Utah FOUNDATION Research Report

Report Number 711, October 2012

THE AFFORDABLE CARE ACT:
PLACING HEALTHCARE REFORM IN A HISTORICAL AND COMPARATIVE CONTEXT

HIGHLIGHTS

- Healthcare has been the fourth highest priority for Utah voters in each gubernatorial election since 2004, however, concern with this issue increased this year, with 69% of voters saying they were concerned or very concerned with healthcare.
- The issue of healthcare is also divisive, with 75% of Utah Republican voters saying the ACA should be repealed, compared to only 12% of Democratic voters.
- Healthcare expenditures have grown dramatically over the last half century. They made up just over 5% of GDP in 1960; by 1980 this was over 9%, and nearly 14% by 2000. In 2010, health expenditures made up nearly 18% of the nation's GDP.
- Healthcare reform has been an important issue in American politics for over a century. There have been many attempts to enact universal health care coverage, but none succeeded until the Affordable Care Act was passed in 2010.
- In *National Federation of Independent Business v. Sebelius*, the Supreme Court ruled that the individual mandate was constitutional, but allowed states to opt out of the Medicaid expansion. Governor Herbert has indicated that he will wait until after the election to decide on the expansion.

10 West Broadway, Suite 307
Salt Lake City, UT 84101
(801) 355-1400 • www.utahfoundation.org

Healthcare reform has been debated in the United States for much of the last century. In 2008, it was a major issue in the presidential election, and Barack Obama was elected on a platform that included an overhaul of the nation's healthcare system. The year following his inauguration was noted for intense debate over healthcare reform, but eventually the Affordable Care Act (ACA), now more commonly known as "Obamacare," was passed in March 2010. Because of the controversial and complex nature of this legislation, a great deal of misinformation is often accepted as fact.

A part of Utah Foundation's mission is to provide "thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues." To that end, this policy paper will present the history and facts about the Affordable Care Act in a straightforward and nonpartisan manner, to enable citizens and policymakers to fully understand its complexities and nuances. It also provides a broad overview of the history of healthcare reform, presents various healthcare models used throughout the world, and explains how the ACA compares to those models. It also addresses healthcare within Utah, and assesses how the implementation of the ACA will affect this state.

HEALTHCARE AS A PRIORITY

During each major election year since 2004, Utah Foundation has conducted the Utah Priorities Survey in order to prioritize the concerns of Utah voters. In the 2012 Utah Priorities Survey, 69% of respondents indicated that they were concerned or very concerned with healthcare, making it the fourth most important issue to voters in this election year. Healthcare has consistently been an important issue to voters throughout the past decade, ranking as the fourth priority for voters in each major election since 2004. In the survey, respondents were asked to rate each issue on a scale of one to five, five meaning they are very concerned about the issue and one meaning they are not at all concerned. In this year's survey, the mean score of healthcare was 3.98, the highest this issue has received in any of the surveys. In addition, more respondents indicated that healthcare was their top election concern than in any of the previous surveys.[1] Therefore, although its ranking has remained consistent, voters are more concerned with healthcare than in previous elections.

Figure 1: 2012 Utah Priorities Survey of Voters and Delegates

How important are the following for the State of Utah's elected officials to address?

Lowering the costs of healthcare

	Republican Delegates	Democratic Delegates	Republican Voters	Democratic Voters	Independent Voters	All Voters
Not Important	10%	2%	9%	8%	8%	8%
Relatively Neutral	46%	28%	43%	25%	35%	37%
Important	43%	69%	47%	67%	55%	53%

Expanding the availability of healthcare coverage

	Republican Delegates	Democratic Delegates	Republican Voters	Democratic Voters	Independent Voters	All Voters
Not Important	17%	2%	13%	8%	9%	11%
Relatively Neutral	56%	16%	47%	18%	38%	38%
Important	25%	82%	40%	74%	52%	50%

To what extent do you agree or disagree with the following statement?

The 2010 federal healthcare law should be repealed.

	Republican Delegates	Democratic Delegates	Republican Voters	Democratic Voters	Independent Voters	All Voters
Disagree	2%	80%	5%	59%	28%	20%
Relatively Neutral	7%	13%	16%	21%	23%	19%
Agree	90%	6%	75%	12%	44%	56%

Healthcare is not only an important issue to voters, but a divisive one as well. The Utah Priorities Survey of Party Delegates and Voters, which was conducted two months after the Priorities survey, showed that Democratic delegates and voters were more likely to prioritize healthcare issues than Republicans. When asked about important issues that state officials should address, 67% of Democratic voters felt it was important to lower the costs of healthcare, compared to 47% of Republican voters. Similarly, 74% of Democratic voters felt it was important to expand the availability of healthcare coverage, compared to just 40% of Republican voters. The starkest difference between the parties concerned the ACA. When asked if it should be repealed, 75% of Republican voters agreed, compared to only 12% of Democratic voters.[2] Not surprisingly, the differences between Republican and Democratic delegates regarding these issues were even more drastic.

