Serena Allen:

Welcome to the Policy Paycheck. My name is Serena Allen. Thanks for tuning in. The Policy Paycheck was born from the idea that all people should have access to factual and relevant economic evidence about the most controversial policy topics we hear about every day. While our intended audience is American High School civics classes, even policy experts may learn something from each episode. Ideally, listeners like you will walk away better informed to not only discuss, but also form your own opinions about the policies as taxpayers we already pay for.

Today, Dr. Neeraj Sood will discuss Medicare, Medicaid, the Affordable Care Act and other health policy matters. Dr. Sood is a professor and the Vice Dean for Research at the USC Price School of Public Policy. He's also a founding member of the USC Schaeffer Center for Health Policy and Economics, and has published over 100 papers in economics, medicine and policy.

Welcome Neeraj, we're happy to have you on the show today. So today we're talking about a topic that can be a little bit daunting to a lot of people involved, myself included. I know very little about healthcare policy. But luckily, we have Neeraj here today, who is an expert on these matters. So we want to start off just by defining some of the terms you hear a lot. What is the difference between something like Medicare and Medicaid?

Neeraj Sood:

Sure. So Medicare is a program that is funded by the federal government, and it is a program primarily for the elderly. So if you are above 65 years of age, you are eligible for Medicare in the US, and it's the federal government that's paying for it. If you are low income or disabled, then the Medicaid program would cover you. And the Medicaid program is a joint program between the state and the federal government. So for roughly for every dollar of Medicaid spending, the state is paying 50 cents and the federal government is paying 50 cents. And then most of us in the US get our health insurance not from Medicare, because most of us are not 65 years or older, or from Medicaid, because most of us are not low income or disabled, but most of us get our insurance from our employer.

So for example, I work, I'm a professor at USC and USC is the one that provides health insurance for me. There are some people who are self employed, like someone who's a podcaster or an actor, and they would basically buy their own health insurance. So they're not low income, hopefully they're earning a living. So the Medicaid program doesn't pay for them, and they don't have an employer and they're not over 65, so they're on their own and they have to buy their own health insurance plans.

Serena Allen:

Interesting. I did not realize the exact numbers there, the state and federal breakdown, or that a self employed person. I believe we have a lot of those around here in LA, everyone seems to be trying to make it as an actor or I guess Uber or Lyft drivers would also fall into that category.

Neeraj Sood:

Mm-hmm (affirmative).

Serena Allen:

So I'm guessing that this is where the Affordable Care Act comes in, or some people know that as Obamacare. So just to explain, I guess further, how does Medicare and Medicaid differ from the Affordable Care Act? And what exactly is the Affordable Care Act?

Neeraj Sood:

So the Affordable Care Act or Obamacare is a law that was passed in 2010 when President Obama was the president, and the idea of the Act was it changed a lot of things in healthcare. So it changed Medicaid in certain ways, it changed Medicare in certain ways. It changed this private health insurance market where self employed people could go and get their insurance or where say Uber and Lyft drivers could go and get their insurance. So it changed a variety of aspects. And we can go step by step to see like, what are the things it changed, and how we feel about them?

Because a lot of people are just sometimes they don't really understand what this law did. And but they still have very strong opinions about this law. So if you talk to a lot of people, they might say, I love Obamacare, or I hate Obamacare, but if you really ask them, so what is Obamacare? They have very little idea. So I think it's important to go over all the things the law did, and then think about, are these good things or bad things or somewhere in the middle?

Serena Allen:

Definitely, yeah, I see Obamacare, at least personally, as a very politically charged partisan issue. When the Republican Party was just elected into office, they were like, "Oh, let's repeal Obamacare," whereas a lot of the Democratic candidates currently say we need to reform it or we need to even expand it. So definitely a very interesting policy that many people, including myself know very, very little about. So I was hoping, yeah, exactly what you said, can we go through some of the pros and cons of the different parts of the Affordable Care Act?

Neeraj Sood:

Sure. So the first feature of the Affordable Care Act was it removed something called the pre-existing condition exclusion. So that's a lot of words. What does that mean? So what that means is that prior to the ACA, or prior to the Affordable Care Act, if you had, say cancer, or if you had heart disease, and you went to buy health insurance for yourself, your health insurer would say, "Hey, sorry, you have cancer, we don't want to give you health insurance," or, "We will give you health insurance, but all your expenses or your health care expenses for the care of your cancer will not be covered by our insurance policy."

So a lot of people thought that that's not the point of insurance, and that's unfair. So what Obamacare did was, it basically tied the hands of insurers. So insurers could no longer say

no to cancer patients, or patients with heart disease, or with any pre-existing health condition. And they had to cover all the health care costs related to that health condition. So the pro is you're helping sick people, right?

