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Synopsis: *Regardless of the Supreme Court's decision, President Obama's health care law is riddled with problems that exacerbate rather than solve the health care system's many problems. It raises taxes, empowers bureaucrats and the IRS, explodes spending, creates inefficiencies, and cooks the Medicare books. He has imposed a mid-20th century health insurance model on a dynamic, 21st century economy, and thereby undermined both systems.*

The Health Care Dirty Dozen:

Twelve Things (Still) Wrong with ObamaCare

by Merrill Matthews, Ph.D.

The U.S. Supreme Court may have upheld most of the Patient Protection and Affordable Care Act, but that won't fix its many flaws. Here are 12 problems that still riddle the 2,700-page law known as ObamaCare.

1. Imposes a Bevy of New Taxes.
Supreme Court Chief Justice John Roberts engaged in some tortured reasoning to allow the mandate requiring people to have coverage based on Congress's power to tax. But if it is a tax, it is far from being the only one created by the legislation. There are at least 20 new taxes, including:

- A 3.8 percent surtax on investment income and a 0.9 percent surtax on Medicare taxes for individuals making more than $200,000 and families making more than $250,000.
- A 10 percent tax on tanning services and a 2.3 percent excise tax on medical equipment.
- A 40 percent tax on comprehensive health coverage that costs more than the designated cap; and
- New taxes that apply to Flexible Savings Accounts and Health Savings Accounts.

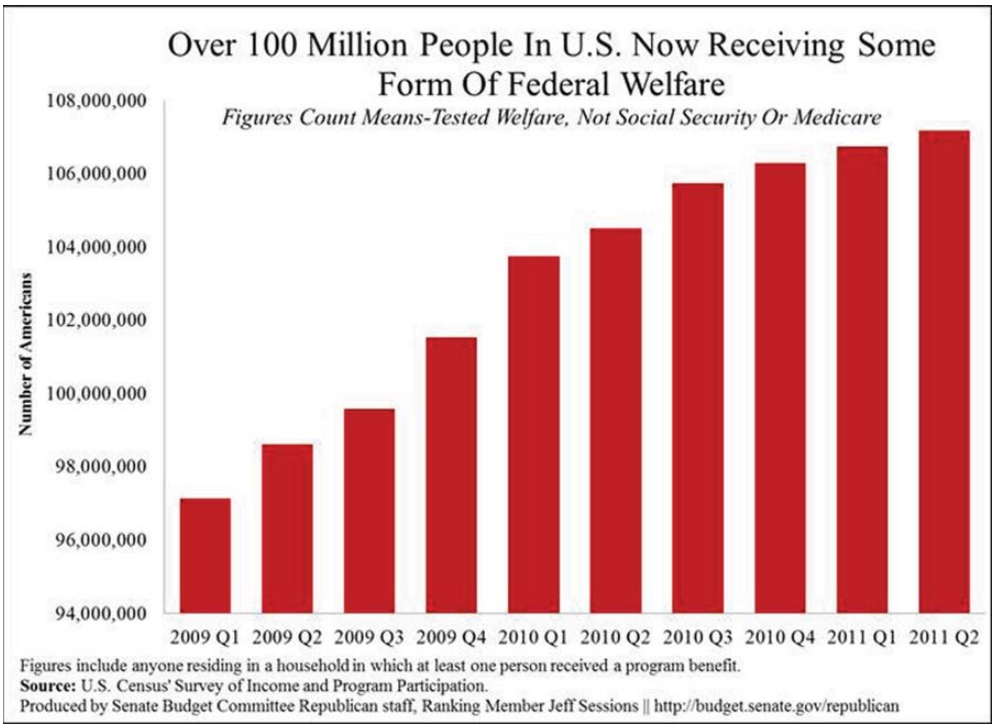
Obviously, several of these taxes will hit the middle class. The Congressional Budget Office (CBO) estimates that the legislation will collect some $813 billion in total revenues over 10 years, when all the penalties and taxes are included. Thus, the tax increases are not restricted to high-income earners only, as the president repeatedly promised. Yet, inexplicably, when Fox News host Bill O'Reilly raised the question about those increases during an interview, the president responded, "I didn't raise taxes once, I lowered taxes over the last two years."

