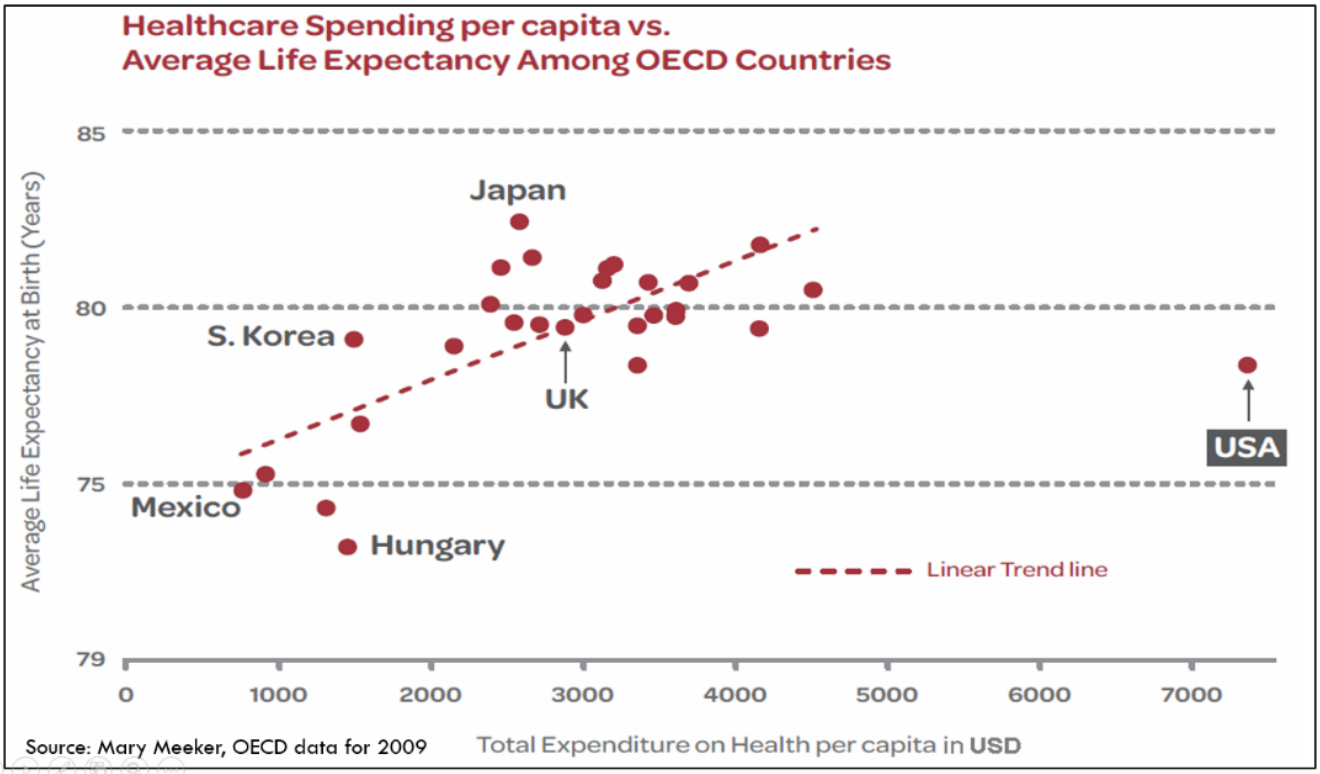
Relative Savings of the Proposed American Health Care Act

by Tatiana Bailey
Director, *UCCS Economic Forum*

In a November article (http://www.csbj.com/2016/11/28/difference-health-care-economics/) I gave an overview of how health care is not a "normal" good, and why that uniqueness calls for a completely different approach. The father of health care economics, Kenneth Arrow, back in 1963 outlined the numerous unique attributes, and he foresaw that treating health care like a widget would cause mounting problems. That November article briefly summarized Arrow's analysis, and it is evident as time goes on that as a nation we will continue to struggle unless we understand and address the true reasons for the health care crisis.