Serena Allen:

Right.

Neeraj Sood:

And that's why this was popular, I think on both sides of the aisle. But there is a con to this. And the con is, so Serena, if you were to say buy insurance, and if you're healthy, you still have to pay a premium. Let's say you have to pay $4,000 a year.

Serena Allen:

Okay.

Neeraj Sood:

And when you're healthy, you're really not going to use that much healthcare. Maybe you will go for a wellness check once a year, and that's it. But you could also buy the same insurance when you get sick. So when would you buy the insurance?

Serena Allen:

Probably when I got sick.

Neeraj Sood:

Right?

Serena Allen:

Yeah.

Neeraj Sood:

You have no incentive to buy it when you're healthy. But that means now what happens to the insurance pool? Only sick people end up buying insurance, and all the healthy people stay out of the market. Because they're like, "Hey, even if I fall sick, this law covers my back, I'm going to get insurance, it's going to be at a good price and they're gonna cover everything. So why pay upfront when I'm healthy?" But then the whole market collapses, right?

Serena Allen:

Right.

Neeraj Sood:

Insurance is not just for sick people, the whole idea of insurance is people get together and pool risks. So there are some healthy people and some sick people. So that overall the cost balance out, right?

So what Obamacare had to do was just eliminating this exclusion was not going to solve the problem.

Serena Allen:

Right, it would create a bubble.

Neeraj Sood:

Because it was going to make insurance markets really unstable.

Serena Allen:

Okay.

Neeraj Sood:

So to counteract that they did two things. The first was they said, "We're going to have a mandate or a tax. So Serena, if you're healthy and you don't buy insurance, you will have to pay a $700 tax."

Serena Allen:

Okay, yeah.

Neeraj Sood:

So now you're like, "Hey, I don't want to pay a tax, I should maybe go buy insurance." So that's... And they did that to encourage healthy people to enter the insurance market, but it's still a tax. So if you are on the right side of the aisle, you will be like, "Hey, you're taxing people. And you're forcing people to do something that they don't want to do because of the tax."

Serena Allen:

Right.

Neeraj Sood:

Right. So though even though the individual mandate the whole idea of that, it kind of goes with pre-existing condition exclusion, which everyone likes, but then people want to pick and choose. And they want to say, we want the pre-existing condition exclusion removed, but we don't want the individual mandate. And that doesn't work. You have to accept both as a package. You cannot choose between one or the other.

The third thing it did was, it basically said, we're going to provide subsidies to people who are low and middle income families to buy insurance, right? So now again, you're saying, "Hey, if I don't buy insurance, I'm gonna pay a $700 tax. But if I buy insurance, the true cost of that insurance is say, $4,000, but the government is going to pay $2,000 on your behalf."

Serena Allen:

Oh, wow.

Neeraj Sood:

And so now you're like, "Hey, this is a good deal. I want to buy this insurance." And so now these three policies combined, which is removing the pre-existing condition exclusion, so that sick people can get insurance, having the mandate and the subsidies so that healthier people find insurance more affordable. So if you combine these three things, you create a more stable insurance market, which is affordable, which includes some help to low income families or middle income families, and it covers sick people. So that was the idea behind these three features of the Affordable Care Act.

Serena Allen:

Right. So, are the subsidies that on a sliding scale? So let's say I'm only making $20,000 a year? Will I only get 2000 off of the 4000 payment, is there any ever a case where they'll cover all of it?

Neeraj Sood:

So it will... you're absolutely right that it is on a sliding scale. So there is something called the Federal Poverty Line. So if you are single, I think the Federal Poverty Line is about $16,000 a year. So if you make about $16,000 a year, insurance is free for you. As your income rises, your subsidies fall down. So if you make more than $65,000 a year, you get no subsidy, that's basically four times the Federal Poverty Line. And between 64,000 and 16,000 there is a sliding scale. So your subsidies are highest, if you're at 16,000, and they are lowest if you're at 64,000.

So now, the other thing the Affordable Care Act did was it changed the Medicaid program. So it changed the Medicaid program by expanding eligibility for Medicaid. So what earlier before Obamacare, Medicaid, you not only had to be low income to qualify for Medicaid, but you had to have some other qualifying condition. For example, you had to be disabled, or you had to be a single mother. What Obamacare did was they said we're going to get rid of all those other eligibility criteria and basically as long as your income is below 100% or 138% of the Federal Poverty Line, we're going to cover you.

Serena Allen:

Okay.

