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ANALYSIS & COMMENTARY

Assessing Health Reform's Impact On Four Key Groups Of Americans

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ABSTRACT Health reform can be assessed from the perspective of four groups that collectively include most Americans. For those who are now in Medicaid or who are uninsured, reform will be a major gain. For those who obtain health insurance in the individual and small-group markets, reform should bring improvements. For those who have health insurance from midsize- and large-group insurers, reform will bring little change. Finally, for Medicare beneficiaries, reform promises to bring positive change. However, financing future health spending overall, and Medicare spending in particular, poses a formidable challenge. Although not a panacea, all-payer rate setting, in which a federal or state agency establishes standard payment rates for each class of payer, may be the only feasible alternative, at least in the short run.

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Although the Patient Protection and Affordable Care Act (PPACA) of 2010 addressed many issues in health care financing, it left many others unresolved. Despite President Barack Obama's hope to be the last U.S. president to have to undertake major health care reform, future presidents will, like Sisyphus in Greek mythology, have rocks to push up the hill. Even if many rocks are pushed to the top, a few may roll back down, and still others will remain strewn about the landscape. In short, the task of implementing the major overhaul of health care contemplated in the Affordable Care Act will require persistence for many years to come.

Four Groups Affected By Reform

Many aspects of the health reform law, such as proposed payment reforms and improved quality measures, are designed to obtain more value for the health care dollar. These represent sound policy and are urgently needed. Examining the new law from the perspective of four groups of Americans can help explain the potential and the

challenges ahead.

One group consists of those who are currently eligible for Medicaid or the Children's Health Insurance Plan (CHIP) or who are currently uninsured. In 2009, about 30 percent of the U.S. population was in this category.

Another group, equal to approximately 10 percent of the population, includes those with individual and small-group insurance purchased by firms with fewer than fifty employees.

A third group is those with insurance from midsize and large employers—equal to about 45 percent of the population.

The final group consists of those enrolled in Medicare—about 15 percent of the U.S. population in 2009.

The distribution of these groups by spending differs markedly from the distribution by share of population. For example, the 30 percent of the population eligible for Medicaid and the uninsured account for 16 percent of U.S. health care spending. Those with health insurance through a midsize or large employer and Medicare enrollees each account for 38 percent of U.S. health care spending.¹

People With Medicaid And The Uninsured

People eligible for Medicaid are combined with the uninsured for two reasons. First, the two groups overlap because a sizable number of the currently uninsured are eligible for Medicaid.² Second, about half of the increase in health insurance coverage scheduled to take place under the reform law comes from expanding eligibility for Medicaid to include low-income parents of Medicaid-eligible children, and low-income adults without dependent children.

MEDICAID ELIGIBILITY EXPANSION Although expanding Medicaid eligibility is a sensible way of reducing the number of uninsured people, it does raise fiscal, administrative, and delivery system issues. One fiscal issue that received a great deal of attention in the reform debate was the capacity of the states to finance their share of the expansion. Because most state budgets are now struggling from the impact of the recession, the federal government will finance all of the costs of the newly eligible Medicaid population for three years after the expansion begins in 2014. The federal match rate will then fall to 90 percent for the newly eligible in 2020 and later. The new match rate is notably higher than those for the current Medicaid and CHIP programs.³

An issue that received much less attention is the chronic budget management problem that Medicaid poses for states—a problem that the expansion of Medicaid aggravates. State tax revenues fall in a recession, while Medicaid spending rises as more people lose jobs and income and become eligible to participate in Medicaid. Unlike the federal government, states by law must have balanced budgets. The mismatch of changes in state tax revenue and spending on Medicaid in a recession forces states to cut other programs. And because Medicaid is such a huge line item in most state budgets, the magnitude of offsetting cuts needed when a state's Medicaid outlays rise is typically large as well.

The bottom line is that although the high federal match rate for the newly eligible is helpful to states, any increase in the number of those eligible for Medicaid that requires state matching funds worsens the budget management problem for states.

ADMINISTRATIVE BURDEN Federal match rates currently vary for traditional Medicaid- and CHIP-eligible individuals. This creates an administrative headache because the division of funding between the state and federal governments for the two programs taken together depends on the proportion of the state's households that are eligible for Medicaid as opposed to CHIP. Which program a family is eligible for depends on its

income as a percentage of the federal poverty level and on the family's assets.

Starting in 2014, Medicaid eligibility will be extended to people who are not now eligible—but at a federal match rate that is different from the rates now in place for Medicaid and CHIP. In effect, this means that a state's overall share of spending will change depending on who becomes newly covered under the Medicaid program. The payment will vary based on a household's position with respect to the Medicaid and CHIP thresholds, and also with respect to the new upper income eligibility limit of 133 percent of the federal poverty level. As a result, a reasonably exact determination of a household's income, assets, and composition will make a difference in who pays. It is easy to envision wrangling between the federal government and the states, potentially involving audits of families, over how much each party should pay.