HEALTHCARE REFORM IN THE UNITED STATES

Healthcare reform has been an important issue in American politics for over a century. Reform efforts often come as advocates argue that costs for medical care have grown too high. As shown in Figure 2, health expenditures per capita have grown significantly over time, from just $1,083 (in 2010 dollars) per capita in 1960, to over $6,000 in 2000 and over $8,400 in 2010. In addition, national health expenditures have grown to make up more of a share of the national GDP each year. As shown in Figure 3, health expenditures made up just over 5% of GDP in 1960; by 1980 this was over 9%, and nearly 14% by 2000. In 2010, national health expenditures made up nearly 18% of the nation's GDP.

Early in the 20th century, many European countries were developing social welfare programs that would eventually develop into their current healthcare programs. While "sickness insurance" could be purchased through employers rather inexpensively, efforts to reform healthcare in the United States failed, in part because there was not powerful working-class support for broad social insurance in the U.S. as there was in Europe.[3]

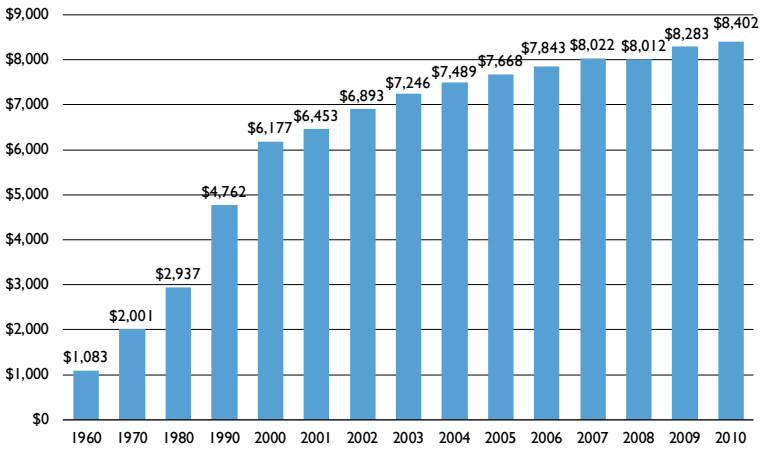
During the Great Depression, medical costs rose and access to healthcare worsened as people could not afford medical services. Citizen groups began to organize calling for social policies to secure employment, retirement, and medical care. In 1934, President Roosevelt appointed a Committee on Economic Security to report on all these issues. While the committee's report did address national health insurance reform, President Roosevelt did not press the policy because he did not want to risk the passage of the Social Security Act.[4] The American Medical Association had strong opposition to such a plan, arguing it would increase bureaucracy, limit physician freedom and interfere with doctor-patient relationships.[5]

President Truman pushed for a national health insurance plan several times during his presidency, but each attempt failed. During this time, hospitals began to offer insurance programs, in part to protect themselves from reduced revenues and occupancy caused by the Great Depression.[6] The first of these was Baylor Hospital, which introduced a pre-paid hospital insurance plan for a group of schoolteachers in 1929. This plan is considered the forerunner of future nonprofit Blue Cross plans.[7] As more hospitals and physician groups began selling group health insurance policies to employers, it became more commonplace for Americans to access health insurance through their employers. These policies also became more widely offered as "fringe benefits" designed to attract employees since employers were forbidden to increase pay because of wage controls during the Great Depression and World War II.[8]

In 1954, Congress passed the Internal Revenue Act, which excluded employee benefits such as pensions or contributions to health plans from taxable income.[9] By this time, it is estimated that 77 million people, or half of the nation's population, had purchased some type of voluntary sickness or accident insurance.[10]

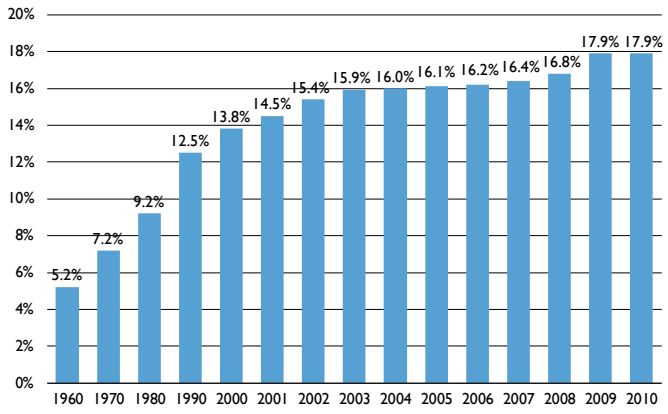
The establishment of Medicare and Medicaid in the 1960s represented the most significant healthcare reform of the 20th century. As employer-based health coverage grew, private plans began to use "experience ratings" to set health premiums, making it more difficult for the sick and elderly to get affordable coverage. Federal grants to help the states provide coverage failed, leading Congress to pass more comprehensive legislation.[11] After an intense congressional

Figure 2: U.S. Health Expenditures Per Capita (2010 Dollars)



Source: Centers for Medicare and Medicaid. Inflation adjustment calculated by Utah Foundation.