Neeraj Sood:

So again, if you look at the pros, it's good that low income people needed help to have health insurance coverage. And this program expands insurance coverage to low income individuals through the Medicaid program. But what states complained about was, remember I had said earlier, how is Medicaid financed? It's 50% states, and 50% the federal government. So the states were saying, "Hey, you're asking us to cover all these people on Medicaid, but you're imposing these costs on us. We want to spend money on roads, and education, and other things in our state and law enforcement and so on, and we don't have money to spend on the Medicaid program."

So a lot of states, depending again, on their political affiliations, said, "Hey, we don't want to expand Medicaid eligibility." So this actually went to the Supreme Court, and the Supreme Court said that the states are right. So later on the states were given a choice. If they wanted to expand Medicaid eligibility they could, and if they didn't want to expand Medicaid eligibility they didn't have to.

And what Obamacare did is they did realize that it was going to cost the state more money. So for a certain amount of time, I think for the first three or four years, they changed the formula. So they basically said, we will cover 95% of the cost, the federal government, and the state has to only cover 5% of the costs for expanding eligibility, but over time, that you would kind of go back to the 50/50 formula.

Serena Allen:

Right.

Neeraj Sood:

And a lot of states wanted to do this because they also thought first like it was just a moral issue, that if you have low income residents in your state, they should be provided help. We are a rich country, they should have healthcare coverage and they should have Medicaid coverage. So that was one rationale for just expanding coverage so that it's like a human right, and we should do it. The other rationale was, look, we're paying for them anyways. So if you don't have coverage, what happens is you don't take care of your health, and then you end up in the ER, or you go to the ER for your primary care and getting care in the ER, or getting care when your health has already deteriorated, cost much more money than if you had nipped the problem in the bud.

So they were like, "Hey, we're already spending a lot of money. We're just doing it in a non systematic way. And now by giving people Medicaid, we'll be able to provide better primary care to them, more preventive services to them, and so it's going to pay off in the long run on its own. It's going to save the state money somewhere else."

Serena Allen:

What states chose to adopt this and what states didn't?

Neeraj Sood:

So it's basically blue versus red state. So a lot of I would say most of blue states expanded eligibility, and some red states did. And it changed over time. So people in some red states saw that your neighboring state was a blue state and they had expanded Medicaid eligibility, and that created pressure on some of these states to expand eligibility later. So there was this move towards more red states as time went on, trying to expand Medicaid coverage.

Serena Allen:

Definitely. So just to clarify a little bit, I think I got confused there. So only the fourth part of the Affordable Care Act, expanding eligibility for Medicaid was the part that states had control over. They had to already remove the existing condition, pre-existing condition and then had to do the mandate or tax to get insurance, and then had to provide subsidies to lower class families.

Neeraj Sood:

Yes.

Serena Allen:

Okay.

Neeraj Sood:

So there was one other aspect. So when they implemented the subsidies for health insurance, so this is basically for people who couldn't get insurance through Medicaid, Medicare or their employer. And before the law, they would go say, go talk to a broker, and try to figure out what insurance policy to buy, and how much to pay for it. And it was... you can imagine, it's very difficult to shop around for health insurance, right?

Serena Allen:

Right.

Neeraj Sood:

Like Serena, if I tell you right now, you need to go figure out what health insurance plan to buy-

Serena Allen:

I would just have no idea.

Neeraj Sood:

You would have no idea, right? And so you're going to rely on this advice of a broker where you don't know what his or her financial incentives are. So what Obamacare did is created something called a health insurance exchange. And what happens in an exchange is, it's

basically a website where you can go buy health insurance. And that website makes it easy for you to shop around.

So basically what it does is you go there and you enter, how much money you make, and some basic information about yourself, like your age and your gender, and so on. And based on that, they figure out how much subsidy you are eligible for. And then you enter your zip code, and it will give you an option of plans. And the plans were, so there was a gold plan, and there is a silver plan, and there's a bronze plan. So I know you don't know a lot of health policy, but you know that gold is better than silver and silver is better than bronze.

Serena Allen:

Definitely.

Neeraj Sood:

So that was the idea that grouping plans that looks similar into different categories, bronze, silver, gold, and then for each plan, making it easy to compare features and compare premiums and also standardizing the features of these plans. So every plan had to cover something called essential health benefits. So you don't have to read the fine print of the plan to figure out, "Hey, does it cover this or not?" You had a law that said, if you're selling a plan on the exchange, it has to cover these features. So they basically standardized the product, made it easier to shop around, it was kind of it's not as cool as the Amazon website, but close enough-

Serena Allen:

Definitely.

Neeraj Sood:

... for a complicated product. So they made it easy for people to shop around. And that was their idea that if people can shop around, if you make it easy for them, and you're providing subsidies, then more people would buy health insurance.

