

The Supreme Court Decision on Obama Care Part II: The Impact on U.S. Health Care

Gilbert Berdine, MD

Part I was a factual statement of the basis for the lawsuit, the textual meaning of the decision, and an explanation of which justices composed the majority for each part of the decision as well as the major dissents. The remaining discussion is both analysis and prediction of what happens next and is necessarily opinion. This opinion is shaped by Austrian Economics.

The proponents of ACA argue that health care costs will decrease by treating problems in the uninsured before they become more expensive emergency room problems. If the U.S. health care system were an unhampered market economy, then each individual would act to minimize their cost of health care. Individuals would voluntarily pay for preventative care whenever it was cost effective. Care that was not cost effective would be purchased only if the individual placed a higher value on that care than other choices for their purchases. The U.S. health care system is not unhampered and government regulations affect the choices that individuals make. Federal regulations make it illegal to deny emergency care to individuals who cannot pay. Individuals can avoid health care costs by using the emergency room. The problem is the separation of the consumer of emergency room services from the cost of those services. A price discovery system no longer exists.

In an Unhampered Market Economy, prices are determined by individual preferences. Buyers have a higher preference for a good than the sellers. The goods move from sellers to buyers and money moves from buyers to sellers. The price of each transaction is known as the process of price discovery. Goods will be sold until the market clearing price is achieved.

Corresponding author: Gilbert Berdine MD
Contact Information: Gilbert.Berdine@ttuhsc.edu
DOI: 10.12746/swrccc 2013.0102.017

The market clearing price is the price at which there are an equal number of buyers and sellers. All transactions occur at prices satisfying the preferences of both buyer and seller. Once the market clearing price has been achieved, no further transactions will take place until preferences are modified by time.

In a Hampered or Regulated Economy, prices are set by government fiat. U.S. law creates situations where some ER services are delivered for free. At a price of zero, the only restraints on the unlimited use of these emergency room services are opportunity costs including time lost waiting in long queues for service, fear of the health care system or the cost of gasoline for transportation. Federal regulations increased the demand for service and, therefore, increased the cost of that service. Subsidies for less expensive office care will not solve the fundamental problem which is a lack of price discovery. Prices cannot be discovered without consumers having to make choices of health care vs. some other want or desire. The subsidies within ACA will only lead to increased demand for office care and an increase cost of office care. Mechanisms such as copayments and deductibles decrease the harm of subsidies but only to the extent that any subsidies are eliminated and consumers of health care must make choices of purchasing health care or something else.

The uninsured are not a homogeneous group. Rather, the uninsured contain separate groups of individuals who will see different effects of ACA. The pre-existing condition of diabetes can be used to illustrate these different effects. Let us create a hypothetical population based on the 2002 HHS data for diabetics.¹ The cost of care for diabetics in 2002 was \$13,242. The cost of care for those without diabetes was \$2,560. There are very few diabetics who could afford an insurance policy covering their expected costs of health care. This group has become, in effect, uninsurable. In contrast, most people without

diabetes could afford insurance. This latter group might elect to pay routine costs of care out of pocket and buy insurance only for the unlikely event of catastrophic illness. The CDC estimated that, in 2011, the prevalence of diabetes in the U.S. was 8.3%.² Using static analysis, an ACA style government administered self-insurance policy could be created with a premium of $\$13,242 * 0.083 + \$2,560 * 0.917 = \$3,447$. At first glance, this might seem a reasonable solution to the effective uninsurability for diabetics.