It would certainly be simpler to have a single match rate, because the state share would remain constant even as people shift among the three categories. The only test would be whether the person or family was above or below a single eligibility threshold. The politics of moving to a single match rate could nonetheless prove nettlesome because, assuming the same federal spending, some states would win and others lose. For example, a state with an above-average proportion of poor, childless adults would not gain as much from a single match rate as it does under the current legislation.

DELIVERY SYSTEM CAPACITY The uninsured rely heavily on safety-net providers such as community health centers and public hospitals for their care. After the Medicaid expansion, many of the currently uninsured will find themselves in Medicaid managed care plans that use the same safety-net providers, but since they will then be insured, they will be likely to receive more services.⁴

Will there be enough capacity in the provider networks of Medicaid managed care plans to accommodate this increase in demand? If not, how much will payment rates have to rise to attract a sufficient number of providers? The reform requires that in 2013 and 2014, Medicaid payments to primary care physicians should not be less than Medicare rates, including payments by Medicaid managed care plans. Although this measure should improve access to primary care services, it will do nothing to meet any increase in demand for specialty services.

Half of the currently uninsured who will gain insurance, however, will not be eligible for Medicaid. Undoubtedly, many of them now seek care from safety-net providers. Once they are insured, will they continue to seek their care

Reforms associated with the Affordable Care Act constitute a major repair job for the individual and small-group market.

there? If so, will there be enough capacity? The experience in Massachusetts after that state reformed its health care financing showed that patients generally did not change their source of care and that community health centers did not have financial problems but did experience increased demand and staffing issues.⁵

Despite these financing, administrative, and potential delivery system capacity issues, the expansion of Medicaid and the subsidies for higher-income uninsured people are major gains for this group and those who may fall into it because of a health problem, the loss of employment, or household dissolution.

People With Individual Or Small-Group Insurance

Of the four groups considered here, this group is the currently the smallest, but that is partly because the individual and small-group market is dysfunctional for reasons described below. The reforms associated with the Patient Protection and Affordable Care Act constitute a major repair job for this market. In fact, if the changes in store for the individual and small-group market were to be analogized to remodeling a house, the house would be totally gutted. As a result of the reforms, starting in 2014, the group buying private health insurance outside of employment-based coverage will be much larger than at present.

ADDING TO THE INSURANCE ROLLS The additional insured people will come in part from the currently uninsured who are not eligible for Medicaid but who as of 2014 must obtain insurance to comply with the new law's individual mandate. They amount to roughly 5 percent of the population—or about fifteen million people. Moreover, with preexisting condition clauses banned and health insurance available to individuals through exchanges, some currently insured people who suffer from “job lock”—

hesitant to switch employers because they fear losing their benefits—might move from large firms to self-employment or to small firms that do not offer insurance. If this dynamic were to materialize, it would increase the size of this group. Finally, a few employers that now provide insurance may elect not to do so and pay penalties.⁶

All told, something around a sixth of the population or more—roughly fifty million people—could be in this group going forward.

CAUSES OF MARKET DYSFUNCTION The current dysfunctional status of the individual and small-group insurance market has several causes.

The most obvious and important is the all-pervading presence of adverse selection: People with known health care needs are more likely to buy health insurance than are healthy or low-risk people. Preexisting condition clauses are an imperfect defense for insurers to use in combating adverse selection.

The phenomenon of adverse selection probably explains the high individual premiums in New York and New Jersey. These two states have pure or “near pure” community rating—where insurers are required to charge the same premium for everyone in a community, regardless of health status. Thus, individual insurance rates in these states are nearly double those in states without community rating. It is worth noting that for those with individual coverage, medical care spending per person is only 10 percent and 23 percent greater in New Jersey and New York, respectively, than the national average.^{7,8}

Sicker people find community rating attractive, and the resulting higher premiums mean that healthier people, who are better insurance risks, don't buy coverage. The threat of adverse selection is greatest in the individual market, but it is also present to some degree in the small-group market. That is why, at present, high-risk people can be medically underwritten out of—or excluded from—a small group.

In addition to the importance of adverse selection in shaping the nature and cost of the insurance available to this group, higher distribution costs add to the higher premiums they face. Individual and small-group insurance is sold in retail fashion through insurance agents or brokers, who receive a commission of perhaps 15–20 percent of the first year's premium. Large employers typically deal directly with insurers—for example, by issuing a request for proposals, in effect getting quotes from insurers to cover their insured workers.⁹ The insurance agent's commission not only adds cost but also creates incentives to steer families toward policies and insurers that pay higher commissions.

HOW REFORM HELPS Health reform addresses

both selection and distribution cost in this market. The individual mandate together with the subsidies and penalties, the prohibition of pre-existing condition clauses, and the establishment of guaranteed issue and guaranteed renewability are all aimed at reducing adverse selection. Additionally, the new law specifies a minimum benefit. That limits the degree to which insurers can compete to enroll individuals who are good risks by offering very low-end policies. The establishment of health insurance exchanges in every state is aimed at reducing distribution costs.

Despite these measures, it is uncertain how much adverse selection will remain after the full implementation of health reform. A principal weapon against adverse selection is the mandate that individuals purchase health insurance. But will the subsidies and penalty structure that the law establishes suffice to bring about near-universal compliance? If not, adverse selection will remain.

