Lights and Shadows of Affordable Care Act and its Influence on World Civilization

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Abstract

The US have one of the most unequal and inefficient healthcare systems. Also as the consequence of the world economic crisis, nowadays millions of citizens are without healthcare assistance. After some partial reforms, very recently the Affordable Care Act (commonly known as "ObamaCare") became law 23rd March 2010 has addressed this issue, with the design of a wider healthcare coverage. Nevertheless, the weaknesses of the federal budget and the opposition of the Republican party have limited its capacity and implementation. We discuss the flaws and the potential strengths of this reform, paying particular attention to its potential implications for the human and economic development of both the U.S. and the rest of the world. We discuss how policies for enhancing human and economic development are needed also in developed countries and that also the developing world may benefit from policy changes in the "first world." However, empirical studies are needed in order to assess the relevance and the dimension of such effects.

Keywords: Obama's reform, health care, human development

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1. Introduction

"Better health is central to human happiness and well-being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more."[3] Availability of healthcare and accessibility to it are main indicators and goal of development. Healthy people are not only happier and have a better quality of life than non-healthy (Dolan et al., 2008 and Foster et al., 2012), but they are also more productive (Weinstein et al., 1998; Audibert and Etard, 2003 and Goetzel et al., 2003). Moreover, the healthier the population, the lower (at least potentially) the costs for the healthcare system. More in general, improving health fosters the social efficiency (Ravallion, 2005) and the social development (Kwon, 2005) of a country and enhances its economic growth (Fogel, 2004). For these reasons, national public healthcare systems are common worldwide; these provide the citizens with services at extremely low (and therefore affordable) costs. Other countries, such as the USA, chose to finance healthcare with public funds only in some specific and particular cases, leaving the provision of most of the services to the private market. This has created a wide market for health insurances, which entails that only insured people have access to the most (some of which basic) health services.

This paper will argue that the human and the economic development pass also through the creation of universal healthcare systems not only in poor and developing countries, but also in the rich. The recent "Obama reform", whose main aim is to allow also the poor to access a series of health services that were otherwise unaffordable to them, is a first response to the problem in the U.S. The aim of this paper is to discuss the reform and, in particular, its implications for the development of the U.S. and of the rest of the world. Indeed, "a focus on public health security emphasizes […] the building of public health systems."[4]

2. The U.S. healthcare system: an overview and a summary of the Obama reform

The U.S. stand alone among the industrialized countries in not providing healthcare coverage to all its citizens and despite the recent attempt of the Affordable Care Act (ACA) to expand health

[3] From the World Health Organisation's page on "health and development."

[4] Koivusalo and Mackintosh (2008), p. 1168.

insurance, the access to healthcare services is still a thorny issue. Currently, 48 million Americans lack health coverage (US Census Bureau, 2013).

The need of reforming the system, to render it accessible to a larger share of the population dates back at least to the 1940s, when President F.D. Roosevelt prepared a comprehensive plan of reform. This was never approved, as Roosevelt died before the plan was presented to the Congress. Roosevelt'oos need of reforminruman, tried to continue on the way of reforms of the healthcare system, but without any success. Only President Johnson managed to introduce relevant changes, namely creating in 1965 Medicare and Medicaid (Morone, 2010; Light, 2011). Bill Clinton in 1993-94 also attempted some changes to the then operating system, but the success of his proposals was marginal. However, within western countries, the US healthcare system is one of the most unequal, since leaves millions of citizens without any health assistance. Also for this reason, a perspective analysis of the Obama's reform could help the policy makers and the stakeholders to better understand the limits of the current system and the potential of a universal healthcare system.

The U.S. healthcare system is characterized, as with all other countries, by private and public insurers. What is unique about the U.S. system is the dominance of the private element over the public element: coverage is provided mainly through private health insurance that is the largest component of the healthcare system. Only 15% of the U.S. population get health insurance through the government that finances about 45% of healthcare spending programs operating at the national, state, and local level. These programs include Medicare, Medicaid, and programs run by the Department of Veterans Affairs (AHRQ, 2007).