Serena Allen:

Definitely, yeah. Amazon is exactly what came to mind for me with this website. It seems like overall a fairly good plan. There's something else that's ringing in my head. I don't know if it's actually coming from the Affordable Care Act, but I have a sister who's just a couple years older than me, she's about 23 right now. And I remember, a couple years ago, there was something where it expanded our health insurance coverage, where we could stay in our parents plan to maybe 25.

Neeraj Sood:

Yes. So that was another way they tried to expand insurance coverage, which was saying that if you are less than 26 years of age, you can stay on, on your parents health insurance policy.

Serena Allen:

Oh, wow. And that was part of the Affordable Care Act as well?

Neeraj Sood:

And that was part of the Affordable Care Act as well. So they did a variety of things to expand insurance coverage. And actually just coming back to the point of these exchanges, or these websites that help people shop around. So there are two models. There's one model say the model California adopted, where they maintain their own website. So it's called Covered California.

Serena Allen:

Oh, wow, okay.

Neeraj Sood:

But there were some states who didn't want to set up their own website. So the federal government came in and helped them set up their website, or helped them set up their exchanges. So there's some variation in that also. So for example, states in like California, were committed to setting up this website. So not only did they set up this website, but they did a lot of outreach, and they did outreach in 15 different languages. They set up storefront shops where people could go in, they would have a person with a laptop sitting there, they could go on the website, help navigate a patient to go and buy health insurance coverage.

California did a lot of advertising on TV, to say, hey, people, you need to get insurance. And we still see those ads in California during open enrollment. But other states which weren't committed to this, they set up a website, but they didn't do the outreach. So what happens with that is if you don't do the outreach, maybe someone who really needs insurance, basically someone who's sick, will still go and buy insurance, right? Because they really need it and they'll figure out. But the healthy people, they will know about it because it's not a top of mind issue for them. So the outreach also helps stabilize the insurance pool because it attracts more healthy people, more young people into the pool.

Serena Allen:

Definitely. I definitely see the Human Rights side of providing healthcare for everyone. I think people who are making less money a year still deserve the right to the highest attainable standard of health. But I'm curious, expanding a program like this so extensively must have changed the cost on not only the federal government, but also the state government, which we touched on briefly. Do you have any idea what the numbers are like, for how much we expanded our spending on healthcare after passing these?

Neeraj Sood:

So what they did was, you're right, that providing subsidies cost money, expanding Medicaid eligibility cost money. So what they tried to do was offset some of these costs by imposing additional or new taxes. So the taxes that were imposed were people above making more than $200,000 a year had to pay more in income taxes. There's something called Cadillac plans. So which is basically say, a lot of employers like USC or other large employers offer very generous health insurance plans.

So they basically said, if you offer very generous health insurance plans, we're going to tax the premiums on those plans. So there was a Cadillac tax, or a tax for Cadillac health insurance plans. There was a tax on pharmaceutical forms, there was a tax on medical device forms. So they try to recoup the cost of the subsidies through these additional taxes. And in the end, I think, I don't know the numbers exactly, but the effect on the government budget or the government deficit was not significant, or maybe it even reduced the deficit. It depends on how you think about it change healthcare costs. I'll kind of come to that next.

Serena Allen:

Right. Quickly, just to clarify, so the Cadillac tax, is that taxing the company or is it taxing the employees?

Neeraj Sood:

It is taxing the company, but taxing the company is what will a company do when it faces the tax? It's going to pass on some of the tax to its employees.

Serena Allen:

Right.

Neeraj Sood:

Right. So the way a company thinks about this is, for example, USC has hired me as a professor. So when they think about the cost of hiring me, is it just what they pay me in my salary or in my paycheck or are there other costs? There are these other costs, right? They provide pension, they don't really provide a pension, they provide retirement benefits, and they provide healthcare benefits to me.

So now if my healthcare costs go up, what is USC going to do? Are they going to give me the same pay raise as they were thinking of giving me? Or are they going to say, "Hey, we already gave him a pay raise, his healthcare costs went up, and we paid for it."

Serena Allen:

Right.

Neeraj Sood:

Right. So ultimately, what economists say is not the entire burden, but some of the burden of higher fringe benefits or higher health insurance costs or retirement benefits are paid by employees themselves, right? Or what companies would do is if they face higher healthcare costs, what are they going to do? They're going to increase the prices of their services. So they're going to charge their customers more. Who are the customers? It's us. So ultimately, who pays for all of this? It is us Americans who pay for all of this.

Serena Allen:

Definitely, yeah. And all of these taxes, do they still stand under the new administration?

Neeraj Sood:

So no.

Serena Allen:

Okay, wow.