EXPERIENCE IN MASSACHUSETTS The Massachusetts experience gives reasons for optimism. Compliance with the Massachusetts individual mandate has been high, although the state's subsidy and penalty structure differs somewhat from that set forth in the federal law. Estimates of the postreform uninsurance rate in Massachusetts vary from 2.6 percent¹⁰ to 3.7 percent¹¹ to 4.8 percent,¹² depending on the year. More than 90 percent of Massachusetts residents, however, had coverage prior to the mandate. That is a level well above those in most other states and was surely an advantage for Massachusetts in achieving high compliance.

SUBSIDIES AND COMPLIANCE The reform law's limit on how much a premium can vary based on a person's age could worsen compliance. Starting in 2014, a sixty-four-year-old cannot be charged more than three times the amount a thirty-year-old is charged for the same policy. Because age rating in many states is now more permissive, these limits are likely to raise premiums for some younger people substantially, which may worsen their compliance with the individual mandate.^{13,14} Although premiums for older people will fall, increasing their compliance, older people have a stronger incentive to be insured, so the compliance issue is more acute among younger people than among their older peers.

Although necessary to achieve compliance, the subsidies will have the negative effect of increasing marginal tax rates. Consider a family of four whose income is \$55,250, or 250 percent of the federal poverty level. Their current marginal tax rate is 22.65 percent plus any state or local income taxes. Assuming that, as of 2014, the family

It is uncertain how much adverse selection will remain after the full implementation of health reform.

buys the most generous health insurance plan covered by the subsidy, the premium will be limited to 8.05 percent of the family's income.

This feature of the law will effectively add 8.05 percentage points to the family's marginal tax rate, since any additional dollar of income will reduce the subsidy by eight cents.¹⁵ Thus, the family's marginal tax rate will rise by roughly a third.¹⁶ Economic research suggests that this would be likely to reduce the labor supply of those who are not the principal income support of the household.

The law tries to boost compliance by requiring employers with more than fifty employees to offer insurance; by subsidizing some smaller, low-wage employers to provide insurance; and by the Medicaid expansion. Still, many of those who are self-employed or employed in firms with fewer than fifty employees will not have employer-provided insurance. They constitute perhaps 10 percent or more of the population.^{17,18}

DETERMINING FAMILY INCOME The health care reform law's reliance on the federal poverty level to determine what families will pay poses administrative issues for this group as well as for the Medicaid group. Not only the premium subsidies—and there are six different premium subsidy rates—but also out-of-pocket payment limits, cost-sharing assistance, and penalties for those not obtaining insurance are tied to the federal poverty level.

The mechanism for ascertaining income in this group is the tax system, but income reporting through this mechanism is lagged, and household circumstances often change. People lose jobs, leave the labor force, marry, separate, and divorce every day. These vicissitudes mean that rules will need to be established for how subsidies and penalties will change when a household's income or composition changes during the year. In hardship cases, the legislation provides for advance payments with reconciliation for any over- or underpayment on the

tax return. It is likely that there will be a lot of reconciliation.

REMAINING RISK-SELECTION POTENTIAL Even if compliance with the individual mandate is high, the incentive for plans to avoid high-risk enrollees still remains. It is desirable for health plans to bargain with providers for good prices, to include cost-effective providers in their networks and clinically important drugs in their formularies, and to discourage low-value care. It is not desirable for plans to overmanage or to target restrictive management of treatments toward chronically ill, high-cost people. The health economics literature describes these practices as “plan manipulation,” “stinting,” and “service-level selection.”^{19–21}

The remaining arrow in the health reform law’s quiver to deal with these behaviors, which are inherently outside the scope of direct regulation, is risk adjustment through the exchanges. Plans with sicker patients will be paid more, and, conversely, those with healthier patients will be paid less. This aspect of the reform has received much less attention, and it is not clear whether risk adjustment will work well enough to keep adverse selection manageable.

Historically, risk-adjustment techniques were not sufficient to keep adverse selection in Medicare at negligible levels. In response, Medicare introduced a much more powerful risk-adjustment method²² that was fully phased in by 2007. Moreover, in 2006 Medicare changed from a monthly to an annual lock-in period, which should have reduced adverse selection. Data have yet to emerge showing how much these reforms have reduced adverse selection.

ROLE OF INSURANCE AGENTS A further uncertainty surrounds the role of insurance agents once exchanges are established. Will individuals buying directly from the exchange over the Internet not have to pay an agent’s commission? If so, one would expect the number of agents to fall, much as the number of travel agents fell once people could buy their own airline tickets online for a modest fixed charge. This issue is left to the federal rule-making process. Even if consumers are permitted to save by not using an agent, health insurance is a more complicated product than an airline ticket, and many people may feel a need to continue to use an agent.

People In The Midsize- And Large-Employer Market

Adverse selection is much less important in the midsize- and large-employer market. This is because larger firms tend to have a reasonably representative distribution of health risks among their employees. Also, many firms self-

insure, which makes insurers’ concerns about adverse selection moot. Because most firms of this size already offer insurance and presumably will continue to do so,⁶ this group is probably the least affected of the four considered here.

