Signed, sealed, delivered

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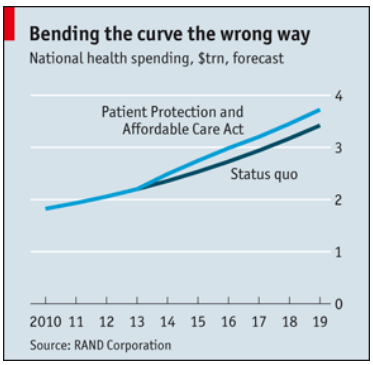
Barack Obama has transformed health reform from near death to fact. So how will Obamacare change America's health system?

THE Barack Obama who addressed Americans at near midnight on March 21st had every right to gloat. After a year in which his proposals for health reform were savaged by Republicans and leftists alike, and declared dead half a dozen times by everyone, he has somehow managed to get them over the finishing line.

The reform package is made up of two bills. One, a flawed and pork-laden version of health reform passed by the Senate before Christmas, has now been approved by the House; Mr Obama signed this on March 23rd. The other is a "reconciliation" bill meant to fix some of its flaws, and the House also passed this. Because this is a new bill, the Senate has to pass it too. It can do so under special "reconciliation" rules that require only 50 votes, not a filibuster-proof 60. As *The Economist* went to press, it looked set to do so.

What will it mean for America? The short answer is that the reforms will expand coverage dramatically, but at a heavy cost to the taxpayer. They will also do far too little to rein in the underlying drivers of America's roaring health inflation. Analysis by RAND, an independent think-tank, suggests that the reforms will actually increase America's overall health spending—public plus private—by about 2% by 2020, in comparison with a scenario of no reform (see chart). And that rate of spending was already unsustainable at a time when the baby-boomers are starting to retire in large numbers.



The heart of the new reform is a restructuring of America's flawed insurance market. Insurers now face tough new regulations forbidding such practices as dropping people with "pre-existing conditions" (real or trumped up), or putting lifetime caps on coverage.

In return, though, the insurance industry will benefit from a big expansion of the country's private insurance market. Heavily regulated exchanges, or insurance marketplaces, would be set up so that consumers not covered by employer-provided plans today could shop for ones more easily. Insurers would be required to offer plans that meet minimum government requirements for health coverage, and to price them transparently.

Some 32m of the country's 49m or so uninsured (most of those left out of the new scheme are undocumented aliens) would, starting in 2014, be required to take out insurance. The working poor and uninsured earning up to $88,000 a year get subsidies on a sliding scale so that they can afford to buy coverage; the poorest of all will be added to the rolls of Medicaid, a health scheme for the indigent. It is this binding requirement on individuals that exercises conservatives most.

They point to recent studies done by the Cato Institute, a libertarian think-tank, which, they claim, are early warnings of trouble to come. Cato recently examined the impact of introducing health reforms similar to Obamacare in Massachusetts a few years ago. It estimates that the law has not improved people's health, but has led to a "substantial crowdout of private coverage" and to 60% fewer young (and presumably healthy) adults moving to the state. It claims that the "leading estimates understate the law's cost by at least one third." Premiums have also risen.

If coverage is the new law's strong point, cost control is its weakness. That is not to say that most ordinary people will pay more for coverage, as critics of reform noisily insist. True, some of those forced to buy insurance will earn too much to qualify for subsidies, and so will be spending more than they do today—but, in return, they will get insurance plans that offer more generous coverage than current basic plans. What is more, many other Americans may end up with lower premiums.

The vast majority of workers enjoy health insurance today through employer-provided schemes. RAND estimates that by 2019 the employer-provided system will benefit from 6m new (mostly healthy) customers, and that premiums for everyone in that system will drop by 2% versus business-as-usual.

Fine, but what about costs to the federal government and the overall health system? The Congressional Budget Office (CBO), a non-partisan agency, estimates that the new health reforms will cost the federal government some $940 billion over the next decade. Of that, roughly $400 billion will be spent by 2020 on the subsidies and about $500 billion on increased spending on Medicaid.