2. Expands a Nation of Takers.
The Mercatus Center at George Mason University recently reported that about one-third of American households received Medicaid, food stamps or some other means-tested program in 2010. Add in Medicare, Social Security and unemployment and nearly half of all households are getting a government check.

ObamaCare dramatically expands that number. Medicaid coverage will go to an estimated 16 million more Americans. Another estimated 20 million people, with incomes up to 400 percent of the federal poverty level ($92,000 for a family of four), will receive subsidies to buy coverage inside the exchange.

We do not know yet how many Americans will take advantage of the exchanges, but it could be millions—especially if employers start dropping their coverage. Indeed, getting most Americans in the exchanges was one of the supporters' goals, and that means that the large majority of Americans will be taking money from the government (i.e., taxpayers).

3. Creates a Maze of Cross Subsidies.
The legislation is also filled with cross subsidies, a way of transferring wealth without using the tax code. Take one example: It requires health insurers to accept people with a preexisting condition—which mostly affects individuals buying their own coverage—and puts a cap (i.e., price controls) on how much insurers can charge for the risk a person brings to the pool. It is a popular provision only because most Americans do not realize they will be paying higher premiums.



In order for individuals with preexisting conditions to get coverage at less than their actuarially rated risk, young and healthy people must pay more than their fair share. The requirement will make health insurance so expensive that many of the young and healthy would drop their coverage; hence the mandate to try and force them to stay in. But even if everyone is in the pool—which they won't be—the young and healthy will spend billions of dollars paying higher-than-necessary premiums to cross subsidize older and sicker Americans.

The same can be said for ObamaCare's prohibition on charging women more than men for similar coverage. Though the president tried to explain the practice of charging women more as an example of gender discrimination, it is based on actuarial science.

Women tend to use more health care services up to middle age at which point men start to become more expensive, and health insurance premiums have historically reflected that difference, charging young women more than men while charging older men more than older women.

There is nothing unusual about this practice. Teenage boys tend to have worse driving records and so pay higher auto insurance premiums than their female counterparts. Men also tend to die earlier than women and so will pay higher life insurance premiums, other things being equal. Everyone seems to know about these variations and accepts them.

But the president could not be restrained either by fact or prudence. By prohibiting insurers from charging an actuarially fair price (i.e., one based on expected utilization) men will pay more in their younger years as they subsidize younger women.

4. Hands Control to Unelected Bureaucrats.
Department of Health and Human Services Secretary Kathleen Sebelius was handed one of the biggest jobs in Washington when she left the Kansas governor's office to run HHS. She oversees about 70,000 employees (full-time equivalents), manages a budget of about $860 billion (for 2010) and runs the largest health insurance programs in the world, Medicare and Medicaid. And now Congress has handed Ms. Sebelius the authority to implement ObamaCare.

A quick search of the legislation reveals that the word "Secretary" appears nearly 3,000 times in the 2,700-page legislation. And the vast majority of those references are to the secretary of HHS.

Over and over again we see: "the Secretary shall establish"; "the Secretary shall promulgate regulations"; "the Secretary shall develop standards"; "the Secretary shall periodically review"; "as the Secretary deems are important"; "the Secretary may develop and impose appropriate penalties"; "the Secretary may adjust the rates"; "if the Secretary determines necessary"; and "the Secretary has the authority."

Democrats gave this former head of the Kansas Trial Lawyers Association the statutory power to remake the U.S. health care system. And within a few years virtually every health-related decision individuals make—with regard to insurance, premiums and co-pays, picking a doctor (if you can find one), treatment and drug options, etc.—will have her stamp on it.