Nonetheless, reform will change some circumstances for this group. There will be a “Cadillac tax” on high-premium plans, something advocated by many economists since the 1970s on the grounds that it will improve economic efficiency. More recently, the Cadillac tax has been promoted as a source of revenue, but until now there has not been sufficient political support to enact it. The Cadillac tax attracted a great deal of attention in the debate and will not be implemented until 2018. For those reasons, it is not discussed in detail here.

There is an additional tax on insurers beginning in 2014, imposed as a means of helping finance the overall reform. Because the insurance market is competitive in most local markets, those who receive coverage through the midsize-to-large-employer-group market are likely to feel the tax in the form of higher fees for self-insured plans and higher premiums for at-risk plans. On the other hand, the coverage expansion should mean less uncompensated care. To the degree that the costs of uncompensated care are shifted to the insurance premiums of this group, their premiums will be less.

Medicare Beneficiaries

THE GOOD NEWS Reform’s impact on Medicare beneficiaries poses the most difficult policy challenge going forward. Despite decades of work by many smart people on Medicare payment systems, some of the widely acknowledged inefficiencies in medical care delivery are induced by how Medicare pays for care.²² To address these inefficiencies, the health reform law establishes a Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services (CMS). If the center is implemented well and given adequate future appropriations, its results should lead to greater value for the Medicare dollar.

Whether these changes will actually lead to lower-than-expected federal spending, or simply better care for the same expenditure, is a more difficult question. Moreover, because Medicare pays for such a large share of care, any gains from the payment center’s work may well spill over to the care of those under age sixty-five. The reform law also establishes a voluntary long-term care benefit and closes the notorious doughnut hole in Medicare’s drug benefit by 2020.

That’s much of the good news from the Medicare front.

PAYING FOR MEDICARE GOING FORWARD The bad news concerns paying for Medicare going forward. The discussion can best be framed with two quotes. The first is from Peter Fisher, undersecretary of the Treasury in 2002: “Think of the federal government as a gigantic insurance company (with a side line business in national defense and homeland security) which only does its accounting on a cash basis—only counting premiums and payouts as they go in and out the door. An insurance company with cash accounting is not really an insurance company at all. It is an accident waiting to happen.”^{23,24}

The second is from Carmen Reinhart and Kenneth Rogoff’s recent book on financial crises: “When an accident is waiting to happen, it eventually does.”²⁵

The expansion of health insurance for those under age sixty-five is financed in part by reductions in the Medicare program relative to what would otherwise have been spent. In particular, payments in the Medicare Advantage program and future increases in reimbursement in the traditional Medicare program are both scheduled to fall. And the legislation establishes an Independent Payment Advisory Board to recommend further cuts in Medicare, with a provision that Congress should either amend the advisory board’s proposals or pass an alternative proposal with equivalent budget savings. Should Congress fail to act, the secretary of health and human services (HHS) is authorized to implement the board’s proposals.

SOURCES OF OPPOSITION TO REFORM Some of the opposition to reform came from people who feared that the called-for reductions in Medicare spending would be carried out and that as a result, Medicare beneficiaries would lose benefits, pay more, or get worse care. In the case of many current Medicare Advantage subscribers, these fears are certainly grounded in reality. Because Medicare Advantage rates are frozen for 2011, it is likely that some benefits will be cut.

But other opposition came from fears that the reform law’s payment reductions in future Medicare reimbursements to providers would not be made because future Congresses could and would increase reimbursement faster than called for in the law and find a way to ignore the new advisory board’s recommendations. As a result, according to opponents, health reform would add to the federal budget deficit, or lead to a tax increase, or both.²⁶ By law, of course, when the Congressional Budget Office (CBO) scored the proposed health reform legislation, it assumed that the reductions would be made and thus concluded that the legislation would reduce the budget deficit.

What seems to have been little remarked upon

is that both scenarios—that Medicare spending relative to the existing baseline budget will or will not fall—raise critical issues of substantive consequences and political feasibility. To understand why that is so, it is helpful to employ the “irresistible force versus immovable object” analogy.

RATE OF COST GROWTH The apparently irresistible force is the rate of growth of total health care and Medicare costs—roughly 2.5 percentage points above the rate of gross domestic product (GDP) growth annually over each of the last several decades. Indeed, over the 1999–2008 period, Medicare grew at an even faster rate than this historical average, 2.8 percentage points per year faster than GDP.²⁷

