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Brookings Cafeteria Podcast:
Fixing, or replacing, the Affordable Care Act

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DEWS: Welcome to the Brookings Cafeteria, a podcast about ideas and the experts who have them. I'm Fred Dews. In 2010 the Affordable Care Act, also known as Obamacare, was enacted into law. Since then, millions of Americans have gained health insurance through either insurance marketplaces or Medicaid expansion in their states. But the legislation received no Republican votes, and GOP members of Congress and presidential candidates including now-President Donald Trump have said that they would repeal and replace the law as soon as possible.

Now that Republicans have unified control over the White House and Capitol Hill, what will happen to the Affordable Care Act and in health care policy more generally? To answer these and other questions I'm joined once again by Alice Rivlin. She's a Senior Fellow in Economic Studies and the Center for Health Policy here at Brookings. Her record of public service is too long to mention in this introduction, so I will just add that in 2008 she was named one of the greatest public servants of the last 25 years by the Council for Excellence in Government. She is also co-author of a new report from the Center for Health Policy titled "Five-state study of ACA marketplace competition" that studies health insurance marketplaces in five states.

Stay tuned in this episode for a new Coffee Break from visiting fellow Jon Sallet. Listen for the Bob Dylan quote on that one. Also, a new Metro Lens in which Elizabeth Kneebone talks about the importance of EITC to poverty reduction. It's the fourth week of the Trump administration's first 100 days. To get the latest analysis and commentary from Brookings experts, visit the Brookings Now blog at brookings.edu/brookingsnow. And finally, news and events are coming at us quickly these days, so we launched the new 5 on 45 podcast that offers rapid analysis from Brookings experts on what the

Trump administration and Congress are doing. Visit brookings.edu/5on45 – those are numerals – to learn more and subscribe.

And now, on to the Affordable Care Act. Alice, welcome back to the Brookings Cafeteria.

RIVLIN: Happy to be here.

DEWS: So, healthcare reform, healthcare policy, Obamacare, the Affordable Care Act – it's all over the news. House Speaker Paul Ryan recently said that the Affordable Care Act is quote “collapsing.” Is it collapsing?

RIVLIN: No, I don't think it's collapsing at all. It has sustained some stresses, particularly in some states, but it's definitely not collapsing. They have just had a re-enrollment period or an open enrollment period which ended at the end of January, and almost as many people are now enrolled as were enrolled last year. So those numbers are quite encouraging. Some people thought there might be an exodus – that people wouldn't sign up because they were so unsure of what would happen – but actually they did.

So it's not collapsing, but the future is very uncertain. And the Republicans, as you know, said that they were going to repeal it right away, Donald Trump said he would repeal it on the first day. I think he'd forgotten that it was an act of Congress and he would need the Congress to do that. But they didn't think about what would happen if they won and if they actually had to deliver on the promise of repeal. What would happen immediately if they just repealed it would be that about 20 million people would lose their insurance – and worse than that, the individual insurance market, which is where you go to buy insurance if you're not covered by your employer or by Medicare or

Medicaid, would likely melt down because they changed the rules under the Affordable Care Act for how insurance companies had to behave in the market. They had to sell to everybody, they couldn't just pick healthy people.

And so if that's true and you withdraw the mandate that everyone must buy insurance then a lot of people won't. And you could have a so-called death spiral in the individual insurance market that would probably affect another 10 million people. So you get 30 million people at risk.

Not only that, but health care is a big industry. It's 18 percent of the GDP. There are all these hospitals and doctors and other kinds of providers, not to mention insurance companies, whose livelihoods depend on continued health insurance. So they would have quite a problem if they just repealed it.

DEWS: All right, so that would be a scenario which is 100 percent repeal. But what about – what can President Trump do with just executive orders to alter the Affordable Care Act? What can he do and what effects what some of those executive orders have?