Figure 3: U.S. Health Expenditures as a Share of GDP



Source: Centers for Medicare and Medicaid.

battle in which supporters argued these policies were necessary, and opponents claimed they represented socialized medicine, President Johnson signed the Social Security Act in July 1965. This legislation established three programs: Medicare Part A paid for hospital care and limited skilled nursing and home healthcare for those over the age of 65, or who met other criteria; optional Medicare Part B (paid in part by premiums) helped pay for physician care for the elderly; and Medicaid, which was established to assist states in covering long-term care for the poor and in providing health insurance coverage for the poor and disabled.

As inflation and healthcare costs increased in the 1970s, several plans for national health insurance were proposed, including proposals from Senator Edward Kennedy and President Richard Nixon. Each of these plans, however, splintered support for any one reform. Action on national health insurance was eventually overshadowed by the Watergate scandal and Nixon's resignation, as well as the 1973 oil crisis and the 1973-75 recession. Later in the decade, President Carter prioritized national health reform, but these efforts were stalled in the face of more economic difficulties, inflation and a second oil crisis.

Throughout the 1980s, Congress passed several bills that essentially expanded Medicare and Medicaid coverage. In 1986, President Reagan signed the Consolidated Omnibus Budget Reconciliation Act (COBRA) into law, which allowed employees to stay on their group health insurance plans up to 18 months after losing their jobs, provided that they pay the premiums.

In 1993, President Bill Clinton proposed the Health Security Act, which called for universal coverage, employer and individual mandates, and competition between private insurers, which was to be regulated by government to keep costs down. Under the plan, private insurers and providers would compete for groups of businesses and individuals in what were called "health-purchasing alliances," and every American would have a "health security card." The size and complexity of the plan not only stymied its passage in Congress but also made it difficult to generate popular support. This was compounded by partisan politics, powerful lobbying groups, and a Clinton administration policy that was viewed as combative and secretive.[12] Eventually, the divided Democratic majority in Congress could not garner enough votes to pass the legislation, and attempts to push it forward stopped after the election of 1994 when Republicans took control of both the U.S. House of Representatives and the Senate. Later in the decade, with a Republican Congress and bipartisan support, the Children's Health Insurance Program was enacted, building on the Medicaid program to provide health coverage to more low-income children.[13]

In 2003, President George W. Bush signed the Medicare Modernization Act into law, which expanded Medicare to include prescription drug coverage. Similar legislation had been passed by Congress in the late 1980s, only to be repealed a year later. This type of policy was still controversial, in part because it included a significant financial gap for seniors that came to be known as the "donut hole," and the program's cost was not offset in the budget by increased revenues.

During the 2008 presidential election season, healthcare reform was a major issue. Barack Obama was elected on a platform that included an overhaul of the nation's healthcare system.[14] Throughout 2009 and into early 2010, healthcare legislation dominated political discourse throughout the country. After months of formal debate in Congress, President Obama signed the ACA into law on March 23, 2010; this legislation comprises the Patient Protection and Affordable Care Act (Public Law 111-148) and the healthcare provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). The law established comprehensive health insurance reforms that would roll out throughout the following decade, with most changes taking place by 2014. The passage of this law did not mark the end of the debate, as opponents introduced legislation to repeal the ACA the day after the president signed it.

Figure 4: Timeline of Healthcare Reform in the United States

1912	Former President Teddy Roosevelt endorses social insurance as part of his platform during an unsuccesful run for the presidency.
1929	Baylor Hospital introduces a pre-paid hospital plan for a group of school teachers.
1934	FDR creates the Committee on Economic Security to address issues dealing with the elderly, unemployment, medical care and insurance. However, the final Social Security Act does not address national health insurance reform.
1945-53	President Truman makes several efforts to implement a national health insurance program, each attempt fails.
1951	An estimated 77 million people, or have the nation's population, had purchased some type of voluntary accident or health insurance.
1954	Employers' contributions to employee health plans can be excluded from taxable income.
1965	The Social Security Act is passed, establishing Medicare and Medicaid.
1970s	Several attempts to reform the health care system are attempted, but are overshadowed by Watergate scandal, inflation, economic difficulties and the oil crisis.
1980s	Congress passes several bills to expand Medicare and Medicaid.
1986	The COBRA law allows employees to stay on their group health insurance plans up to 18 months after losing their jobs.
1993-94	President Clinton proposes the Health Security Act, often dubbed Hillarycare, which would have provided universal health care for all Americans. The controversial legislation is never passed.
2003	The Medicare Modernization Act expands Medicare to include prescription drug coverage, but still leaves a coverage gap known as the "donut hole."
2008	Healthcare reform is a major part of the presidential primaries and general election.
2010	The Affordable Care Act is passed, establishing comprehensive health insurance reforms that would roll out throughout the following decade. Most notably, the law includes a mandate that, with a few exclusions, all individuals must purchase health insurance.
2012	The Supreme Court largely upholds the ACA in National Federation of Independent Business v. Sebelius.