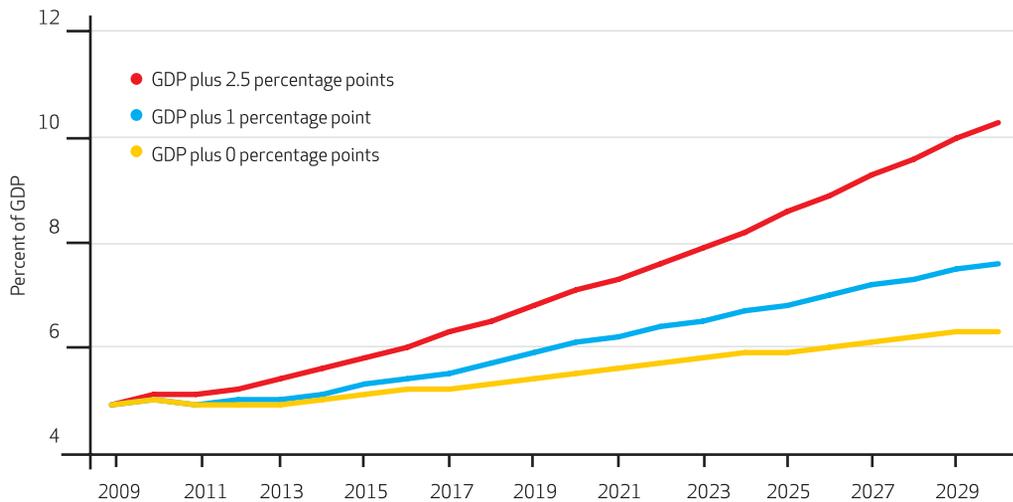
If Medicare continues to grow 2.5 percentage points per year faster than GDP, four percentage points of GDP will shift to Medicare over the next fifteen years (Exhibit 1). Even a one-percentage-point excess rate shifts two percentage points of GDP to Medicare.

Two- and four-percentage-point shifts may sound tiny, but they are not, in the context of the immovable object: the historical unwillingness of the American electorate to allocate much more or much less than 18 percent of GDP to the federal government in tax revenue (Exhibit 2). In fact, only once in the decades since World War II ended has the federal take from GDP gone over 20 percent, and that was in 2000, at the height of the stock market boom, when many people realized capital gains and exercised stock options.

FINANCING MEDICARE How likely is it that this share will rise two to four percentage points just to finance Medicare? There appears to be little appetite in the current electorate for a major tax increase. Furthermore, President Barack Obama ran on the promise that taxes would increase only for households with very high incomes—a promise consistent with most of the additional taxes in the health reform law. Clearly, if Medicare payment cuts in the law are avoided when future administrations and Congresses flinch at the prospect of losing the votes of the elderly, there will be a collision between force and object, with reverberations outside of health policy to the entire economy.

This collision cannot be avoided by borrowing. Most economists, as well as the CBO, believe that if the debt-to-GDP ratio rises to the 80–90 percent range, there is a substantial risk of a vicious downward cycle. Buyers of Treasury bonds could lose confidence that they will earn a positive return—net of inflation—and begin to demand higher real interest rates, crimping future economic growth.^{25,28}

Exhibit 3 shows two CBO projections of alternative future paths for the debt-to-GDP ratio. The

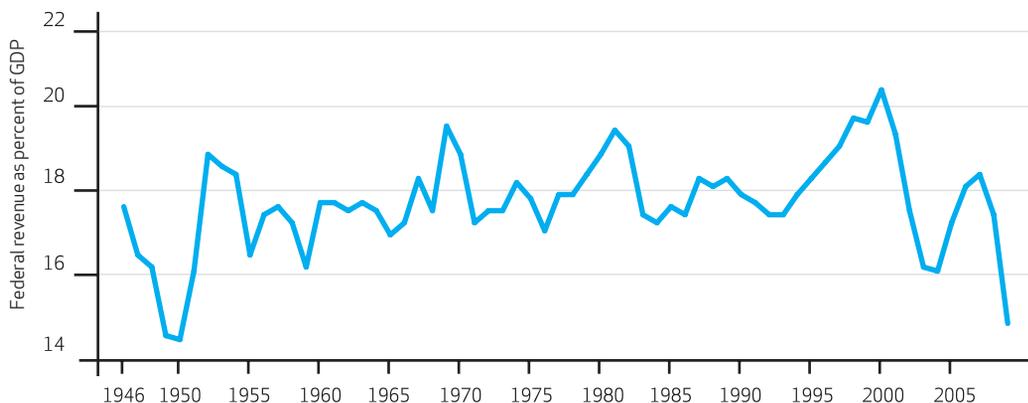
EXHIBIT 1**Medicare's Share Of Gross Domestic Product (GDP) At Various Growth Rates, 2009–2030**

SOURCE Author's calculations based on data supplied by the Congressional Budget Office, updated to 2010. Congressional Budget Office. The long-term outlook for health care spending: a CBO study [Internet]. p. 15. Washington (DC): CBO; 2007 Nov [cited 2010 Jul 9]. Available from: <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>

more optimistic line reflects current law, while the less optimistic one, the one approaching the 80–90 percent danger zone in the 2018–21 period, reflects the CBO's view of likely changes to current law that will increase spending.²⁹ If the less optimistic scenario is close to reality, continued borrowing on any substantial scale to finance future Medicare spending growth is a highly risky option at best and might not even be feasible.

