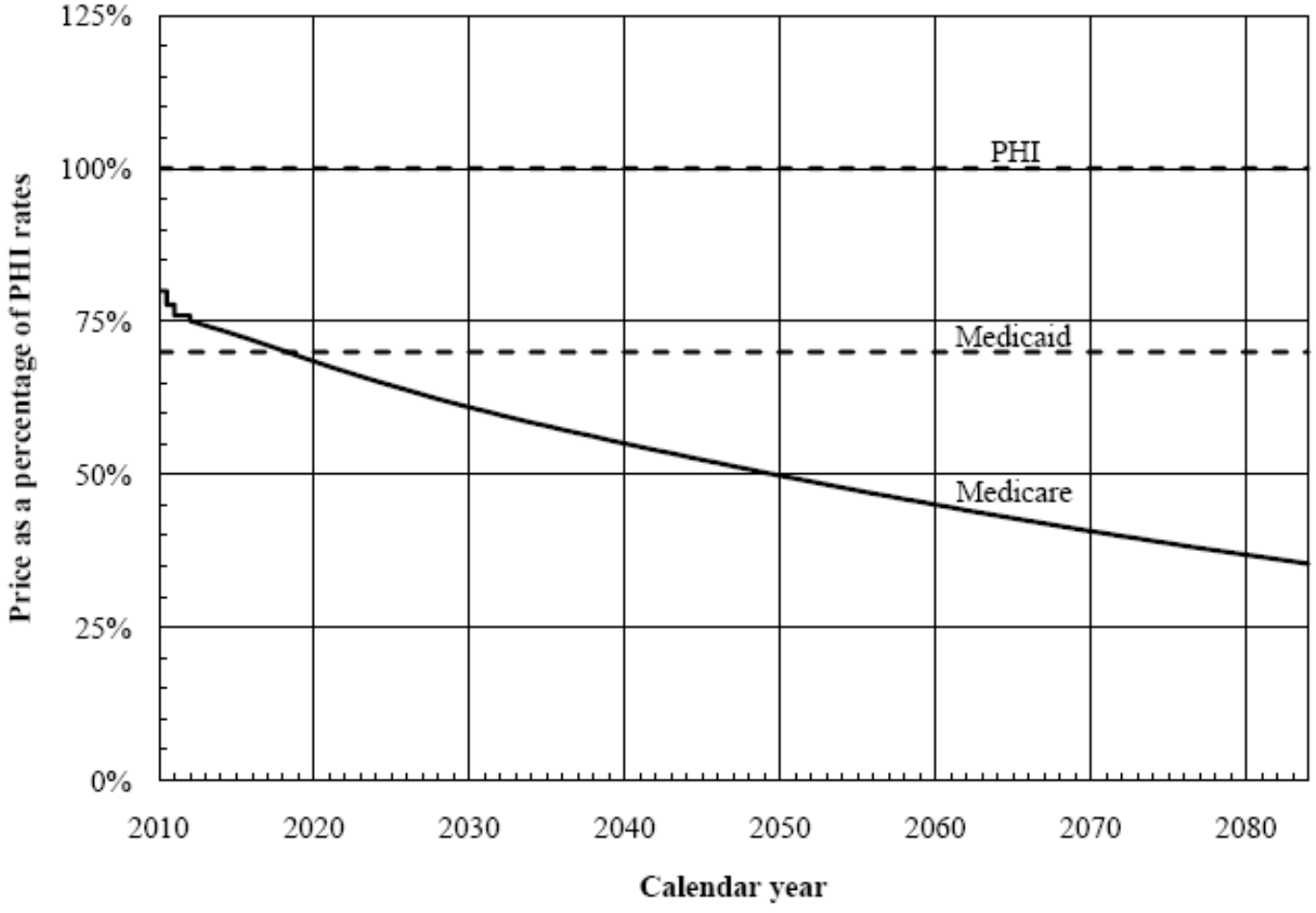
Near-Term Deficit Impact of PPACA



Source: CBO Letter to House Speaker Nancy Pelosi, March 20, 2010 and Author's Calculations Based on CBO Note on Health Reform's Impact on HI Solvency, December 23, 2009