RIVLIN: Well he did issue a rather vague executive order that asked the agencies, presumably HHS, Health and Human Services particularly, to see what they could change to – I think the order said – make it less burdensome or something like that. There are certainly some things that could be changed, but – for one thing they could stop enforcing the mandate that people buy insurance – but this puzzle has a lot of pieces and they fit together. So if you start tinkering with pieces of it you might be sorry you did. And I don't think they have a clear idea of what might happen by executive order. Repealing takes law, but it can be done in a special budget process

called reconciliation that only takes 51 votes in the Senate; isn't subject to a filibuster. So they could repeal it that way, but they couldn't really replace it. If they have a serious plan for replacing the Affordable Care Act – and they don't at the moment – it would take legislation and that would be subject to filibuster in the Senate.

DEWS: What is your sense of their timeline? Because President Trump has said now the process might take ‘til some time next year, Speaker Ryan said legislation to repeal and replace would be completed this year, but the very conservative part of the GOP caucus in both chambers really thinks that they need to repeal and replace it right away. That's something that they campaigned on in 2016 and in 2014 and in 2012. What is your sense of a realistic timeline?

RIVLIN: Well, that's exactly the problem. Different people have different agendas. President Trump has said several times that he wants repeal and replace to be simultaneous and that he wants a smooth transition of some sort; that he doesn't want to leave people without insurance. And other members of the Republican Party such as Senator Cornyn from Texas have said the same thing, “We have to do it in an orderly way.” So there are various agendas here. Clearly Speaker Ryan would like to get something done quickly and show that he can get it done, so he has said by the end of this year, meaning 2017, but that may not be possible. The fact is that they don't have a consensus around a plan that involves the different wings of the Republican Party and the president. Now until you have that, you can't push something through quickly.

DEWS: I do want to get to your ideas for reform and improving the health care system in a minute but I want to stick on the politics a little bit longer and actually come back to this concept of a death spiral that you just brought up. You've written that

keeping the law's regulations on the very popular features, like a ban on preexisting condition exclusions and keeping children on their parents plans until they're 26, which are provisions that some Republicans have said they like –

RIVLIN: Including the president.

DEWS: Exactly. But keeping those without the law's subsidies and mandates – that's what could cause the individual market to go into a death spiral. Can you explain how that triad or a constellation of issues works?

RIVLIN: Yes. Before the Affordable Care Act, the individual market for people buying insurance policies on their own, so to speak, was pretty chaotic. Insurance companies made money by trying to attract the most healthy people. So they made a big effort to get healthy people to buy health insurance because they didn't have very many health expenditures, and they avoided people who were really sick and therefore had high expenditures. So they often didn't sell to people who had some preexisting condition, or they'd charge a *very* high price, or they dropped people from insurance when they got sick. So all of those things are outlawed by the Affordable Care Act, which said you have to sell to everybody. You can't charge more because people are unhealthy – unless they smoke, you can do that. And you can't charge a lot more for being older.

This was probably a mistake, but they said that the charges – the premiums – for people at the high end of the age group, that's people in their 50s and 60s, could only be three times the low end. That made it a little more expensive for younger people. But we have now all of these rules, and almost everybody likes them. They don't want to go back to that old market where you couldn't tell whether you could get insurance or not,

and you might not be able to if you were really sick. So if they keep all those rules but they get rid of the mandate to buy insurance and the subsidies to make it affordable, then what happens? People who are really sick will do everything they can to buy insurance. People who are pretty well will say, “I might not get sick, I'll wait, and they have to sell it to me.” So they would drop out and that would mean that the high-cost people who were in the insurance – on their insurance policies – the insurance companies would have to jack up the premium to stay alive, and that would make it more expensive and more people would drop out. So that's what is meant by a death spiral.

DEWS: One alternative idea that we've heard, usually from the conservative side, is a health savings account. What is a health savings account? How does it work? Does that do some of the things that, you know, regular health insurance does?