Assume, however, that a substantial portion of

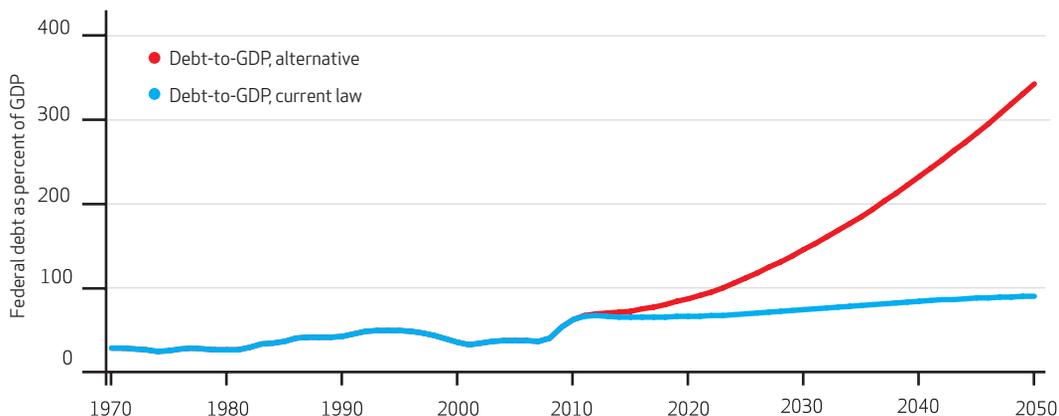
the Medicare reductions called for in the health reform law are not made, and that further borrowing is off the table. If commensurate cuts cannot be made elsewhere in the budget, the immovable object will be forced to move. Taxes will need to increase to finance Medicare. Going out well past 2020, however, the implied tax increases are simply not plausible. For example, Exhibit 4 shows the consequences for individual income taxes if the historical rate of health spending increase continues until 2050 and

EXHIBIT 2**Percentage Of Gross Domestic Product (GDP) Allocated To Federal Tax Revenue, 1946–2009**

SOURCE Author's calculations based on data from the Congressional Budget Office. For years before 2006, see CBO. The budget and economic outlook: fiscal years 2006–2015 [Internet]. Washington (DC): CBO; 2005 Jan [cited 2010 Jul 16]. Available from: <http://www.cbo.gov/ftpdocs/60xx/doc6060/01-25-BudgetOutlook.pdf>. For 2006 and after, see CBO. Effects of selected policy alternatives on the deficit. In: Budget outlook 2010 [Internet]. Washington (DC): CBO; 2010 [cited 2010 Jul 16]. Available from: http://www.cbo.gov/ftpdocs/108xx/doc10871/BudgetOutlook2010_Jan.cfm. **NOTE** Transition quarter in 1977 omitted.

EXHIBIT 3

Federal Debt As A Percentage Of Gross Domestic Product (GDP) Projected To 2050 Under Current And Alternative Laws (Debt-To-GDP Ratios)



SOURCE Author's calculations based on data from the Congressional Budget Office. CBO. The long-term budget outlook [Internet]. Washington (DC): CBO; 2010 Jun [cited 2010 Jul 16]. Available from: <http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf>

individual income taxes are used to finance that spending.

In short, it is hard to imagine that reductions in the rate of Medicare spending growth will not be made at some point. One way or another, the steady-state growth rate will fall; the curve will be bent. But it is equally hard to imagine cutting only Medicare spending while spending by the commercially insured under age sixty-five continues to grow at historic rates, which would lead to a marked divergence between what providers are paid for treating the commercially insured relative to what they are paid for Medicare beneficiaries. This gap could jeopardize Medicare beneficiaries' access to mainstream medical care.

PATTERNS FROM MEDICAID What could happen can be seen in today's Medicaid program, where

rates to providers are typically well below both commercial and Medicare rates. As a result, many physicians do not accept Medicaid patients, and those eligible for Medicaid use a somewhat separate delivery system than both the commercially insured and the Medicare population, neither of whom frequent the community health centers and public safety-net hospitals used by many Medicaid patients. Moreover, Medicaid enrollees often are treated less intensively for a given condition than the commercially insured.³⁰⁻³¹

If Medicare rates were to look more like current Medicaid rates—relative to commercial rates—Medicare beneficiaries could find their access to care diminished. Some providers would start to specialize in commercially insured patients and others in Medicare patients. A foreshadowing of this is already evident with the emergence of concierge medicine for the very well-to-do elderly. Concierge practice physicians request a lump-sum payment for additional services not covered by Medicare. The message to nonpaying customers is that these physicians will no longer treat patients who do not make the lump-sum payment.³²

Such a scenario is not likely to be tolerable to either Medicare beneficiaries or their adult children. They think that they have a social contract, such that in return for paying Medicare taxes through their working years, they will receive mainstream medical care in their retirement. In fact, it has been so unthinkable that the growth of Medicare spending would diverge from growth in private health spending that, in making their long-term projections, CMS actuaries have long assumed that Medicare spend-