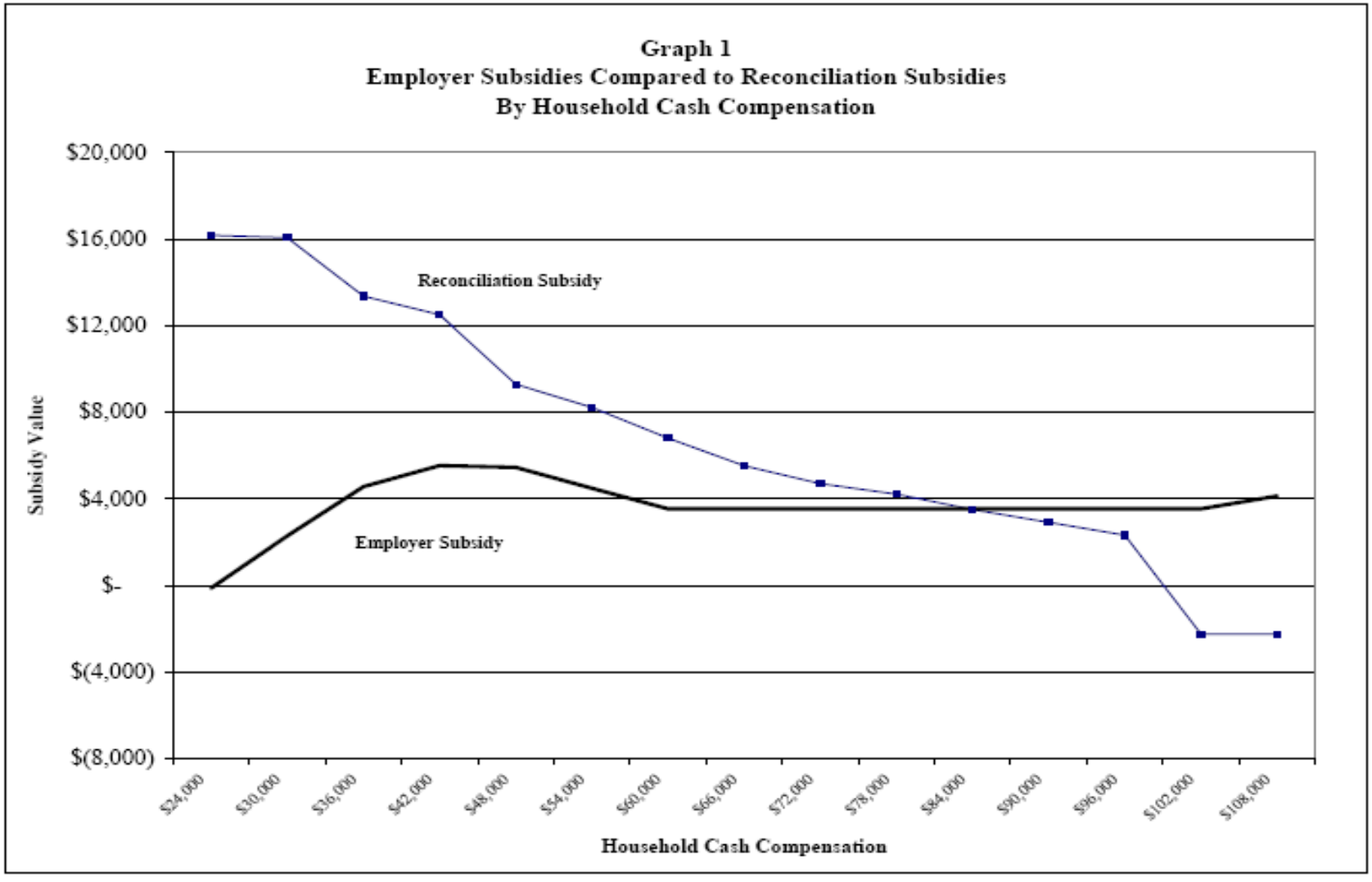
Comparison of Provider Payment Levels

Figure 1. Simulated comparison of relative Medicare, Medicaid, and private health insurance prices under current law