Medicare is a federal program funded through social security payments. It provides health coverage mainly to people aged 65 and older, to some disabled people under 65, to people with end-stage renal disease and amyotrophic lateral sclerosis. Although during its 40 years of operation Medicare has provided elderly Americans with the opportunity to benefit from health insurance coverage, this scheme is extremely basic and has a number of gaps. Medicare does not cover the full range of health services needed by many elderly people: the gaps include incomplete preventive care coverage, no coverage for dental, hearing, or vision care. In addition, Medicare does not cover chronic Long Term Care (LTC) needs, most notably nursing home care for the disabled elderly (Rowland and Lyons, 1996). To have additional protection, most of the enrollees buys own supplemental insurance coverage (i.e. Medigap insurance also known as Medicare supplement insurance).

Medicaid is funded jointly by the federal and state authorities and is available for individuals of all ages and families with low income and resources who cannot afford proper medical care. Each state sets its own rules about eligibility and covered services. The eligibility depends on several factors among which: age, pregnant status, disability, income and resources and on whether people are a U.S. citizen or legal immigrant. Thanks to the ACA, Medicaid has been expanded to include all nonelderly citizens and eligible legal residents whose family income does not exceed 133 percent of the Federal Poverty Line (FPL). Medicaid-ineligible people with incomes up to 400 percent of the poverty line can receive premium subsidies through tax credits for health plans offered through state health insurance exchanges. The reform will guarantee insurance coverage for many individuals who before would have been living in a kind of limbo: not poor enough to be covered by Medicaid but not rich enough to afford private insurance.

Most people (about 60% of non-elderly Americans) get health insurance through their employers or organizations such as unions, professional associations, or other groups to which they belong, while people who do not have access to group insurance may choose to purchase their own individual health insurance directly from an insurance company[5].

In the wake of the Great Recession, the U.S. have seen a crisis in the labour market with escalating unemployment rate that today stands at 6.6 percent (Bureau of Labor Statistics, 2014). Since employers provide health insurance as part of the benefits package for employees, unemployment has resulted in the loss of health benefits for millions of Americans, exposing individuals and families to potentially catastrophic healthcare costs in the event of a serious illness.

Currently, workers who lose their job-based health benefits have few affordable insurance options. Unemployed with incomes that are modest but too high to qualify for Medicaid, can buy health insurance in the individual insurance market but the majority of those who seek coverage there do not end up buying a plan because of the prohibitive cost. Under the COBRA (which stands for Consolidated Omnibus Budget Reconciliation Act), unemployed individuals, who are employed by a firm with 20 or more workers, have the right to temporary continuation of health coverage at group rates (for up to 18 months). Few people, however, decide to continue their coverage through

[5] The individual market covers part of the population that does not receive healthcare coverage thorough employer (about 5% only purchase insurance on the private non group individual market) (AHRQ, 2007).

COBRA since the participants generally have to pay the entire premium themselves and plans tend to be too expensive. The new ACA legislation does not make any changes in COBRA, however, unemployed may have expanded health insurance options, including subsidies to purchase insurance through exchanges, and expanded access to Medicaid coverage. However, at this time, roughly half of the states have indicated that they will implement the Medicaid expansion for 2015. In states that chose not to expand Medicaid, persons below 100% of FPL will not be eligible for either Medicaid or subsidies on the exchanges.

Even though losing or changing job is the primary reason for people to experience a gap in the health insurance coverage, other categories of people face similar difficulties, especially younger, low-educated individuals and racial/ethnic minorities (CDC, 2013). Aware of these problems and starting from the legal framework summarized before, President Obama has proposed a comprehensive reform of the U.S. healthcare system. The ACA reform envisages important changes from 2014 for workers, young adults, those on low income and those at high health risk. As far as access is concerned, in exchange for tax cuts employers with over 50 employees are obliged to supply their employees' with insurance coverage. The enforcement of this law is supported by a $2,000 fine per employee for each year of missed coverage. In view of this, therefore, there would be a real improvement in access to healthcare for many workers thanks to insurance coverage being guaranteed by law. Again, concerning access, an extension of the Medicaid program is envisaged from 2014. Moreover, the Obama reform will not allow insurance companies to fix premiums based on a patient's clinical history (the c.d. preexisting conditions). This substantially limits the possibility for companies of dumping or rather of refusing to cover high-risk individuals through price policies (McDough, 2014). Insurers will not be allowed to turn away people with pre-existing health problems, to cancel coverage when beneficiaries need expensive treatment, or to charge women higher premiums than men. Beginning in 2014, all individuals will be required, with exceptions, to have health insurance or pay $695 per person, up to $2850 per family. Comprehensive coverage will be mandated, with caps on annual out-of- pocket costs. Young adults can stay on their parentsums than men. Beginning in 2014, all individuals wiGostin and Connors, 2010; Light, 2011).