Neeraj Sood:

So the Cadillac tax was repealed or delayed, some of the medical device tax was repealed or delayed, and a lot of people knew that this was going to happen. So when Obamacare was passed, they had all these taxes, but then they knew that... So for example, the Cadillac tax is not very popular among unions, because unions negotiate benefits for their employees, or for their members. And a lot of those benefits are these Cadillac health plans.

So everyone knew that these things were going to be repealed in the future, right? And similarly, the medical device companies and pharmaceutical firms, they have strong influence on DC politics. So everyone knew that there was a very good chance that these additional taxes would be repealed. And now if you repeal those taxes, then it starts creating a deficit, right? And who's going to pay for this deficit? It's future Americans, right?

Serena Allen:

Right.

Neeraj Sood:

Because ultimately, right now we finance our deficits by borrowing money from either US citizens, or China, or India or other countries, but ultimately we'll have to repay back those loans.

Serena Allen:

Right, definitely.

Neeraj Sood:

And whoever is alive 40 years from now is going to be repaying those loans.

Serena Allen:

Yeah.

Neeraj Sood:

And that's why people worry about deficits.

Serena Allen:

So I understand why repeal the Cadillac tax like I guess it hurts unions and negotiating those actually premium healthcare plans for their employees, but why repeal the medical devices tax?

Neeraj Sood:

So I'm sure if you talk to a medical device manufacturer, they'll tell you the hardship the tax imposes on them. They'll say that it increases the price of say hip surgery because you need to put a artificial hip, and who's going to pay for that? So you're imposing costs and people getting hip surgeries, or joint replacements, or getting pacemakers and other medical devices, right?

So there's always an argument you can make for why you shouldn't be taxed and somebody else should be taxed.

Serena Allen:

Definitely.

Neeraj Sood:

Why the service you're providing is better than what others are providing.

Serena Allen:

Definitely. So my next question is, I hear this said a lot from a lot of people on the left, mostly, but just covering healthcare for everyone make the costs cheaper for everyone? And if so, how does that work?

Neeraj Sood:

That's a difficult question. And let's take it step by step.

Serena Allen:

Sure.

Neeraj Sood:

And this is related to Medicare for all, right? So one argument is that if I provide health insurance then health insurance is going to lower healthcare costs, because I am providing everyone with access to primary care or preventive care, and that will save me costs down the line in terms of hospital visits or ER visits and so on, right?

Serena Allen:

Right.

Neeraj Sood:

So they're saying providing healthcare is good because you get... or providing health insurance is good because you get timely healthcare, which avoids downstream costs. So now if you say, "Okay, Neeraj, what's the evidence in this? Does it really do this or not?" And the evidence is, it doesn't do it.

Serena Allen:

Oh, interesting.

Neeraj Sood:

So there was a big study done, called the RAND health insurance experiment, where basically what they did was to simplify it, like they basically said, we're going to toss a coin. If it's heads, you get super duper health insurance, and if it's tails, you get really stingy health insurance, right? And then they follow these people for five years, right? So when you toss a coin, and suppose you are in this, there's a group in the generous health insurance group and there is a group in the stingy health insurance group. Do you think they're going to differ in terms based on their health status at the beginning of the experiment?

Serena Allen:

Probably not.

Neeraj Sood:

No, because it was determined by luck, right?

Serena Allen:

Right.

Neeraj Sood:

So now they follow these people over time, because they're comparable to each other, but one has really good insurance and the other has bad insurance. And what they found out was the group with good insurance, actually spend more money on healthcare. And the group with less

generous insurance spent less money. But if you looked at and you can say, "Hey, Neeraj, that's fine, but the group with more generous insurance must have had better health." And that wasn't the case.

Serena Allen:

Oh, wow.

Neeraj Sood:

So they spend more money, but they didn't have better health. So now, what happened? So this is what economists call moral hazard. So basically, imagine that if you don't have insurance, how much does a doctor visit cost? What do you think?

Serena Allen:

Oh man, I have absolutely no idea. I know I pay a $5 premium when I go in for an appointment.

Neeraj Sood:

You pay a $5 copay.

Serena Allen:

Copay, yeah.

Neeraj Sood:

Let me tell you the cost of a doctor visit if you didn't have insurance would be about $150.

Serena Allen:

Oh my gosh.

Neeraj Sood:

Okay, so now imagine you have a slight fever and a cold, do you want to go to the doctor if you're uninsured?

Serena Allen:

Heck no. It's more than what I pay on groceries and gas.

Neeraj Sood:

But if you have to pay five bucks would you go to a doctor?

Serena Allen:

Definitely.

Neeraj Sood:

Probably yes. Would going to a doctor matter if you have a little cold or a fever?

Serena Allen:

Probably not.

Neeraj Sood:

Probably not.

Serena Allen:

Might make me sleep better at night, but that's about it.