Arrow's list of the differentiating attributes of health care is lengthy; however, the first one he states is the most obvious. Health care is at the root of our very existence and livelihood and for that reason, people will feel passionately about it. Given that it is an essential, even critical part of our lives, it has strong moral undertones if certain groups do not have access to it. Most people are not comfortable at the thought of denying care to a child (see table), anyone who suddenly has an acute care episode and needs hospital attention, or someone with a chronic condition. Yet, how do you reconcile this with the reality that we are the most expensive country in the world to provide care, but have subpar outcomes (see graph)? Similarly, how do you address the fact that approximately 75% of all health care expenses in the U.S. are preventable and tied to unhealthy lifestyles, especially being overweight/obese? Can we dictate health behavior without infringing upon individual rights? Can we mandate that everyone has health insurance so that risk is spread across both healthy and sick populations, and all children and adults live with the security of health care coverage?

Medicaid Enrollment		
Geographic Area	Total Number of Enrollees	Number and Percent Children
Number of **Colorado state** residents enrolled in Medicaid in 2015/16 fiscal year	1.3 million people (or 25% of state population)	546,310 (or 43%) of all Medicaid enrollees in the state
Number of **Colorado Springs** residents enrolled in Medicaid in 2015/16 fiscal year	181,000 people (or 26% of MSA population)	77,462 (or 43%) of all Medicaid enrollees in the MSA
Source: Colorado Department of Health Care Policy and Financing		



These are tough questions and like most tough questions, there are no easy answers. In fact, oversimplification is dangerous. Health care is a highly complex issue not conducive to Band-Aid approaches. Health care expenses, at 17.5% of GDP, have been on a (per capita) upward trajectory for decades: before and after both Medicare/Medicaid and Obamacare. The hope with the new American Health Care Act (AHCA) is that these spiraling costs will finally abate. However, as the recent, nonpartisan, Congressional Budget Office (CBO) estimates have shown, the new health care proposal will not significantly change that cost trajectory. The bill recently passed by the House is indeed estimated by the CBO to reduce the deficit by $151 billion from 2017-2026, or $16.7 billion in savings per year. That sounds like a lot of money except when you put it in context of total health care expenditures, which were $3.2 trillion last year. *If you do the math, the annual savings with AHCA is only 0.52% of total, annual health care expenditures.* The relatively miniscule savings highlight the enormity of the problem.

Furthermore, these estimated savings do not incorporate a) changes in the coverage offered by plans in the individual market nor b) the age distribution of enrollees. One of the major tenets of AHCA is to move to state, block grants for Medicaid, essentially capping the per person allocation. This will translate to fewer benefits for enrollees as estimated by the Brookings Institute. Obamacare also had provisions on mandatory benefits that all insurers had to include, which would go away under AHCA, likely changing the generosity of plans for everyone. Moreover, under AHCA, insurers would be allowed to charge seniors up to five times more than younger cohorts. On the other end of the spectrum, the CBO estimates that younger, healthy individuals will opt out of health insurance since there would no longer be a mandate under AHCA. Many argue no one should have to purchase health insurance if they don't want it; however, we all pay for the non-insured's care through cost shifting because providers bump up charges to cover the costs of nonpayers. Cost shifting (to the insured) would undoubtedly increase: the CBO estimates 24 million more uninsured people by 2026. In sum, the proposed plan, which will likely shift further once it gets to the Senate, has significant tradeoffs and doesn't truly deliver on any substantial savings.

It would be wonderful to embrace any party's health care plan if it did indeed deliver on lower costs, as well as on higher quality and access for all. The truth is that such a plan does not exist until we fully understand and embrace the underlying causes of the cost increases. Unfortunately, there is no quick and easy fix, and the sooner we acknowledge this the more likely it is we will begin to work effectively on this critical issue, which impacts us all.

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