5. Empowers the IRS.
The Internal Revenue Service may be the public's least favorite federal agency in a field with a lot of competition. Nevertheless, ObamaCare vests the IRS with enforcement authority to ensure Americans are getting health coverage or paying a penalty (or tax). Indeed, Chief Justice Roberts relied in part on IRS's enforcement power to proclaim that the coverage mandate functions like a tax.

The legislation will create an estimated 16,000 new IRS employees whose job it will be to monitor Americans to ensure they are getting the qualified coverage the legislation demands. And yet it is not clear that the IRS actually has the authority to enforce the mandate, which could leave the issue in limbo if millions of Americans decide to ignore the coverage mandate and the penalty.

6. Imposes Perverse Economic Incentives.
The problem with the current health care system is that the economic incentives are all wrong. Patients have little reason to be value-conscious shoppers in the health care marketplace, because in the vast majority of cases someone else is paying the bill.

Doctors don't know who their real customer is: the patient getting care or the government, employer or insurer paying for it. Patients are increasingly unsure whether they can trust their health care providers. Is that provider recommending what he or she thinks is best, or is the provider just recommending what insurance will pay for, or worse yet, the therapy that the insurer or government has decided to pay a bonus for because some committee has determined that is the best care in most cases.

The situation often pits health care providers against patients who want everything and the payers who want to limit costs. It's a no-win situation of perverse economic incentives, and ObamaCare only exacerbates the problem.

7. Explodes Health Care Spending.
Team Obama believes that if you get more people covered for even more services—including numerous "free" services, such as contraceptives—health care spending will go down.

Virtually any health actuary knows just the opposite will happen: health care spending will explode. Just consider that insured people spend a little more than twice what uninsured people spend on health care. ObamaCare is supposed to provide an extra 32 million previously uninsured people with very comprehensive coverage. It's a recipe for massive new spending.

8. Enhances Rationing under IPAB.
When health care spending explodes, Washington will scramble to find a way to contain what wasn't supposed to happen in the first place.

The reason is that the government will be subsidizing so many people that even minor increases in health care costs will have huge federal budget implications. The Obama administration has committed U.S. taxpayers to hundreds of billions in health care subsidies that will strain an already drained federal budget. That means that cuts in care and services will be made.

Just consider Massachusetts, which adopted a prequel to ObamaCare in 2006. Although there were promises then, just as with ObamaCare today, that spending would decline, that hasn't happened. So the state has passed legislation creating a board to oversee health care prices and to enforce arbitrary limits. As the Wall Street Journal writes, "An 11-member board known as the Health Policy Commission will use the data to set and enforce rules to ensure that total Massachusetts health spending, public and *private,* grows no more than projected gross state product through 2017, and 0.5 percentage points lower thereafter." [Emphasis in original]

The mechanism to make those cuts in ObamaCare will likely be the Independent Payment Advisory Board (IPAB). While the IPAB is only making recommendations for Medicare, that could change, either explicitly or implicitly. For example, Medicare sets the prices the government will pay for both hospital procedures (Diagnosis Related Groups, or DRGs) and physician visits (Resource-Based Relative-Value Scale, or RBRVS). Because Medicare is such a large payer, its arbitrarily set prices become a benchmark for private sector insurers. In addition, private insurers often wait until Medicare agrees to cover certain therapies and prescription drugs before they do. It is probable that IPAB decisions will similarly become the benchmark for what therapies and drugs private insurers will cover and how much they will pay.

9. Allows Fewer Health Insurance Options.
ObamaCare creates four levels of qualified coverage: platinum, gold, silver and bronze. This approach largely abandons the trend towards so-called consumer driven health plans (CDHP), in which people get high-deductible insurance to cover major accidents or illnesses, combined with a tax-free health spending account known as a Health Reimbursement Arrangement or a Health Savings Account.

While the Obama administration denies that it has directly targeted consumer driven health insurance options, it has imposed "actuarial equivalence" requirements on policies dictating how much a policy must cover. That effort has raised substantial concerns about whether consumer driven policies would be able to meet the standards of "qualified coverage." That jury is still out.