EXHIBIT 4

Implied U.S. Federal Tax Rates By 2050

| GDP–health care cost growth gap | Effect on economy (real GDP) | Effect on income taxes |
|---------------------------------|------------------------------|---|
| 1% | 3–16% reduction | ≥70% increase: Lowest bracket (10% to 17%) Middle bracket (25% to 43%) Highest bracket (35% to 60%) |
| 2.5% | Substantial reduction | ≥160% increase: Lowest bracket (10% to 26%) Middle bracket (25% to 66%) Highest bracket (35% to 92%) |

SOURCE Congressional Budget Office. Financing projected spending in the long run [Internet]. Washington (DC): CBO; 2007 Jul 9 [cited 2010 Jul 16]. Available from: http://www.cbo.gov/ftpdocs/82xx/doc8295/07-09-Financing_Spending.pdf. NOTES Excludes effect of premium and cost-sharing subsidies. GDP is gross domestic product.

ing will grow at the same rate as all other health care spending over an extended period of time.²⁴

ALTERNATIVE TO MEDICARE CUTS If Medicare payment cuts are just as problematic as allowing Medicare payments to continue growing unabated, what is the alternative? There is one, of course: reducing the rate of growth not just of Medicare spending, but of total health care spending. At some point this will be unavoidable.

Exhibit 5 shows projected amounts of spending on nonhealth goods and services under different health spending growth scenarios. The “no gap” scenario assumes that real per capita GDP and health spending will grow at the same rate, thus leaving room for an increasing rate of growth in spending for nonhealth items. The other two scenarios show gaps of one and two percentage points between health care cost growth and real per capita GDP growth. The two-percentage-point gap, which is below the historical level, will ultimately leave little or nothing left over for growth in spending on all other goods and services.

Just how total health care spending growth will be reduced is far from clear. To some degree, it will occur naturally as health care costs increase. But it is entirely possible that many non-elderly households will want to take advantage of medical advances and buy expensive care for themselves or their loved ones, and so chafe at any spending limits. At the same time, they may not be willing to incur the tax burden needed to finance such spending for others. This state of affairs would surely create considerable social tension.

There is, without doubt, waste, inefficiency, and even fraud in health care today. This reality

makes it tempting to say: “Cut the waste first and then come back to talk about more spending and taxes.” But until some mechanism for reducing spending growth is identified, it is impossible to say just what services or costs will be jettisoned, much less to conclude that the cuts will remove only spending that is wasteful.

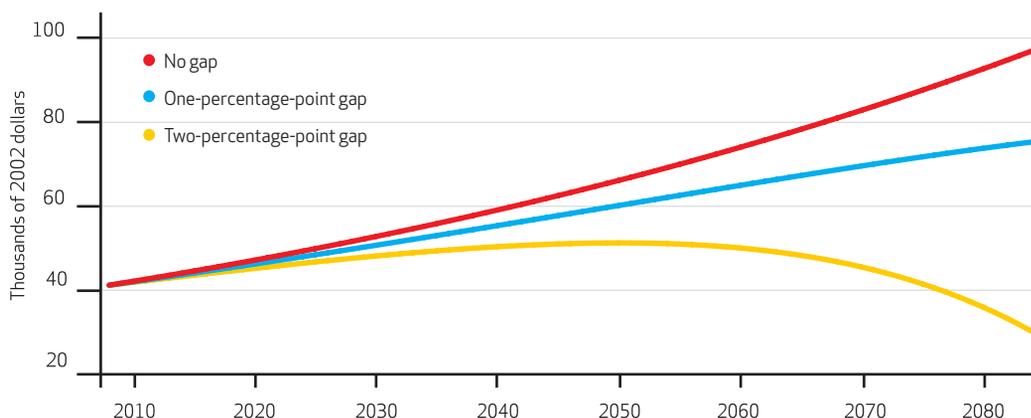
CUTTING TOTAL HEALTH SPENDING Supporters of a single-payer system are likely to favor controls on total health care spending. For example, Congress could establish a budget and stipulate that providers be paid using Medicare payment methods. But such a simple idea is not necessarily a good one.

First, such a course would build in the inefficiencies from existing pricing errors in Medicare.^{21,33} In fact, it would increase them because margins on commercial insurance can now be used to cross-subsidize some instances where Medicare pays too little.³⁴ Second, there is no assurance that the services that would be reduced would be among the least valuable. Third, a pilot project of such a system is already under way with Medicare’s sustainable growth rate for physician payment. The sustainable growth rate limits growth in Medicare physician payment to the growth of GDP. Yet the pressure of the sustainable growth rate has not been used for the past seven years, as successive Congresses have voted to defer the payment limits.

Part of the reason that the sustainable growth rate has not been sustainable politically is the need to keep Medicare rates within striking distance of commercial rates—a reason that would not apply in a single-payer or all-payer regulatory regime. But even if the sustainable growth rate system had been more successful, the task of

EXHIBIT 5

Income Available For Nonhealth Goods And Services, Under Different Gaps Between Growth Rates Of Health Spending And Gross Domestic Product (GDP) Per Capita (Projected), 2008–2084



SOURCE Author’s adaptation from Chernew M. Bending the cost curve, *Health Affairs* issue release briefing, 2009 Sep 9. Powerpoint slide No. 14.

allocating a budget for all people for all health care providers is clearly much more daunting than just reimbursing physician costs for Medicare beneficiaries. In effect, it would mean expanding an administered price system to a sixth or more of the economy.