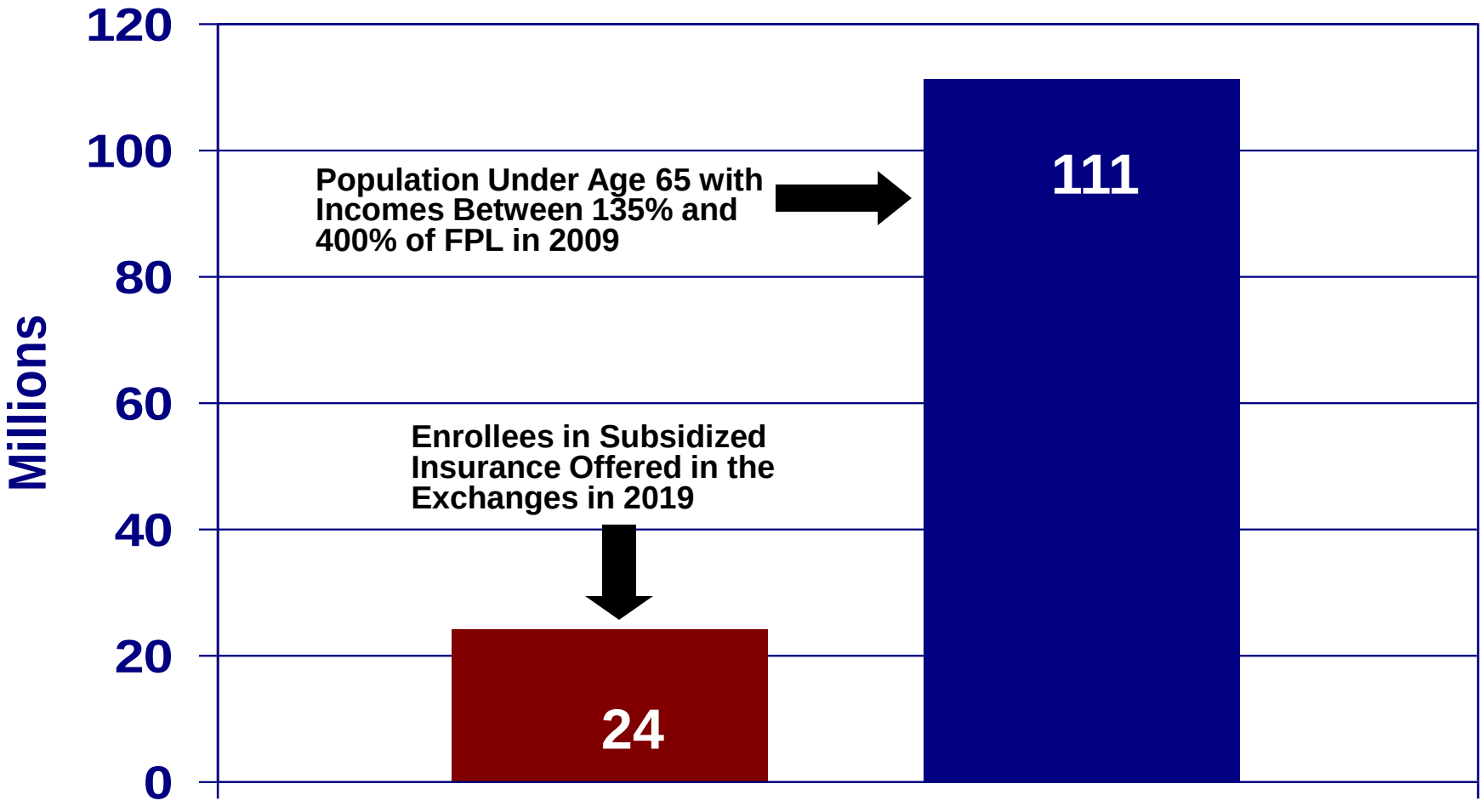
Source: "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," CMS OACT Memorandum, August 5, 2010

Disequilibrium in Federal Insurance Support



Source: "Health Reform: A Two-Subsidy System," Stephanie Rennane and C. Eugene Steuerle, Tax Policy Center, April 2010

Exchange Enrollment vs. Eligible Population



Sources: CBO, Census Bureau

State-Based Exchanges

States That Have Passed PPACA-Compliant State Exchange Legislation (10)
California
Colorado
Connecticut
Hawaii
Maryland
Nevada
Oregon
Vermont
Washington
West Virginia

States That Seem Likely To Set Up PPACA-Compliant Exchanges (10)
D.C.
Illinois
Maine
Massachusetts
Montana
New York
North Dakota
North Carolina
Rhode Island
Virginia