RIVLIN: Well, a health savings account is a special account that you can set up, and you get a tax advantage for doing that. And then you can use it only for health expenditures. The idea behind this is a sensible one. Conservatives have said that one of the reasons that health care is so expensive is that consumers don't care what they pay. They're covered by insurance. They go to the best doctor they can find or the nearest hospital or whatever and they don't shop around for the best deal.

And the idea behind the health savings account is if you're spending your own money out of your own health savings account then you'll be more careful. If you need a hip replacement or something you will make inquiries as to what it would cost in different hospitals or something like that. The trouble with that is that most people don't like to shop for medical care. They want to have a regular doctor that they know is their

doctor that they can go and see if they get sick, and they like having insurance. They like having insurance that covers even fairly routine visits to the doctor so they won't have to worry about it. It's a kind of security thing, and a good job is often thought of as one that not only pays good wages but has good benefits like generous health insurance. So health savings accounts have not been very popular except among higher income people for whom the tax advantage is considerable.

DEWS: It also strikes me as problematic for people who might live in a rural area where they have limited access to medical choices – I mean, there's one doctor in the whole county or one hospital nearby – I mean, they're not going to shop around.

RIVLIN: No. And there are certain kinds of things that it would be sensible to shop for – big expenditures that are not emergencies, like a hip replacement. You know you're going to need it, you can figure out where is the best place to get it. But most things aren't like that. If you have a heart attack you're not going to go shop around. You're going to go to an emergency room and get the treatment as fast as you can.

DEWS: Let's pause here for a coffee break, where you'll meet Jon Sallet. He was most recently deputy assistant Attorney General for Litigation in the Justice Department's Antitrust Division.

SALLET: I'm Jon Sallet. I'm a visiting fellow at Brookings in the Governance Studies program. I grew up in New England. I was in a little town called Norwood, Massachusetts, or Na-wood as we pronounce it, which when people say they haven't heard of it I tell them it's halfway between the location of the Sacco-Vanzetti trial and where the New England Patriots play their home games. And I haven't lived in New England for a long time, but I have remained a fervent Red Sox fan. So when I showed

up at the Department of Justice last June I was asked what state flag I wanted in my office. I picked the Commonwealth of Massachusetts because I didn't think I could actually get a Red Sox banner.

I have thought for a long time, really since I was an undergraduate at Brown University, that learning should never end and that scholarship is the way to ensure that learning continues. One of my favorite Bob Dylan lines is the quote, “He not busy being born is busy dying,” and it seems to me that scholarship and learning is a way of, to quote a different song, “staying alive.” And so I feel very fortunate to be at Brookings where ideas are in the air, where rigor is important, where learning is the life and where thought is action.

I had known Darrell West for a long time. I'm a Brown alum and he was at Brown when I first met him. And so I thought it was a wonderful opportunity to be able to come and work in his program. There are a lot of very important issues, of course. But let me tell you one I'm thinking about, and that's the idea of truth. In other words, we have the concept of truth around the notion that there's an objective reality that can be discovered or proven by anyone regardless of his or her background. And that is critical to the way society has evolved. It's critical to the idea of science. It's the scientific method. It's critical to the notion of technological innovation that comes from science.

It's critical to capitalism, people being able to choose what they want to buy. It's critical to democracy, people being able to choose who they want to govern. And so it seems to me that this notion of truth – how we find it, how we hold on to it, and how we challenge what other people’s truth is, is in a in a world in which debate is encouraged and learning is encouraged – this seems to me a critical, critical issue for our times.

One article I'm working on is about Louis Brandeis, the Supreme Court justice. He was confirmed to the Supreme Court 100 years ago last year, 1916. And I've been thinking about him because Brandeis came of age, became very influential, in a time when there was great economic unrest, right? There had been populism at the turn of the century, William Jennings Bryan and all. And there was a great feeling that the economy was not working for everybody. Remember, this was the time of muckrakers, the Triangle Shirtwaist Factory fire, anti-competitive trusts – Standard Oil; and Brandeis gave a speech in the spring of 1985 which he said people are discontent. And he said and I quote, “They're beginning to doubt whether there is a justification for the great inequalities in the distribution of wealth.” Well. That sounds pretty familiar to us today.