Source: Kaiser Family Foundation

Since it was passed, dozens of votes have taken place to repeal or defund portions of the law.

Soon after the ACA was passed, a number of parties sued the federal government, claiming that the law was unconstitutional for various reasons. These cases eventually were merged into *National Federation of Independent Business v. Sebelius*, and decided upon in the U.S. Supreme Court. On June 28, 2012, the Court upheld the individual mandate, a provision in the ACA requiring individuals to purchase healthcare or face a penalty, declaring the penalty implemented as a tax was constitutional.[15] Immediately following the Supreme Court decision that upheld the ACA, opponents once again vowed to repeal it.

MAJOR COMPONENTS OF THE ACA

The final version of the ACA was over 2,400 pages, and the Supreme Court case regarding the law was nearly 200 pages. The breadth and depth of this law make understanding it difficult. However, this section of the report explains the major components of the law.

Individual Mandate

All individuals are required to have insurance, with some exceptions, beginning in 2014. Those who are not covered by an employer-sponsored health plan, Medicaid, Medicare or other public plan, must purchase an insurance policy unless they fall under one of the few exemptions provided in the law. Those who do not purchase coverage will be required to pay a yearly financial penalty of $695 per person or 2.5% of household income, whichever is greater. The penalty will be phased in over a number of years according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016; or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. After 2016, the penalty will be increased annually by cost of living adjustments. Exemptions are given for financial hardship, for religious objections, to American Indians, or to people who are uninsured for less than three months.[16] This portion of the law was especially controversial, but the penalty was upheld as a tax in the Supreme Court decision.

Changes to Private Insurance

The ACA enacted several policies that will profoundly influence private insurance:

- Individuals may not be denied insurance coverage because of pre-existing medical conditions. In addition, insurers will be required to offer the same premiums to all applicants of the same age and location regardless of gender or pre-existing conditions.
- Young adults will be allowed to remain on their parent's health insurance up to age 26.
- Health insurers will be prohibited from imposing annual or lifetime limits on coverage or from rescinding coverage.
- New health plans will be required to cover certain preventive services with no co-pays or deductibles.
- Insurers will be required to spend at least 80% of premiums on medical costs.

Health Insurance Exchanges

Each state will offer a health insurance exchange where individuals and small businesses can compare policies and premiums and ultimately purchase insurance. Low-income individuals and families will receive federal subsidies if they choose to purchase insurance through such exchanges. Access to these exchanges will be limited to U.S. citizens and legal immigrants.

Expansion of Medicaid Eligibility

Medicaid eligibility will expand to include all individuals and families at or below 133% of the poverty level, which for a family of 5 in Utah, is equal to $2,859 a month.[17] This creates a new minimum Medicaid eligibility level for adults and eliminates the limitation that prohibited most adults without dependent children from enrolling. The federal government will provide 100% of the funding for the costs of the newly eligible Medicaid recipients from 2014 to 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% beginning in 2020. The U.S. Supreme Court ruling allowed states to opt out of this expansion. Utah's Governor Gary Herbert has indicated that he is not completely against this expansion, but