Neeraj Sood:

So, basically the RAND health insurance experiment found that. They just spend in today's dollars, about $500 million trying to figure out that answer in an accurate way. So that's the first argument.

The second argument is that in the US, other than the Medicare program, like the employers and the private insurers, they negotiate with doctors and hospitals and pharmaceutical firms. And then based on those negotiations, they decide how much to pay for a doctor visit, how much to pay for a day in the hospital, how much to pay for an MRI, how much to pay for a prescription drug and so on. And if you look at US healthcare costs, they are, it is true, they are way higher than any other country. Even when we account for the fact that we are richer than other countries.

So we're still paying more for health care. And then the question is, why are we paying more for healthcare? It's not because we use more healthcare. So it's not because we go to the doctor more often, or we buy more prescription drugs, or we stay in the hospital longer. It's because we pay more for everything. So, a day in the hospital in the US costs much more than in any other country. One visit to the doctor costs much more in the US than any other country. And so what is the difference between the US and other countries? Well, other countries just set the price of healthcare. Which means the government says, "Hey, Serena, or Dr. Allen, you're going to get 50 bucks a visit."

Serena Allen:

Okay.

Neeraj Sood:

You have no choice to say, "Hey, I don't like it," or... that's what it is. But in the US, an insurer cannot go to a doctor and say, "Hey, you're going to get 50 bucks a visit." Because the doctor can say, "Hey, I don't want to take you. I have another insurer who's going to pay me 70 bucks a visit, and I want to go with them."

So as a result of that, US prices are higher. And then you can say, is that good or bad? So that's bad for consumers because then we end up spending more on healthcare. And the reason why people think prices are higher in the US is because there are a lot of monopolies. So there are a lot of areas where there's just one hospital. So they can really dictate what price they want to charge.

Serena Allen:

Definitely.

Neeraj Sood:

Or there's a shortage of physicians and they can dictate what price they want to charge and so on. So, those in favor of single payer healthcare or health care for all say, it's not just healthcare for all, but it's the government deciding what price to pay for healthcare for everyone.

So we're taking going away from a market system where it's a negotiation between parties to just saying there will be someone in the Department of Health and Human Services, who's going to decide and say, "For our hospital visit, we're going to pay you $100, for physician visit, we're going to pay you $50.' So that's what happens in in the Medicare program. Because remember Medicare at least a part of the Medicare program is completely run by the government, and so the government decides whatever they want to pay doctors and hospitals.

So the threat with that is suppose now this happens throughout the system. If you set the prices, right, it's a great system. Because you've lowered costs for everyone, and things are good. But there are two threats. So one threat is you don't have market information to decide how to set these prices. So you could set the price too low. So for example, you say, "Hey, I want to save money right now, because I want to win my next election. So I'm going to set the price of an office visit at $30." And it's going to make everyone, all my constituents happy other than the doctors, right? And then what will happen is some doctors will start going out of business, or some people will say, "It's not worth for me to be a doctor to earn $30 a month a visit, I want to do something else." But that's going to take some time to play out.

So one worry with the government setting prices is that they might set the price too low, which might mean people not going into medicine, hospitals closing, people closing pharmaceutical firms because it's not enough money to be made, people spending less money on R&D and innovation and so on.

Serena Allen:

Right.

Neeraj Sood:

The other threat is the other way around. So do you think if the government is setting prices, what are hospitals going to do? Are they just going to provide patient care, or are they also going to set up an office in DC to lobby for higher rates?

Serena Allen:

Probably lobby.

Neeraj Sood:

Right. And who's going to succeed, right? It's going to be now trillions of dollars at stake when you change your price. And they're going to come up with creative ways of justifying why they need higher prices. So we could end up with even higher prices than we have today.

And so that's the rub that in principle, it makes sense that we can set the price right, but in practice, we don't know, we might set the prices too low, we might set the prices too high.

Serena Allen:

Definitely.

Neeraj Sood:

And that's why in the US, we rely on the market to set prices, right? In every field, right? We don't say, for computers, does the government set the price of computers? No, it's the market, right?

Serena Allen:

Yeah.

Neeraj Sood:

If you have a computer that's not valuable, and you set the price too high, no one buys your computers, and that's how the prices adjust to the right level. But for the market to work, you need competition. You need many people selling computers, right? You need competition between MacBooks and Windows laptops. But if there was just only one type of computer that could be sold, then the price of computers would be too high. But is the solution then for the government to take over the computer industry, or to get more people to sell computers to actually increase the competition in the market? So in some sense, that's the debate.