And so I'm looking for lessons in how Brandeis confronted those challenges. I mean he stood for very important things. He stood up for free speech and diversity of views. He wrote the seminal article on privacy in the face of new technological innovations – the technological innovation of his day was the portable camera. But he fought for antitrust and for competition, and this is what I'm focusing on because I think it's interesting to look at him as an example of a person in a time of economic frustration who relied on the rule of law, who relied on governmental institutions to do the job of preserving and creating economic opportunity.

Well the history book I've read recently that I find most impactful is by Margaret McMillan. It's entitled *Paris 1919: Six Months that Changed the World*. It's the story of the Treaty of Versailles – how it came to be. And one of the things we should think about as we come up to the 100th anniversary of the Treaty of Versailles is what impact it had – those decisions made in Paris had – around the world. If one traces world

history in the last century, from the origins of World War II to conflict in South East Asia to the Balkans to unrest in the Middle East; so many of these issues find their genesis in decisions made by a group of leaders in Paris those six months. And so I find the book to be extremely instructive.

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DEWS: Alice, let’s talk about reform ideas now. I know you and others at Brookings like Stuart Butler and Henry Aaron have written a lot about healthcare policy, health reform ideas. Let's imagine a scenario where the GOP Congress and that Trump didn't actually just want to repeal and replace the Affordable Care Act; that they just wanted to improve America's health care system, America's health insurance system. What are some of the things that you recommend that they should do?

RIVLIN: Well, I would do two things principally. One would be to improve the basic structure of the Affordable Care Act. You can call it something else, you can call it Trumpcare or something new. But the structure is basically quite a good one because it does rely on competition among health insurance plans, it does give consumers a choice among plans, and that's a good kind of competition. It seems to me it's better than having people out there trying to shop around for particular medical services. You can shop for a good plan and then stick with it. So the basic idea was a good one in execution.

There were some problems. One of them was that in rural areas, as you noticed, there are not very many people, there are not very many doctors or hospitals, and insurance companies can't make money there very easily because they can't cut a good deal with the providers. So many rural counties, and we've got a lot of them, didn't have

more than one or two insurance choices. I'm not sure what you do about that, but it's a problem.

I think there are some modifications that could be made to make the Affordable Care Act move in conservative or Republican directions. You certainly could increase health savings accounts as a supplement to insurance. You could make the regulation less regulatory and return the real power over insurance regulation to the states, who were doing it before. The Affordable Care Act took some powers of insurance regulation to the national level for the first time. And you could find a substitute for the mandate: some set of incentives that would get people buying insurance if they're younger and healthier but didn't actually say you have to. You could say if you don't you're very heavily penalized, it'll cost you a lot to get into the system. You could also relax the ratio between younger and older premiums so that premiums for younger people were less.

You could also do something to take the high risk cases off the responsibility of the insurance companies: something like high risk pools with a subsidy or reinsurance, so that insurance companies were more likely to be able to stay in the market and not blindsided by very high risk people – and there are few of them but they're very costly. So I think we could cut a deal that would preserve the best features of the Affordable Care Act and make it more acceptable to conservatives.

The other thing I would do is Medicare. I think there are a series of reforms to Medicare that would modernize it and also put it back in the sound fiscal condition that's necessary. And I would start with Medicare Advantage because that actually is competition among private plans. It's quite a good program. It covers about a third of the Medicare population but it isn't organized nearly as well as it could be. It could have

better competition and probably lower prices if the competition were organized better, and then would probably appeal to more people.