The irony is that consumer driven plans are the one option that really is bending the health care cost curve. A recent Rand Corporation study found that 17 percent of Americans with employer-sponsored coverage were in a consumer driven plan, and that 59 percent of large employers offered

at least one CDHP. But more importantly, Rand found that families that switched to a CDHP spent 21 percent less on health care after switching than those who remained in a traditional health insurance plan. That is exactly the kind of response the president had hoped for his plan, but will never see short of explicit price controls.

Finally, only larger health insurers are well suited to offer the micromanaged, rich-benefit coverage requirements ObamaCare imposes. As a result, most small health insurers will not continue to offer health insurance options, leaving only a few of the largest insurers involved and dramatically reducing the competition.

10. Creates More Inefficiency.
Insurers selling to small companies and individuals must spend 80 percent of their received premiums on claims—known as the medical loss ratio (MLR)—leaving 20 percent for administrative costs, which under the law must include agent commissions, marketing and profit. Insurers selling to large companies must spend 85 percent on claims, leaving 15 percent for administration costs. Those companies that don't meet the MLR ratio will have to rebate to policyholders the difference between their MLR and the actual claims paid.

This top-down effort to control admin costs discourages actively managing claims costs, since there is no incentive to lower claims payouts below the MLR rate of 80 or 85 percent. Indeed, the law encourages inefficiency. Higher claims costs allow more dollars (in absolute terms) to be spent on administration costs, including profits. Thus, instead of looking for ways to cut claims costs, insurers may be more willing to pay questionable claims, creating exactly the kind of perverse economic inefficiency the legislation was trying to reduce.

11. Includes Pork and Calls It Prevention.
There was no way Washington—though only Democrats in this case—was going to pass a 2,700-page bill without stuffing it with pork, known as the Prevention and Public Health Fund. ObamaCare dedicates $16 billion over 10 years to this fund, which is supposed to go to communities to "invest" in ways to improve health care and address problems such as childhood obesity. However, critics have called it a slush fund that can be used, like earmarks, to reward supporters.

12. Cooks the Medicare Books.
ObamaCare requires the Medicare trustees to make several ludicrous assumptions in their annual report that makes Medicare look like it is in better shape than it is.

Fortunately, Medicare's Office of the Actuary has released, for the third time since Democrats pushed through ObamaCare in 2010, a 21-page "memorandum" to highlight the challenges—to put it mildly—the government faces in adhering to the Medicare and Medicaid growth rates imposed by the president's health care law.

The memorandum explains that ObamaCare requires the trustees to assume a steady decline in hospital reimbursement rates for both Medicare and Medicaid—to about 39 percent of what private insurance would pay in 2086.

Worse yet, the trustees must assume that physician reimbursements under Medicaid will drop to 55 percent of private health insurance by 2086, while physicians serving Medicare patients "would eventually fall to 26 percent of private health insurance levels."

The memorandum closes by warning that "readers should interpret the current-law Medicare projections cautiously." That's an understatement! "For example, the 2011 Trustees Report showed estimated Part B [physicians] expenditures of $220.5 billion for 2012. The actual amount is now expected to be $246.9 billion, which is $26.4 billion or 12 percent higher than last year's estimate …"

ObamaCare's Greatest Failure.
ObamaCare imposes a mid-20th century health insurance model on a 21st century global economy.

- The Internet brings consumers countless products and services from countless vendors; ObamaCare provides four choices from a handful of insurers.
- Technology creates fast-paced health care changes while ObamaCare's 2,700 pages ties up almost everything in the snail-paced legislative and bureaucratic processes.
- Innovators and entrepreneurs are asking what consumers want; ObamaCare tells both patients and providers what they can and can't have.

The Affordable Care Act looks backward—to the days of big-government and grand social schemes. It is the wrong policy for the dynamic and fast-paced 21st century. It is an albatross fit for 1960, not 2012.

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