States That Are Waiting/Oppose/May Have Different Ideas (31)	
Alabama	Missouri
Alaska	Nebraska
Arizona	N.H.
Arkansas	New Jersey
Delaware	New Mexico
Florida	Pennsylvania
Georgia	Ohio
Idaho	Oklahoma
Indiana	South Carolina
Iowa	South Dakota
Kansas	Wisconsin
Kentucky	Tennessee
Louisiana	Texas
Michigan	Utah
Minnesota	Wyoming
Mississippi	

Key Question:
Does the federal government have the capacity and political will to put in place a federal fall-back in 60 percent of the country (including real-time income verification on tens of millions of people)?

The Individual Mandate and the Courts

- **The U.S. Court of Appeals for the D.C. Circuit just upheld the mandate based on the "necessary and proper" clause. Consistent with 6th Circuit decision.**
- **Conflicts with the decision from 11th circuit (case involving 26 states).**
- **Supreme Court likely to decide whether to take the case this month (seems likely).**
- **Could see a decision by June 2012.**
- ***Big issue that isn't being discussed: regardless of constitutionality, the individual mandate is unlikely to be effective because the penalty is far too low relative to premium costs.***

CBO's Updated Baseline (Summer 2011)

	$ Billions		
	2011	2015	2021
Deficit excluding Budget Control Act	-1,284	-395	-592
Effect of BCA Provisions Excluding Joint Committee	0	+73	+182
Deficit Reduction from Joint Committee/Sequester	0	+117	+161
CBO's Projected Deficits	-1,284	-205	-279
Effect of Extending Current Law Tax Provisions (not 2011 payroll tax cut)	*0*	*-402*	*-778*
Effect of Freezing Medicare Physician Fees at 2011 Levels	*0*	*-27*	*-59*

Joint Select Committee on Deficit Reduction

- **Goal: $1.5 trillion in additional deficit reduction over ten years (including debt service savings).**

- **Membership:**

Republicans	Democrats
Rep. Jeb Hensarling (Co-Chair)	Sen. Patty Murray (Co-Chair)
Rep. Dave Camp	Sen. Max Baucus
Rep. Fred Upton	Sen. John Kerry
Sen. Jon Kyl	Rep. James Clyburn
Sen. Rob Portman	Rep. Xavier Becerra
Sen. Pat Toomey	Rep. Chris Van Hollen

Joint Committee recommendations need the support of seven members to become privileged legislation in House and Senate (guaranteed to come to an up or down vote, with no amendments, and no filibuster in the Senate).

The Sequester Fall-Back

Joint Committee Target: Recommendations of at least $1.2 T in deficit reduction signed into law by December 23rd.

Back-Up Sequester: If target is not met, automatic sequester cuts spending to ensure achievement of $1.2 T in deficit reduction over the nine year period 2013 to 2021 (any deficit reduction achieve by the Joint Committee is subtracted from the $1.2 T sequester).

Sequester Mechanics: 50 percent will come out of defense discretionary spending and 50 percent out of non-defense discretionary plus selected entitlement programs.

Treatment of Health Care: Medicare included in the sequester, but only 2% of provider payments; most of PPACA is exempt but not cost-sharing subsidies, high risk pool funds, public health funds, and perhaps risk adjustment payments.

What the Debate Is Really All About

The Key Question	What *process* has the best chance of bringing about continual improvement in the productivity and quality of patient care?	
Competing Views	**A Governmental Process**	**A Market-Based Process**
Solutions	• Health Information Technology • Comparative Effectiveness Research • Medicare-led payment reforms to encourage more efficient delivery (Accountable Care Organizations, Bundling of Payments) • Medicare Commission	• Move toward defined contribution financing systems in tax and entitlement programs • Foster cost-conscious consumers and incent doctors and hospitals to re-organize for efficiency • Government provides oversight but does not allocate resources • More Medicare Part D than Medicare Parts A & B
Criticisms	• Governmental process always devolves into across-the-board price setting that drives out willing suppliers and makes no distinctions based on quality • Cost control by supply control (queues)	• Patients with serious ailments cannot make rational decisions about use of services • Relying entirely on markets and prices to allocate resources is inequitable to those with less ability to pay