Figure 5: Timeline of Major ACA Policies

May 2010 (at enactment)	The FDA is authorized to approve generic versions of certain drugs and allows certain drug manufacturers 12 years of exclusive use before generics can be developed.
	The Medicaid drug rebate for brand name drugs is increased and extended.
	Certain chain restaurants are required to display the caloric content of their foods on menus and vending machines.
June 21, 2010	Adults with pre-existing conditions are eligible to join a temporary high-risk pool, to be replaced by the health care exchange in 2014.
September 23, 2010	Insurers are prohibited from imposing lifetime dollar limits on essential benefits, dropping policy holders when they get sick, and their abilities to enforce annual spending caps are restricted.
	Dependent children are allowed to remain on their parents' insurance plans until the age of 26.
	Children cannot be denied health insurance because of pre-existing conditions.
	All new insurance plans must cover preventive care and medical screenings of certain ratings, and cannot charge co-payments or deductibles for these services.
	All new insurance plans must include childhood immunizations and recommended adult vaccinations.
	Individuals affected by the Medicare "donut hole" will receive a $250 rebate.
January 1, 2011	Medical Loss Ratio: Insurers must spend 80-85% of premium dollars on health costs and claims.
	Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap and begins phasing-in federal subsidies for generic prescriptions.
March 23, 2011	Provides grants to states to begin planning for American Health Benefit Exchanges and Small Business Health Options Program Exchanges.
September 1, 2011	The "Rate Review" policy goes into effect: all health insurance companies must inform the public when they will increase health insurance rates by 10% or more.
August 1, 2012	All new insurance plans must cover preventative services without charging a co-pay, co-insurance or deductible.
January 1, 2013	A tax of 0.9% will be imposed on individuals with an annual income above $200,000 or married couples filing jointly with annual income above $250,000.
	Increases the Medicare Part A tax rate on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly. Also imposes a 3.8% tax on unearned income for higher-income taxpayers.
August 1, 2013	Religious organizations are no longer exempt from the contraceptive mandate.
January 1, 2014	Insurers cannot charge higher rates based on gender or pre-existing conditions.
	An annual penalty of $95, or up to 1% of income (whichever is greater), is levied on individuals not covered by an acceptable insurance policy.
	Medicaid eligibility is expanded in certain states.
	Health insurance exchanges are established.
October 1, 2015	States can transfer children currently covered by CHIP to health care plans sold on their exchanges.
January 1, 2016	States are permitted to form health care choice compacts and allows insurers to sell policies in any state participating in the compact.
January 1, 2018	A 40% excise tax on high cost "Cadillac" insurance plans is introduced.
	All existing health insurance plans must cover approved preventive care and checkups without co-payment.
January 1, 2020	The Medicare Part D "donut hole" is completely closed.

Source: Kaiser Family Foundation.

believes the federal government should allow states more flexibility to provide healthcare.[18]

Preventive Care

Co-payments and deductibles will be eliminated for certain healthcare insurance benefits considered to be preventive care, such as annual doctors' visits or certain types of screenings.

Medicare Part D Coverage Gap

Currently, when beneficiaries of Medicare reach the prescription drug coverage limit, they become financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold. The ACA will provide significant personal savings to individuals who fall in this "donut hole."[19] Beginning in 2010, Medicare beneficiaries who reached the Part D coverage gap received a $250 rebate. The gap will then be phased down gradually until 2020. For brand-name drugs, pharmaceutical manufacturers are now required to provide a 50% discount on prescriptions filled in the coverage gap. Additionally, federal subsidies of 25% of the brand-name drug cost will begin to be phased in beginning in 2013. For generic drugs, federal subsidies of 75% are now provided for prescriptions filled in the coverage gap.

THE AFFORDABLE CARE ACT AND THE FEDERAL BUDGET

In March 2011, the Congressional Budget Office (CBO) estimated that for the 2012–2021 period, the insurance coverage provisions of the ACA would have net costs of over $1.1 trillion, but when other provisions that affect spending and revenues were taken into account, government outlays would increase by a cumulative of $604 billion.[20] It is expected that the costs of the ACA will be offset by an $813 billion increase in revenues, resulting in a $210 billion reduction in the federal deficit over the ten-year period.[21] In March 2012, the CBO and Joint Committee on Taxation (JCT) revised the projected costs of the ACA to reflect new legislation, technical changes and updated economic data. According to the new estimates, the insurance coverage provisions of the ACA will have a net cost of $1.25 trillion over the 2012–2021 period.[22]

Projected cost and revenue projections were once again updated in July 2012 to reflect the Supreme Court decision, specifically, the portion that allowed states discretion regarding Medicaid expansion. The CBO and JCT estimated that the Medicaid program would cover fewer people than originally expected, as more people will obtain health insurance through state insurance exchanges or would be uninsured. According to these new estimates, the ACA will have a net cost of $1.17 trillion over the 2012–2022 period, a net reduction of $84 billion from the March 2012 estimates.[23]

The ACA raises a large share of its revenue from taxes on high-income households, such as an additional Medicare payroll tax on those with incomes over $200,000 (single) and $250,000 (married). The law also creates an excise tax on high-cost plans.[24] Additionally, provisions are designed to offset the costs of the coverage expansions under the ACA, including one designed to slow the growth of federal healthcare spending by a reduction in Medicare Advantage plan payments and the development of tools to help reduce fraud and waste in Medicare and Medicaid.