As implied in the title of the ACA law, one of the key provisions in the law is the expansion of coverage to the socially and economically disadvantaged population. This is done first by expanding Medicaid to all citizens under age 65 with incomes up to 133% of the federal poverty level. In addition low income families earning between 133-400% of the federal poverty level will

be eligible to receive tax credits to assist them with purchasing a basic health plan through the new state-based American Health Benefits Exchanges.

However, ACA still presents several elements of weakness. For instance, the huge increase in the number of individuals, covered by state insurance through raising the threshold of those families and individuals eligible for Medicaid, may create a massive increase in the number of requests for healthcare at tariffs fixed by the individual States as it happens within the Medicaid program. Nowadays, however, only a limited number of doctors are ready to offer their services for reimbursement tariffs that have been leveled down by the Medicaid program (Decker, 2012; Goodnough, 2013). The concrete risk is that, as there will not be a corresponding increase in services, this massive rise in the number of people insured by Medicaid will considerably increase the average waiting time for Medicaid covered patients. Moreover, the extension of Medicaid and the subsidies available to economically disadvantaged individuals and families may not be utilized by the low income individuals and families who are not aware of these options. Therefore, states should be more active in facilitating outreach efforts to effectively reach healthcare consumers and educate them about the ACA.

Under the ACA law, insurance companies will be obliged to include some "essential" services, such as mental health treatment and some preventative measures, in the insurance plans. Such provisions are generally less profitable and often not offered by the insurance companies in their attempt at atment and some preventati of Medicaid and the subsidies available to economically disadvantaged individuals and famipulsory introduction of this type of care into the coverage is an important innovatory measure that aims at guaranteeing a level of insurance provision that is in line with many European insurance plans. However, the apparent nerally less profitable and o coverage has meant thousands of cancellations by the insurance companies who have been informing many of their customers that it will be impossible for them to renew their policy because it is not in line with some of the y the insurance companies who have wn by law. This may well mean that millions of Americans, and in particular those who do not receive health insurance either through the state or by their employer, will need to buy insurance coverage that complies with the law, but that if for sure more expensive.

3. The implications of the reform for the domestic development

While the reform presents the shortcomings that we have highlighted in the previous section, and while ObamaCare is far from being a European-style healthcare reform, it might have some

merits in perspective. These merits are far from being proved in the U.S case, as the implementation of the reform is just at the beginning. However, the past experiences and the empirical evidence provided by the economics and sociologic literatures allow us to attempt some prospective evaluations. Our aim is to provide a balanced evaluation between the current flaws and the potential benefits that the reform could engender.

First, from a social point of view, the improvement of the health coverage and healthcare access of a population should be a major goal *per se* and therefore this objective should suffice to justify the reform. However, the liberal and the neoliberal theorists may argue that the private provision of healthcare services is more efficient than the public and that the problem of unaffordability should be solved by the market. In particular, if a relevant share of the population is currently excluded from the healthcare services, one might argue that the insurance policies cost "too much" because the competition in the market is insufficient. In such a situation, then, the government should intervene to increase competition, rather than to provide healthcare services using public funds. One might also argue that people who cannot afford these services do not exert sufficient effort to secure wages that would make it possible. However, both these possibilities present fallacies. On the one hand, as we have already stressed, people must be healthy to be able to work with continuity and to secure good wages. On the other hand, the high prices of health insurance policies may be due to inefficiencies in the healthcare sector that reflect in the costs of the services and, in the end, in the prices of the policies. For example, Zhivan and Diana (2012) find that general hospitals in the U.S. tend to introduce information technologies in an economically inefficient way so that the hospitals with a lesser intensity of IT are more cost-efficient. This suggests that relevant inefficiencies are present in the market, but it also highlights that these inefficiencies characterize not only the market of the insurances but also that of the healthcare services.