It is impossible in practice for an administered price system to closely match reimbursement with the cost of the constantly changing methods of treating patients. As a result, there will always be price signals to produce too much or too little of something.

Finally, and perhaps most important, any kind of regulatory control on medical spending is likely to dampen useful clinical innovation.

NO PANACEA Ultimately, there is no panacea. Despite all of the substantive and political problems of price setting, some sort of all-payer regulatory regime may be the only feasible alternative. The other choices would be to allow a much larger discrepancy between commercial and Medicare rates than at present, raising the likelihood of access issues for Medicare beneficiaries, or keep Medicare rates within striking

distance of commercial rates, allowing Medicare spending to claim a much larger share of GDP as time passes. To finance that larger share, however, taxes would have to rise—probably by a substantial amount. What to do about Medicare going forward is a boulder that remains at the bottom of the hill.

Conclusion

Health reform will accomplish many good things for a great many people. Above all, it promises to greatly reduce the number of uninsured people as well as the risk of becoming uninsured. But it is doubtful that the steps included in the Affordable Care Act to reduce the steady rate of growth of health care costs will suffice.

In fairness to those who devoted many of their waking hours in 2009 and early 2010 to passing this legislation, doing more than was done about cost was not politically feasible. Nonetheless, the nation remains in a fiscal hole, and the digging continues. ■

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NOTES

- 1 Author's calculations based on data from the Medical Expenditure Panel Survey (MEPS) 2007 Full-Year Consolidated Jobs and Person-Round-Plan Files.
- 2 Holahan and Headen quote a CBO takeup rate among Medicaid eligibles of 57 percent. Holahan J, Headen I (Urban Institute, Washington, DC). Medicaid coverage and spending in health reform [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2010 May [cited 2010 Jun 14]. Available from: <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL-Executive-Summary.pdf>
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- 5 Ku L, Jones E, Finnegan B, Shin P, Rosenbaum S (George Washington University, Washington, DC). How is the primary care safety net faring in Massachusetts? [Internet]. Washington (DC): Kaiser Commission on Medicaid and the Uninsured; 2009 Mar [cited 2010 Jul 9]. Available from: <http://www.kff.org/healthreform/7878.cfm>
- 6 Although some fear many employers who now offer insurance may drop it, the subsidy and penalty structure make that unlikely. For example, consider a single person with a \$40,000 income and an insurance policy with a \$5,000 premium. If the premium is entirely exempt from individual income tax, the current tax subsidy is \$1,250 plus any subsidy from state income taxes. The new subsidy in PPACA would be slightly less, \$1,200, and no subsidy is available for employees above 400 percent of the federal poverty level (\$43,320 for a single person); in addition, employers with more than fifty employees that drop insurance pay a \$2,000 penalty for each person who gets a subsidy.
- 7 These values, which come from the online insurance site ehealthinsurance.com, do not control for the characteristics of the policy. Although average deductibles are notably less in New York and New Jersey, the effect is not large enough to account for this difference in spending.
- 8 For data on per capita spending by state, see Centers for Medicare and Medicaid Services. National health expenditure data [various data tables] [Internet]. Baltimore (MD): CMS; [cited 2010 Jul 9]. Available

from: <http://www.cms.gov/NationalHealthExpendData/downloads/res-us.pdf>

- 9 In lieu of a broker, large employers often employ a fee-based benefit consultant to advise them and to negotiate with insurers.
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- 11 Centers for Disease Control and Prevention. Short-term effects of health-care coverage legislation—Massachusetts, 2008. *MMWR [serial on the Internet]*. 2010 Mar 12 [cited 2020 Apr 7];59(09):262-7. Available from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a3.htm>
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- 13 For example, WellPoint's analysis for California is that the premium of a younger, healthy individual will rise 106 percent, while that of an older, less healthy individual will fall 41 percent. WellPoint. Health care reform premium impact in California—December 2009 addendum [Internet]. City (ST): WellPoint; [cited 2010 Jul 9]. Available from: http://www.wellpoint.com/pdf/December_2009_Analysis_California_Update.pdf
- 14 Similar analyses for other states are available on the WellPoint Web site.
- 15 The subsidy is the lesser of the premium for the plan the family buys or the premium of the second-cheapest Silver plan (the Silver plan covers 70 percent of expected expenses). In the latter case, if the family buys a more expensive plan, it pays the entire additional premium.
- 16 The family's marginal individual income tax rate is 15 percent, and they pay 7.65 percent in payroll tax for Social Security and Medicare (not counting the employer's share).
- 17 Thirty percent of people working for pay are self-employed ("non-employee firms") or in firms with fewer than twenty paid employees. Another 15 percent are in firms with 20-99 paid employees. U.S. Census Bureau. Statistics about business size (including small business) from the U.S. Census Bureau [Internet]. Washington (DC): The Bureau; [cited 2010 Jun 14]. Available from: <http://www.census.gov/epcd/www/smallbus.html>
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