But that underestimates the full cost of this new reform. Elizabeth McGlynn of RAND points out that the huge numbers of newly insured—who now typically skip medical care or simply turn up, in a crisis, in emergency rooms—will soon consume a lot of routine medical services. She thinks this spending will expand the country's health outlays even more than the direct cost to the federal exchequer.

This need not be a waste of money. Spending more on routine care today is sure to save some money in the long run: paying for someone to pop statin pills daily, for example, is much cheaper than treating his eventual heart attack. The snag is that economists disagree on whether and how much this will really save the government or the health system. What is clear, argues Ms McGlynn, is that this new spending will improve the health and probably extend the lives of those many unfortunates currently without insurance.

Paying the piper

So how is the bill going to be paid? The CBO's analysis suggests that the federal deficit will be slashed by well over a trillion dollars over the next two decades by this reform. That suggests this reform effort is fiscally prudent. Not so, howl Republicans. Paul Ryan, a Republican congressman, believes the reforms will prove a "fiscal Frankenstein" (meaning the monster) because the CBO's rules on "scoring" bills have led it to rely on several sleights of hand.

For example, insist critics, a big chunk of the savings is made up of politically implausible cuts in doctors' reimbursements (known as the "doc fix") and in Medicare, the government health scheme for the elderly. Also, some of the income provisions will kick in soon, but the main spending on subsidies will not begin until 2014—skewing the ten-year analysis. The cost to the government of expanding coverage over the ten years from 2014 to 2023 will be $1.6 trillion, not $940 billion.

Such talk infuriates Peter Orszag, the head of the White House's Office of Management and Budget and the administration's most important health expert. He insists all the fuss about ten-year windows obscures three big ways in which this reform will curb costs, by shifting the incentives in the delivery system to reward value and results rather than mere piecework (or "fee for service").

The first big idea that he stresses is the creation of a new agency to spearhead innovation and scale up any of the many pilot schemes contained in the bills that manage to reform delivery or payment systems. It is true that the reform effort began with earnest intent to "bend the cost curve". Alas, explains Mark McClellan of the Brookings Institution, the most meaningful proposals have since been watered down or delayed.

The second lever of change that Mr Orszag says is underappreciated is an excise tax introduced on the most expensive (or "Cadillac") insurance plans. Most economists like this idea, as it is likely to discourage excessive consumption of health care. Unfortunately, because of political pressure from labour unions and other groups, the Cadillac tax has been diluted, and delayed until 2018. Sceptics wonder if a future Congress will really implement this tax when the time comes. Mr Orszag is right that, if implemented, this provision will represent an important lever of cost control. But it's a big "if".

The third and strongest argument Mr Orszag makes is for the potential of an independent payment-advisory board on Medicare spending. Under the new law this group is to make recommendations to Congress on how to reduce the rate of growth in spending per head in Medicare if that expenditure exceeds a target figure.

Sceptics abound. Yes, the approach succeeded when used by the Pentagon to decide which military bases to shut down. But an earlier version of this idea, known as MedPAC, flopped because Congress simply ignored even worthy ideas that proved politically inconvenient. And the new law carves out a ten-year exemption for hospitals—appalling, when one considers that runaway costs and misaligned incentives in hospitals lie at the very heart of the cost problem. But Mr Orszag believes this approach will help in two ways: it insulates tough decisions from politics, and it encourages ongoing reform rather than one-shot heroics. Critics say that is a lot of faith to put in a weakened body.

All this points to the only certain thing about Obamacare: that this is just another episode in the long saga of health reform. Indeed, by adding tens of millions of people to an unreformed and unsustainably expensive health system, this reform makes it all the more urgent to tackle the question of cost.

On that, at least, left and right seem to agree. Paul Krugman, an economics professor at Princeton and a liberal booster of reform, wrote on the eve of the votes: "There is, as always, a tunnel at the end of the tunnel: we'll spend years if not decades fixing this thing." Robert Moffit of the Heritage Foundation, a conservative think-tank opposed to the effort, agrees, albeit in darker terms: "This marks the beginning of the next phase of this hundred years war."