Making the healthcare services accessible also to the share of the U.S. population that cannot currently afford them will improve the average level of health of these citizens. In accordance with the empirical evidence, we should therefore expect an improvement in the productivity of these people, with consequent benefits for both them and the national economy, as well as an increase in fiscal revenues. Together with education, health is a component of human capital (see for example Gyimah-Brempong and Wilson, 2004) and investing in health increases the stock of human capital, and its relative and absolute returns. In particular, an increase in the productivity of the new beneficiaries should reflect in higher salaries (either because healthier people are less absent from work, or because they can access better-remunerated jobs). This

increased wages will (partially) be used to increase consumption, what, in turn, will enhance the production of consumables and durables and foster the occupation in these sectors.

It is worthwhile to recall here that the share of population in the U.S. currently excluded from healthcare services is almost one fifth of the population, i.e. 48 million people. Increasing the expenditure capacity of such a large number of people will have relevant effects on the aggregate levels of consumption. The economic benefits are however not limited to the private sector. The increase in the level of consumption will likely foster the profits of the firms. Since these pay taxes on their profits, also the tax revenue (at the state and at the federal level) will increase, with positive consequences on the stressed current situation of the federal budget. However, as Marmor (2009) points out, the reform may accentuate or mitigate the tensions on the federal budget. On the one hand, the implementation of the Obama reform will increase the tax revenue, but on the other hand, it will also increase the expenditures. The effectiveness of the controls on costs and on efficiency of the public health system represents another crucial issue.

Last, but not least, the reform entails also some income redistribution: part of the federal tax revenues will indeed be used to expand Medicaid; the beneficiaries will therefore receive transfers in the form of in-kind services. However, the tax cuts will transfer resources from the public hand to the private market of insurances. This means that, on the one side the government increases the weight of the public hand in the economy, while, on the other side, this weight diminishes.

4. The implications of the reform for the international development

The relevance of the country (the U.S.) where the reform is taking place is such that the effects will involve also other countries, given that the ACA applies not only to the U.S. citizens, but also to people who qualify as U.S. residents for federal income tax purposes. This definition includes a large number of immigrants who are not U.S. citizens, but who work regularly in the U.S. How can the Obama reform have positive consequences on the rest of the world and which is the link between it and immigration?

People who immigrate in the U.S. and get a job there (as in any other developed country), generally send part of their income back to the country of origin, where relatives still leave. These remittances help the worker qualify as U.S. residents for federan the countries of origin. The World Bank calculated that the outflow remittances from the U.S. amounted to more than 51 billion dollars in 2011, a relevant sum, even considering that it is divided in thousands of small contributions to as many households sparse in the world. In the previous section, we have argued that health and salaries are linked positively. Consequently, the reform, by potentially increasing healthcare

coverage and healthcare access inequality and consequently improving Americans‘ health status and their productivity, is likely to increase the flows of remittances from the U.S. to the rest of the world. This would have the effect of improving the living conditions of the families of the immigrants, and of increasing their expenditures in the countries of origin, with positive effects on the economies of these countries.

Another aspect is that this would also strengthen the process of international redistribution of income. Remittances are already a way to redistribute it from the rich to the poor countries; however, the Obama reform would activate an additional mechanism, which is already at work in the European systems. In the U.S., the reform accentuates the redistribution from the rich to the poor, given that the federal tax system is progressive and that Medicaid and Medicare are financed from the federal budget. Among these beneficiaries much are regular immigrants, who send remittances to the countries of origin. Through this mechanism, the rich U.S. citizens transfer part of their income to the developing countries in the form of returns on the federal investment in the poor's health. Of course, this is a complex and indirect mechanism, but it is still a way of redistributing income internationally. We are far to claim that this be the solution of the problems of developing countries. The increase in remittances would probably be in the order of few billion dollar, but this is already a remarkable amount of money.

A last positive effect on the foreign countries may be in terms of attractiveness of the U.S. labor market. Its dynamism, its size, the "American dream" are already the main attractors of the U.S. for foreign citizens seeking to improve their lives and those of their relatives. The addition of the Obama reform, which renders the conditions for the poor workers more favorable than before, and which adds positive perspectives, will likely attract even more immigrants. Of course, this perspective will perhaps increase the opposition of the conservatives to the reform. However, to increase attractiveness means also to increase the number people who produce income (and taxes) in the U.S. and who send remittances to their countries of origin. In brief, the Obama reform is likely to activate a virtuous circle.