DEWS: We've heard Speaker Paul Ryan talk about significant changes to the Medicare program, if not phasing it out entirely for the youngest cohort of workers. I'm not sure how my cohort of workers would be affected by that, but what would kind of be the overall effect on the US healthcare system of a plan to just phase out, over 10 years, over 20 years, Medicare as we know it today?

RIVLIN: I don't think that Speaker Ryan has in mind phasing out Medicare. I worked with him on this about seven – six, seven – years ago when we were both on the Simpson-Bowles Commission. His concept is to convert the Medicare program to a premium support program where the government would have a responsibility for paying a fixed fee which would be risk-adjusted – it would be the insurance company would get more if you were sicker. But it would be related to the average premium in the area. And then if you wanted a better plan or a richer plan or one that included a very high end hospital or something you'd have to pay more. That's the basic concept.

I'm in favor of that, although I wouldn't do it all at once. I would start by seeing if we can't improve the competition in Medicare Advantage and then maybe bring the regular fee-for-service Medicare into the system.

DEWS: Just as kind of a final question, Alice just looking at the healthcare system overall, you said it's 18% of the overall U.S. economic activity and involves providers and involves patients. Health care is a really, really fundamental issue in everyone's lives. What do you see as the overall best outcome for healthcare system in America?

RIVLIN: Well I think we have to start from where we are, and improve the system in some of the ways that we've been talking about. Some people would say blow it up, start over, go back to 1965 or something and instead of doing Medicare and Medicaid do a national health insurance that would affect everybody. I don't think that we need that much change or that it would necessarily be good. Now, it's true that many European countries and Canada have systems that function very well that are universal coverage and that cost less than ours do. But that doesn't mean we could do that. We're a very big, diverse country and people like the kind of health coverage that they've got. If you scare them by saying we're going to blow it up and start over, I don't think very many people would like it.

Even in the Affordable Care Act, the president was at pains to say that this doesn't really affect the employer system and it didn't, he was right, and it doesn't affect Medicare. So if you're in those systems and you like it don't worry you can keep it. Now he misstated that a bit, he overstated it, he said if you like your insurance you can keep it and that wasn't quite true. It was about 95% true. And that got him in trouble. But the reason he said it was a political perception which is absolutely right – that people like what they've got and they're sort of scared of the unknown. So I would not blow things up and start over.

DEWS: Well, Alice, I want to thank you for your time today. I know it's early in the Trump administration, there's a lot more to come. I know you and your colleagues at the Center for Health Policy, and others at Brookings, will be following this issue closely and I hope to have you back to talk some more about it. Thank you so much.

RIVLIN: Absolutely.

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DEWS: The Earned Income Tax Credit or EITC is an important tool to help lower income people. You'll find out more next in our latest Metro Lens offering.

Kneebone: Hello, I'm Elizabeth Kneebone, a fellow at the Brookings Institution's Metropolitan Policy Program. As people across the country file their taxes this tax season, they may not be aware of an important function that the nation's tax code serves – alleviating poverty. The tax code does so through two key provisions, the Earned Income Tax Credit and the additional child tax credit, both of which are targeted primarily to lower income working families. What makes these credits special is that they're refundable. That means that after offsetting taxes owed, filers can get the remainder of the credit as a part of the refund. So these credits effectively boost the take home pay of low- and moderate-income working families.

In doing so, research has shown that they have a wide range of positive effects on the recipients according to the U.S. Census Bureau supplemental poverty measure, which offers a more nuanced look at poverty than the official measure because it takes into account things like tax payments work incentives and in-kind benefits. According to that measure, in 2015 the ETC alone was responsible for lifting more than 6 million people out of poverty. Combined with the refundable portion of the child tax credit, that number rises to 9.2 million people, more than half of whom were children. Without these credits, the national poverty rate would have been three percentage points higher.