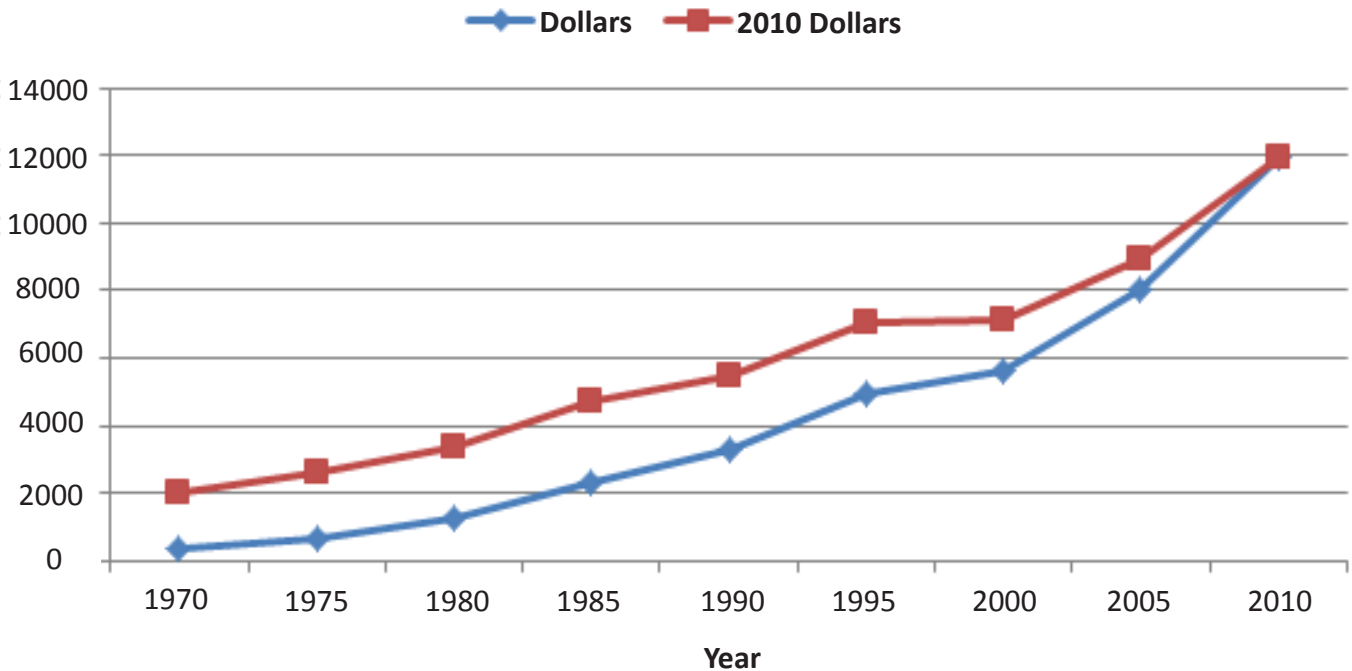
While such a policy might make ‘insurance’ affordable to diabetics, it will not reduce the cost of care. The diabetics receive a subsidy for their care and will demand more care. The subsidy will be paid by those without diabetes. Those without diabetes will also demand more care. The previously uninsured would make choices between health care purchases and other consumer options. Once forced into an ‘insurance’ plan, the reduced marginal cost for health care services will lead the newly in-

sured to obtain more care than they would have – at increased total cost – had they not been insured.

Unfortunately, the premium must account for all risk groups – not just diabetes. The minimum premium for a single pool health insurance policy is the expected average cost of health care. This expected average cost can be estimated by Census figures. Total U.S. health care expenditures in 2009 were \$2,486.3 billion.³ The U.S. population in 2010 was 308.7 million.⁴ These figures yield a per capita U.S. health care expenditure of \$8,054 in 2009. If we strip out Medicare expenditures of \$509 billion to its 46.3 million beneficiaries⁵, we have \$1,977.3 billion expenditures on 262.4 million people not covered by Medicare for a per capita health care cost of \$7,535. This is the minimum premium – without considering administration overhead or incentives to increase use of care – for an ACA style health insurance plan in the U.S.

The above premium (\$7,535) is high enough to dissuade anyone without a pre-existing condition

Average Medical Costs Per Beneficiary



from participation. The subsidy to those with pre-existing conditions will necessarily increase their use of health care and its cost. The subsidies to low income people without pre-existing conditions will necessarily increase their use of health care and those costs. Anyone who pays the full premium without a pre-existing condition has an incentive to use care they would avoid if they had to pay out of pocket – their demand for health care will increase as will those costs. The only group who will not increase their use of health care and increase costs will be those who avoid participation in the program either illegally or legally by paying IRS penalties.