So far we have presented and debated some positive aspects for the international development from a theoretical point of view. In fact, further research in health and public economics should address this issue from an empirical point of view. In particular, the Obama reform as well as the comparison between different healthcare systems in the western world constitute a natural experiment to test the effects of the health system in a country on – for example – the remittances on the immigrants and on their labour productivity.

5. Conclusions

The discussion presented in the previous sections depicts the reform as a bright development for the world civilization. However, as we have already outlined, the reform is not flawless nor its implementation will necessarily be. In this concluding section we wish to discuss the main limits that the reform is showing and/or could show in the future and that help to sketch a lesser optimistic and idealistic, but a more realistic picture.

As Johnson's reform, also Obama's has been highly contested, especially by the conservative political areas, since it entails a dramatic change in the historical U.S. policy of non-intervention in the domestic economy (Connors and Gostin, 2010). The opponents claim, in particular, that the reform is in contrast with the need of reducing the federal budget deficit (Gruber, 2010), and that the European style systems are not sustainable, especially after the economic crisis of the last years. Actually, the Obama reform is far from revolutionarily copying the European model of "socialized medicine". It is still too early to evaluate the consequences of, perhaps, the thorniest part of the reform, that referring to the healthcare costs and budget sustainability. For now the United States are spending more on healthcare than any other nation in Western Europe (around 17% of the gross domestic product) and this is not justified by any large improvement in the quality of the care (OECD Health Data, 2010). The ACA has been built on the existing structure of hybrid public/private insurance and healthcare costs are still the fastest growing component of the federal and state government expenditures: Medicare, Medicaid and Affordable Care Act marketplace subsidies together accounted for 24 percent of the federal budget in 2014. Early two-thirds of this amount goes to Medicare, the most rapidly growing program for the federal Government, which still cover elderly and permanently disabled and has not been part of the ObamaCare's Health Insurance Marketplace.

The ongoing economic recession has until today exacerbated the dilemma of financing ObamaCare: the US have seen a crisis in the labour market with rising unemployment levels that has meant many more Americans eligible for Medicaid. States face an acute fiscal dilemma: they must find a way to pay for growing Medicaid enrollment precisely when tax revenues are declining. The idea of financing part of the reform through the Cadillac Tax would probably go in the right

direction but the Republicans continue to oppose it (Gruber, 2010)[6]. The Cadillac Tax will target the so called "Cadillac health plans" (also known as "gold-plated" insurance plan) obtained through collective bargaining agreements which often include much more generous benefits than other employer-sponsored plans (low, if any, deductibles and little cost sharing for employees). The goals of the tax are to help finance the ACA and decrease the overall cost of healthcare making the use of "generous" insurance plans, which some argue encourage overuse of medical care, less attractive. The "Cadillac Tax" on health insurance plans will begin in 2018 imposing 40 percent excise tax on the cost of coverage for health plans that exceed a certain annual limit ($10,200 per year for individual coverage and $27,500 per year family coverage). According to the most recent report of the non-partisan Congressional Budget Office, the Cadillac tax will raise $80 billion between 2013 and 2023.

In spite of the probable higher tax revenues generated by the Cadillac tax, the net effect of the reform on the federal budget may be negative in the end. Given the need for the U.S. government to cut its expenditures, the reform may turn to be unsustainable, or may oblige the government to cut other expenditures to preserve the reformed system. Moreover, the Democrats will not hold the government forever, and a strong Republican government may change the reform, and even dismantle it, not to decrease, for example, the military budget. In other words, the survival of the reform in its current form is a matter of sustainability of the federal budget and of political willingness. Recent surveys show that the U.S. electors look at public interventions in the economy unfavorably (Skocpol and Williamson, 2011); moreover the political process (i.e. the debate in the Congress and in the Senate) has already modified the original proposal (i.e. the debate in the Congress and in the SenaSkocpol and Williamson, 2011). Last but not least, the implications of the Obama reform and of any other possible reform of the US healthcare system do not appear to be limited to the domestic market, but are likely to have implications also for several countries in the developing world. Future empirical research will test whether these international spillovers really affect the wellbeing of people living in countries other than that whose healthcare system has been reformed.

The future of several lives both in the U.S. and in a number of developing countries crucially depends on the path that the reform will follow, on its implementation and on the courage of the

[6] The term derives from the Cadillac automobile founded in 1902, in the General Motors' luxury division.

U.S administration to pursue equality, redistribution and social justice both domestically and abroad.

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