Beyond its effectiveness in alleviating poverty, research has also shown that refundable credits boost workforce participation among adults, and improve the school performance, college enrollment, and eventual earnings of their kids. And not only do

the families themselves benefit from these credits, but because EITC filers spend the bulk of their refunds on necessities like groceries and school supplies for their kids, these credits have a multiplier effect for the local economy. That helps supports local jobs and businesses. Our recently updated EITC interactive page on the Brookings website provides a number of resources that show how residents and communities across the country are affected by federal tax policies like the EITC. Through that portal, we provide detailed administrative data from the IRS on the EITC filing population, including how those filers are distributed across different types of geographies like congressional and state legislative districts, metropolitan areas, counties, cities, and zip codes.

Other resources on the interactive page come from our metro tax model, which allows us to produce profiles of the EITC eligible population that offer a look at demographic and workforce characteristics not available through administrative records. The tax model also allows us to estimate the impact of potential changes to the tax code on people and places. Take the Fresno metro area in California, for example, where one in four residents live below the poverty line. In 2015, more than 100,000 taxpayers claimed the EITC, which brought almost $300 million into the region. Two thirds of those filers also went on to claim the refundable child tax credit which brought in another $95 million. That's a significant level of federal investment in low-income workers and communities, and because California recently enacted a state version of the credit, those resources and their positive effects were further buoyed by additional state investments.

According to our tax model, Fresno's EITC eligible filers are primarily working families. A quarter of them are married couples. More than half are single parent households. More than half of these tax payers have a high school diploma or less. And they're most likely to be employed in agricultural jobs or service sector jobs like retail, healthcare, and accommodation and food services. The EITC and the refundable child tax credit play a critical role in helping bolster the low wages often paid by those jobs because these credits are both pro-work and effective at reducing poverty. They have a history of bipartisan support. Given that President Trump and the new Congress both have tax reform high on their agendas, it's important to keep in mind the things the tax code gets right, like these refundable credits.

But that doesn't mean these credits couldn't be improved. A number of proposals have been put forward to expand the EITC for workers without qualifying children, which in its current and quite modest incarnation doesn't provide the same level of work incentives and poverty-alleviating effects as the credits for working families. Doubling the credit would benefit 14.4 million workers across the country, including 50,000 taxpayers in the Fresno region, who would either become newly eligible for the credit or see the size of the credit they receive increase. In addition, for all the positive effects these refundable credits bring to workers, families, and communities, they're currently only available to recipients at tax time.

That once-a-year lump sum payment is a poor fit for helping families shore up budget gaps or deal with unforeseen financial shocks throughout the year, like a car breaking down or an unplanned medical expense. The Center for Economic Progress piloted a periodic payment mechanism in Chicago that delivered the credit in four

quarterly payments instead of one. Participants in the Chicago pilot missed fewer bills, racked up fewer late fees, and were less likely to resort to payday lenders. They also reported less food insecurity and less financial stress throughout the year. Implementing a periodic payment option along these lines would go a long way to helping these already-effective refundable credits provide financial stability throughout the year, not just at tax time. To learn more about the EITC and explore these resources in more detail, visit the EITC interactive page available at brookings.edu.

DEWS: Hey listeners, want to ask an expert a question? You can, by sending an e-mail to me at bcp@brookings.edu. If you attach an audio file, I'll play it on the air and I'll get an expert to answer and include it in an upcoming episode.

And that does it for this edition of the Brookings Cafeteria, brought to you by the Brookings Podcast Network. Follow us on Twitter @policypodcasts. My thanks to audio engineer and producer Gaston Reboredo, with assistance from Mark Hoelscher. Vanessa Sauter is the producer, Bill Finan does the book interviews, and our intern is Kelly Russo. Design and web support comes from Jessica Pavone, Eric Abalahin, and Rebecca Viser; and thanks to David Nassar and Richard Fawal for their support. You can subscribe to the Brookings Cafeteria on iTunes and listen to it in all the usual places. Visit us online at brookings.edu. Until next time, I'm Fred Dews.

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