In July 2012, the CBO released analysis of H.R. 6079, a bill that aimed to repeal the ACA. The CBO and Joint Committee on Taxation (JCT) estimated that this bill would increase federal budget deficits. Deficits would be increased because the net savings from eliminating the insurance coverage provisions would be offset by the combination of other spending increases and revenue reductions. In total, H.R. 6079 would reduce direct spending by $890 billion, but reduce revenues by $1 trillion over the 2013–2022 period, thus adding $109 billion to federal budget deficits over that period. The CBO also noted that the estimated budgetary effects of repealing the ACA are not equivalent to an estimate of the budgetary effects of the ACA with "the signs reversed."[25]

HOW THE AMERICAN HEALTHCARE SYSTEM COMPARES

There are many ways in which countries throughout the world attempt to manage healthcare. Despite these variations, healthcare systems tend to follow general patterns and can be grouped into four basic systems: the Beveridge Model, the Bismarck Model, the National Health Insurance Model and the Out-of-Pocket Model.[26] The healthcare system in the United States has elements of each of these models. This section will also compare the ACA to the healthcare system in Massachusetts, which was significantly reformed in 2008 and served as a model for some of the national reforms in the ACA.

The Beveridge Model

In the Beveridge Model, healthcare is provided and financed by the government through tax payments. Medical care is treated as a public service, much like public education or the police department is treated in the United States. These systems tend to have low costs per capita, because the government controls what doctors can charge. England is the birthplace of the Beveridge Model, and there, healthcare is provided to all residents through the National Health Service (NHS), including hospital and physician services and prescription drugs. The NHS is financed primarily through general taxation and requires very little patient cost sharing.[27] The Beveridge Model is also utilized in Spain, most of Scandinavia and New Zealand. In the United States, the treatment of military veterans through the Department of Veterans Affairs is similar to the Beveridge Model.

The Bismarck Model

The Bismarck Model, also known as the Socialized Medicine Model, uses a non-profit insurance system that is required to cover all citizens, and is usually financed jointly by employers and employees through payroll deduction. Costs are controlled through tight regulation of medical services and fees. This model originated in Germany, and is named for Prussian chancellor Otto von Bismarck, the father of the welfare state. In Germany, most residents receive statutory coverage through competing nongovernmental social insurers, or "sickness funds." The statutory system is financed through employer and employee contributions, which are pooled into a central fund and redistributed among the sickness funds. These offer a uniform benefit package covering most medical care, prescription drugs, and dental care.[28] The Bismarck Model is also used in France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America. The U.S. approach resembles the Bismarck Model when insurance is provided through employers but differs in most other respects.

Figure 6 : Healthcare Models

Model	Description	Countries That Utilize Model
Beveridge Model	Healthcare is provided and financed by the government through tax payments. Healthcare is viewed as a public service, and per capita costs are kept low by government controls.	Great Britain, Spain, New Zealand, Hong Kong, Cuba, most of Scandinavia
Bismarck Model	Also known as socialized medicine, uses a non-profit insurance system that is required to cover all citizens, and is usually financed jointly by employers and employees through payroll deduction. Costs are controlled through tight regulation.	Netherlands, Japan, Switzerland
National Health Insurance Model	Also known as the single-payer model, uses private-sector providers, but payments come from government-run insurance programs that every taxpayer pays into. Controls costs by giving the single payer the power to negotiate lower prices, limiting the medical services that will be paid, and wait periods.	Canada, Taiwan, South Korea
Out-of-Pocket Model	Those who can afford medical care receive it.	Most countries in the developing world

As noted in the text, the U.S. heatlhcare system is composed of elements of all four models.

National Health Insurance Model

The National Health Insurance Model (NHI), also known as the Single-Payer Model, uses private-sector providers, but payments come from government-run insurance programs that every taxpayer pays into. This type of plan controls costs by giving the single payer considerable market power to negotiate lower prices, by limiting the medical services they pay for, or by making patients wait to be treated. The most well-known national health insurance system is found in Canada, where each province is responsible for delivering care within its borders according to a broad set of principles laid out in the Canada Health Act. Medically necessary hospital and physician services are fully covered across provinces, although there are variations in prescription drug coverage.[29] This type of system can also be found in Taiwan and South Korea. The U.S. utilizes this model when treating Americans over the age of 65 on Medicare.

Out-of-Pocket Model

The final model is the Out-of-Pocket Model, which basically applies to most developing countries. Such countries are generally too impoverished to provide any kind of mass medical care. Industrialized nations are almost exclusively the only countries which provide some type of universal healthcare.[30] In impoverished nations, however, only those who can afford medical care receive it. This type of system can be found in rural or impoverished regions of Africa, India, China and South America, where hundreds of millions of people go their entire lives without ever seeing a doctor.[31] Under the ACA, the U.S. system will theoretically no longer resemble the Out-of-Pocket Model, to the extent that individuals comply with the mandate.

Massachusetts

The Massachusetts State Legislature passed a healthcare reform law in 2006, informally referred to as Romneycare. This law mandated that all Massachusetts residents, with a few exceptions, obtain health insurance and show evidence of their coverage on their income tax return or face a tax penalty. The statute also created a clearinghouse for insurance plans and payments, and established the subsidized Commonwealth Care Health Insurance Program, which allows residents who do not have health insurance and make below 300% of the federal poverty level access to certain subsidized private insurance health plans. The law also expanded MassHealth (Medicaid) and the Children's Health Insurance Program coverage for low-income children.