So what Obamacare tried to do was still work within the system we have, right? People who wanted their employer provided insurance could get it. People who needed help in buying private insurance got that help through these subsidies and mandates, but they were still buying insurance from private companies. These private companies were still negotiating with private hospitals and doctors and so on, right? So they tried and they said, "Hey, we know the system doesn't work, for example, sick people were not able to buy insurance. So let's try to fix that." But Medicare for all says, "We're going to ditch all of that. We're going to start brand new with a new system where the government is in control," right?

Serena Allen:

Definitely.

Neeraj Sood:

So I think that's what the big difference here is.

Serena Allen:

And that ties right into our High School question of the day from Rebecca Blum, who's a senior at Cranbrook school in Bloomfield Hills, Michigan. And that was her big question. So she actually had two here, one was how Medicare for all system differs from the Affordable Care Act.

And I think you touched on it there where basically Medicare for all, correct me if I'm wrong, is setting the prices for the different pharmaceutical and medical care providers. And then people pay a set price. And so it's more of the European big government almost style of things. Whereas the Obamacare or Affordable Care Act, created a way for people to enter the market if they were already sick and mandated that other people had to buy insurance to open the pool. The other question here was, what would be the positive and negative effects of repealing the Affordable Care Act? Which is something that was discussed heavily in the last election we had and some That was said to have been one of the goals of the Trump administration's presidency.

Neeraj Sood:

So I think there would be two big effects. So one, which we've already touched upon, which is what the Affordable Care Act did was, provided help to a lot of people to get insurance, right? Either through expanding Medicaid eligibility, through removing the pre-existing condition exclusion, through providing subsidies, to making young people eligible to be on their parent's policy till age 26.

Serena Allen:

Right.

Neeraj Sood:

So if you remove all of that, a lot of people who got insurance as a result of that won't have insurance. So what's going to happen is a number of uninsured people in the US is going to rise. The other thing that Obamacare did, which a lot of people don't know about is it tried to change the way we pay for healthcare. So for example, if you take the Medicare program, if I go, suppose I have a Medicare card, and I go to a hospital, and I get some care. Now the hospital provided me poor quality care, and they discharged me after two days. So the hospital gets paid for providing care to me from the Medicare program.

Now, five days later, because they provided me not really good quality care, I end up in the hospital again. So what happens is now the hospital makes more money, because that's a new visit to the hospital, Medicare pays again, right? So what the Affordable Care Act did was, they said, "Hey, that doesn't make sense. Those are the wrong incentives for hospitals. So we're

going to try to correct that." So the way they tried to correct that was they said, if you're a hospital, and you have more readmissions than we think is appropriate, then we're going to penalize you.

Similarly, what happens is suppose you are a physician. Now, when you are providing health care to a patient, it has long term implications for a patient. So if you provide good care to a patient, the patient is their health is going to be maintained, and they won't end up at the ER, or they won't end up at the hospital. So what Obamacare did was created something called accountable care organizations, where they're giving incentives to physicians or a group of physicians to say, if you save us money by providing good care to patients, so we the Medicare doesn't have to pay hospital costs for these patients, we will give you some of the money back. So we will give you a bonus if you save us healthcare costs down the line.

So what happened was, so these were all kind of innovations, there are other things they did. So what happened was that not only did this change the Medicare program, but private health insurers looked at this, and they said, "Hey, these are good ideas. And we need to implement them in the private health insurance market also." So this basically led to a lot of reforms or a lot of changes in the way we pay for healthcare.

Serena Allen:

Oh, wow.

Neeraj Sood:

So it created this movement of like, let's get the incentives right in healthcare, let's try to figure out if we can pay hospitals and doctors in better ways, so that it saves money for the system as a whole. And if you get rid of the Affordable Care Act, I think you're going to put that movement to a halt.

Serena Allen:

So what are some of the pros of... that the Republican party in particular, and also some of the less well known like Libertarian parties in general, what are some of the pros that they see in repealing the Affordable Care Act? Why do they want to do this? Because all policymakers no matter what your party affiliation is, they're trying to help people in the best way they can. So why would they want to appeal healthcare without posing something new, or going to the old way that we were doing things?

Neeraj Sood:

So I think some of this is just politics. But the other thing is, so people don't like the fact that it increased the deficit, right? Because you had all these taxes, but then you repealed some of them. So that's one aspect of it. The second is people don't like the individual mandate. So they're like, "Hey, you cannot tax people, and then force them to buy health insurance." So that's another aspect of it. The third thing they're saying is, they want more decisions to be made by the states. So they're basically saying, let the state decide what healthcare they want

to provide to their citizens. The federal government should not come in and say you need to expand Medicaid eligibility and so on.

Similarly, states want the freedom to decide what are essential health benefits. So right now, the federal government says, what are the benefits that should be covered in an insurance plan? States say they want to be able to decide, what's covered or not. Some of the objections are also along religious moral lines, should health plans cover abortion services? Should they cover contraception or not? And things like that.