While ACA moves in the direction of a single fully homogenized risk pool, it retains some stratification of risk. Smokers can be discriminated against through higher premiums. Excepting those above age 65, age remains an actuarial risk factor so younger people will pay lower premiums than older people. According to the Congressional Budget Office (CBO) in January 2013, the least expensive premium avail-

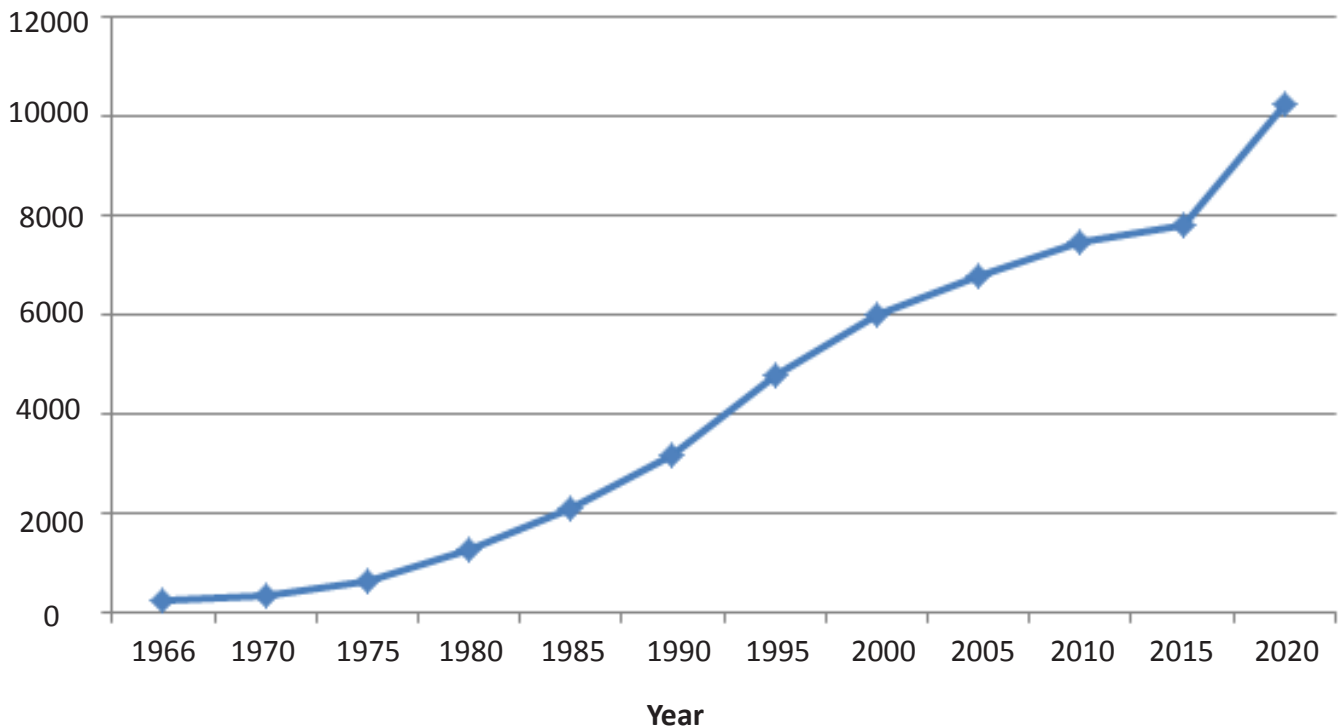
able under ACA will be \$20,000 for a family of 5.¹⁰ This is high enough to dissuade employers from covering as many employees as they previous did.