The Massachusetts healthcare reform statute and the ACA are similar in several ways. For instance, in Massachusetts, companies with more than 10 employees must offer health insurance or pay penalties; at the federal level this requirement applies to companies with 50 employees or more. In Massachusetts, dependents up to age 25 can be covered on their parents' plans; the federal law allows dependent coverage up to age 26. Young adults in Massachusetts from age 19 to 26 can purchase special lower-cost, lower-benefit plans through the exchange; the federal law creates a similar type of plan in the exchange for those up to age 30 who cannot find affordable coverage. Both plans reformed the private insurance markets. In Massachusetts, the law merged the individual and small-group markets; the federal law placed new regulations on those two markets but kept them separate. Finally, both plans put limits on the ratio between the highest and lowest premiums. In Massachusetts, the highest premiums can only cost twice as much as the lowest; at the federal level, premiums can only vary based on age and geographic area.

There are also important differences between the Massachusetts plan and the federal law. The Massachusetts plan has no cost-containment provisions, while the federal law makes changes that are intended to lower program costs. Both plans are financed in part by revenue generated from the individual and employer mandates, but the Massachusetts plan's financing is heavily dependent on leveraging federal matching funds, while the federal plan taps cost savings from levying new taxes on, for example, high-cost healthcare plans.

Figure 7: Insurance Coverage for Utah (2010-11) and the U.S. (2011)

	Utah		U.S.	
	Total	Children	Total	Children
Employer	59.5%	63.9%	48.5%	49.9%
Individual	5.7%	5.3%	5.0%	4.0%
Medicaid	9.5%	17.6%	16.5%	34.9%
Medicare	10.5%	na	13.0%	na
Other Public	na	na	1.2%	1.4%
Uninsured	14.3%	11.2%	15.8%	9.7%
Total	100.0%	100.0%	100.0%	100.0%

Source: Kaiser Family Foundation, Current Population Survey.

Figure 8: Percent of the Population who are Uninsured, Utah and U.S.

Source: U.S. Census Bureau, Current Population Survey.

HEALTHCARE IN UTAH

A majority of people in Utah had coverage through employment-based private insurance (59.5%) in 2010-2011, followed by coverage through Medicare (10.5%), Medicaid (9.5%) and individual private insurance (5.7%). At the national level, a plurality of people had coverage through employment-based private insurance as well (48.5%), followed by Medicaid (16.5%), Medicare (13.0%), individual private insurance (5.0%), or other public-based insurance (5.0%). Within Utah, 14.3% of the population is uninsured, compared to the national average of 16.5%.[32]

Within Utah, 17.5% of children were on Medicaid in 2010, and 34.9% of children within the United States were on Medicaid; this means a larger proportion of children than adults were on Medicaid at both the state and national levels. This is because Medicaid and CHIP, or the Children's Health Insurance Program, provide no-cost or low-cost health coverage for eligible children. This makes it so fewer children are uninsured in Utah (11.2%) and at the national level (9.7%).

As shown in Figure 8, the proportion of people who are uninsured has increased over the last decade, both in Utah and at the national level. In 1999, fewer than 12% of Utahns were uninsured, in 2011, it was over 14%. At the national level, the proportion of uninsured grew from 14% in 1999 to 16% in 2011.

One of the requirements of the ACA is that each state establishes a health insurance exchange where individuals and small businesses can purchase health insurance by 2014. However, Utah developed its own exchange in 2010, making it the second state in the nation to do so.[33] The exchange is a virtual market where people can compare health insurance plans using a fixed amount of money from their employer. The "defined-contribution" design helps employers better predict out-of-pocket costs and allows employees to pick the policy that best suits them. This exchange was renamed Avenue H in 2012, in part to differentiate it from a government-run program.[34]

In *National Federation of Independent Business v. Sebelius*, the U.S. Supreme Court allowed states to opt out of the Medicaid expansion. Utah's Governor Gary Herbert has indicated that he has several important questions for the federal government before he decides whether to accept or opt out of the expansion. He has also indicated that he wants to wait until after the presidential election, saying "If President Obama is re-elected that will tell us one thing about the direction of healthcare in this country. If Gov. Romney is elected... it will change the direction of healthcare and hence, Medicaid as we go forward for the next four years."[35]

ENDNOTES

1 "Study Conducted for Utah Foundation: Utah Priorities Project," Dan Jones and Associates, February 2012.

2 Utah Foundation Report 708, "The 2012 Utah Priorities Survey of Party Delegates and Voters," April 2012.

3 Murray, John E. (2007). *Origins of American health insurance: a history of industrial sickness funds.* New Haven: Yale University Press.

4 "National Health Insurance: A Brief History Of Reform Efforts In The U.S.," Kaiser Family Foundation, March 18, 2009.