So and it's when they say, we're going to repeal and replace, it's unclear what that replacement looks like. I haven't seen a single proposal which is clear or like, "Okay, this is what we want to do." One of the proposals I've heard is something called block grants for Medicaid, which is basically right now what the federal government says is, we're going to pay 50% of your Medicaid costs, and the state pays 50% of the Medicaid costs. But that since we're paying 50% of the cost, you have to abide by certain rules. You have to abide by the rules of the federal government.

So another option is to say, we're just going to give you a fixed amount of money. So we're going to give you $50 million. If your actual costs are higher than $50 million, too bad, you deal with it. But since we're giving you a fixed amount of money, and you're taking on risk, we're going to give you freedom to decide who you want to cover, how you want to cover and so on. So if you don't want to cover disabled it's up to you, you don't want to cover middle income families, it's up to you. You want to provide coverage for contraception, go ahead. You don't want to provide... you can decide what you want to do.

So the Republican proposal is kind of saying, "Look, these Medicaid costs are going... are really rising fast. And these states don't have enough money to spend on roads and education and other things. So let's give them a fixed amount of money. And then let them decide how they want to run their state and how they want to manage their healthcare benefits and so on."

Serena Allen:

That's very interesting. I hadn't heard many ideas either. But the block grants sounds like something where you could perhaps in one state receive about the same care, maybe if not better, depending on how much your state values health insurance. But of course, there's the cons of living in a state that maybe doesn't support certain rights to women's health, or I imagine for the LGBTQ plus community, there could be certain problems there with receiving healthcare as well. So it really just depends on the differences there. I also know... Sorry, go ahead.

Neeraj Sood:

And I think the block grants in terms of incentives, get the incentives right, right? So for example, if I say, hey Serena, I'm going to give you $10 and you need to manage whatever lunch you want to buy for the $10.

Serena Allen:

Okay.

Neeraj Sood:

But the $10 are yours. So you will say, "Okay, you know, I'm going to buy $8 sandwich and keep the $2 for the future." But now if I say, "Hey, Serena, I'm going to pay 50% of your lunch costs, no matter what it is." What are you going to do? You're going to say, "Hey, I'm going to buy a $20 sandwich."

Serena Allen:

I'm going to go get lobster actually.

Neeraj Sood:

You're going to get your lobster because someone else's footing 50% of the bill, right? So what they're saying is, look, we're going to give you a block grant, and then you figure out what works in your state. It's not a one size fits all solution. But you're absolutely right that people on the left don't like that because they say, "Hey, this is going to leave a lot of people with not good coverage." And then in certain states, certain groups who are in minority might be left out, and that's not fair. Like, we should be able to cover everyone. And then what would happen if a state goes into a deficit? And ultimately the federal government might have to step in and help the state out. So that's where some of the debate is.

Serena Allen:

Definitely. And it seems like under the current forum, it was definitely at the time very innovative, but now there seems to be quite a handful of problems in the state versus federal power. And overall, with the taxes changing, it seems just as complicated as about I imagine, even though now I understand it better. And we've been talking a lot, so far about just the facts. And I want to end on a question. We're kind of asking all the experts that come in here, but what is your opinion on how we can better approach healthcare from a non partisan lens to better allocate American tax dollars?

Neeraj Sood:

So I think, I'm not in favor of Medicare for all because I think the risks are too high, right? That I still believe in the markets being able to set prices, rather than the government deciding what the prices of anything should be, whether it's healthcare, computers, cars, and so on.

I like certain aspects of Obamacare which is a mix of relying on private markets, but at the same time providing help to low income families, help to the elderly. I like the fact that it tried to come up with new ways to pay for healthcare, trying to get the incentives right. Are there things that could be fixed in Obamacare? Potentially, yes. Can we do more to make private markets in the US work better? Definitely. So I think that's the direction I would go in. I

don't want to abandon private markets. But I think I definitely agree that there is a lot of room to make these private markets work better. So I think that's the direction I would head in.

Serena Allen:

You just heard Dr. Neeraj Sood explain Medicare, Medicaid, the Affordable Care Act and more. Thanks for listening. If you're like me, you've been listening to different political figures debate different health policies for some time now, without fully understanding the cost and implications of different policies.

A big thank you to Dr. Sood for teaching me a simplified version of what the policies actually are. I hope listeners like you gained as much as I did. If you enjoyed today's episode on health policy, be sure to check out our other episodes and share this one with a friend. To learn more about what Dr. Sood does or Medicare and Medicaid and the Affordable Care Act, please go to bedrosian.usc.edu/paycheck where you can also provide feedback or request topics for future episodes.

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