Proponents of ACA argue that free access to preventative care will lower costs by eliminating more expensive care for complications of chronic disease. If the argument were valid, then Medicare should have lowered health care costs for the elderly by improving access to preventative care. The historical data for Medicare expenditures say otherwise.⁵ Nominal dollar data were adjusted for CPI.⁶

One might argue that Medicare patients are too old for preventative measures to be cost effective. One might see cost savings from health insurance in younger patients. The data from Medicaid also say otherwise.⁷

Data are from the 2011 Medicaid Report written by the CMS actuaries. Including the projected effects of ACA, enrollment in Medicaid is expected to increase from 53.9 million in 2010 to 85.1 million in 2020, ex-

Medicaid Expenditures Per Enrollee (Dollars)



penditures are expected to increase from \$401.5 billion in 2010 to \$871.0 billion in 2020, and per person expenditures are expected to increase from \$7,449 in 2010 to \$10,235 in 2020. Note that current data are in line with the national average health care expenditures outside of Medicare. Enrolling someone in Medicaid does not save money today and the CMS actuaries do not expect enrollment to save money in the near future.

The availability of office care to insured patients does not eliminate ER use by those patients. The availability of office care will not have any effect on trauma costs. People who have their blood pressure and blood sugar checked still have heart attacks. People who are vaccinated against pneumococcus still get pneumonia. Many of the routine treatments received from an office visit have very high numbers to treat for each benefit and cost savings are doubtful at best. The use of statins is an excellent example.⁸ The testing and approval of diagnostic tests and therapies are not based on cost-effectiveness. The standard of care is based on evidence based efficacy. Efficacy is defined on the basis of mortality or morbidity without regard to the cost of prevention.

It is not clear that improved health maintenance can even offer a possibility of reduced total cost. As we age, our organs deteriorate. Everyone will eventually die from something. Good quality primary care of diabetes may delay the onset of complications, but the complications cannot be eliminated. It is well known that health care costs are much greater in the last year of life.⁹ This study of health care expenses in Medicare patients from 1992-1996 showed that health care cost \$37,581 during the last year of life vs. \$7,365 for patients who survived. Preventative care can delay the last year of life, but nothing can prevent that very expensive last year of life.

The above analysis considers health care as a consumer good. In some cases, health care can be a producer good. It is possible for health care to improve worker productivity sufficiently to offset the cost of the care. Consider a hypothetical infectious disease. If untreated, the disease will last 8 days. One shot of an antibiotic can reduce the length of illness to 4 days. The worker cannot work at all during the illness.

In this hypothetical situation, the antibiotic would be cost effective whenever the cost of the antibiotic was less than the value of 4 days of worker output. Such a treatment would never be cost effective in the retired or unemployed. The treatment would only be cost effective for higher paid workers. While this hypothetical situation could be reduced to a bureaucratic algorithm, real life situations have many uncertainties. The number of sick days is a variable. There may be unwanted side effects of the antibiotic. In an unhampered market economy, each worker would act as an entrepreneur and make a forecast whether treatment with the antibiotic was cost effective or not. The ACA, however, would treat all workers without discrimination and become less cost effective even for circumstances where cost effective prevention was possible.

Part 3 of this series will examine the unintended consequences of ACA on those who already have health insurance.

Author Affiliation: Dr. Berdine is a pulmonary physician in the Department of Internal Medicine, TTUHSC.

Received: 3/10/2013

Accepted: 3/22/2013

Reviewers: Kenneth Nugent MD, Clarke Cochran, PhD

Published electronically: 4/16/2013

Conflict of Interest Disclosures: None

References

1. <http://www.foh.dhhs.gov/NYCU/diabetescost.asp>
2. <http://www.cdc.gov/diabetes/pubs/estimates11.htm>
3. <http://www.census.gov/compendia/statab/2012/tables/12s0134.pdf>
4. <http://www.census.gov/compendia/statab/2012/tables/12s0002.pdf>
5. Medicare Trustee Report 2010
6. <ftp://ftp.bls.gov/pub/special.requests/cpi/cpi.ai.txt>
7. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/MedicaidReport2011.pdf>
8. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079612/>
9. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1464043/>
10. <http://cnsnews.com/news/article/irs-cheapest-obamacare-plan-will-be-20000-family>