5 "A History of Overhauling Healthcare," New York Times. Available at: http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html

6 "Tax Policy and the History of the Health Insurance Industry," Robert B. Helms, American Enterprise Institute, February 29, 2009.

7 "Timeline: History of Health Reform Efforts in the U.S.," The Kaiser Family Foundation. Available at: http://healthreform.kff.org/flash/health-reform-new.html

8 Ibid

9 "National Health Insurance: A Brief History Of Reform Efforts In The U.S.," Kaiser Family Foundation, March 18, 2009.

10 "A History of Overhauling Healthcare," New York Times.

11 "National Health Insurance: A Brief History Of Reform Efforts In The U.S.," Kaiser Family Foundation, March 18, 2009.

12 A History of Overhauling Healthcare," New York Times.

13 "National Health Insurance: A Brief History Of Reform Efforts In The U.S.," Kaiser Family Foundation, March 18, 2009.

14 "Healthcare Reform: Major Moments in History," The Washington Post, June 2012.

15 *National Federation of Independent Business, et al. v. Kathleen Sebelius, Secretary of Health and Human Services, et al.; Department of Health and Human Services, et al. v. Florida, et al.; Florida, et al. v. Department of Health and Human Services, et al*. U.S. Supreme Court, 567 U.S.

16 Implementation Timeline, Kaiser Family Foundation. Available at: http://healthreform.kff.org/timeline.aspx

17 Utah Medicaid Program. Available at: http://health.utah.gov/medicaid/

18 "GOP governors name their price on healthcare law expansion," Politico, July 14, 2012. Available at: http://www.politico.com/news/stories/0712/78499.html#ixzz27WZezQMh

19 "AP Newsbreak: Medicare's drug coverage gap shrinks," Ricardo Alonso-Zaldivar, Associated Press, November 27, 2011.

20 "CBO's Analysis of the Major Healthcare Legislation Enacted in March 2010," Congressional Budget Office, March 30, 2011.

21 Ibid

22 "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," Congressional Budget Office, March 30, 2012.

23 Figures do not include the budgetary impact of other provisions of the ACA, which in the aggregate reduce budget deficits.

24 "ACA: A Brief Overview of the Law, Implementation, and Legal Challenges," Congressional Research Service, March 2, 2011.

25 "Letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act," Congressional Budget Office, July 24, 2012.

26 "Healthcare Systems: Four Basic Models," PBS, April 15, 2008.

27 "International Profiles of Healthcare Systems," The Commonwealth Fund, June 2010.

28 Ibid

29 Ibid

30 "A Map of the Countries That Provide Universal Healthcare (America's Still Not on It)," *The Atlantic*, June 28, 2012. Available at: http://www.theatlantic.com/international/archive/2012/06/heres-a-map-of-the-countries-that-provide-universal-health-care-americas-still-not-on-it/259153/

31 Healthcare Systems: Four Basic Models," PBS, April 15, 2008.

32 Kaiser Family Foundation, Current Population Survey.

33 "Utah Renames its Online Health Exchange Avenue H," *The Salt Lake Tribune*, October 4, 2012.

34 Ibid

35 Herbert waits on presidential election to decide on Medicaid expansion, KSL, August 12, 2012.

This research report was written by Utah Foundation Research Director Morgan Lyon Cotti, Ph.D. Comments or questions should be directed to Dr. Lyon Cotti at (801) 355-1400 or by email at morgan@utahfoundation.org.

MAJOR SUPPORTERS OF UTAH FOUNDATION

Platinum

Questar
Rio Tinto
Rocky Mountain Power
Union Pacific

Gold

George S. and Dolores Doré Eccles Foundation
Intermountain Power Agency
MountainStar Healthcare
Regence BlueCross BlueShield
Utah Transit Authority
Wheeler Machinery
Zions Bancorporation

Silver

Intermountain Healthcare
Key Bank
Merit Medical Systems
Parsons
Parsons Brinkerhoff
University of Utah Health Care
Wells Fargo
Workers Compensation Fund

Bronze

Brigham Young University
CBRE
Central Utah Clinic
Chevron
Deloitte
Deseret Management Corp.
Energy Solutions
Ernst & Young
Fidelity Investments
Garbett Homes
Granite Construction
HDR Engineering
Holland & Hart
IM Flash Technologies
Parsons Behle & Latimer
Ray Quinney & Nebeker
Sandy City
Staker & Parson Companies
Southern Utah University
Thanksgiving Point Institute
University of Utah
US Bank
Utah System of Higher Education
Utah Valley University
Wasatch Front Regional Council
Westminster College

The mission of Utah Foundation is to promote a thriving economy, a well-prepared workforce, and a high quality of life for Utahns by performing thorough, well-supported research that helps policymakers, business and community leaders, and citizens better understand complex issues and providing practical, well-reasoned recommendations for policy change.