

## PART 1

# The Healthcare Debate



# The Fiscal Consequences of the Affordable Care Act

*This article was originally published at E21 on April 10, 2012.*

I had never sought to enter the fierce national debate over healthcare policy. When I first began serving as a public trustee for Medicare and Social Security in 2010, I had an established track record writing about Social Security policy, and chose to follow the tradition of previous trustees in making such analyses available to lawmakers, press, and public. I had no similar record of publicly opining on differing visions for the future of Medicare. Amid the intense, ongoing political debate over healthcare policy, I felt that my honest-broker role as a trustee would be best served by avoiding such engagement, except for providing information about the program's financial challenges—as trustees are routinely asked to do.

After the Affordable Care Act (ACA) was enacted, the Mercatus Center asked me if I would perform a similar analysis of the ACA's public finance implications, a project that struck me as interesting and appropriately within the contours of my self-imposed restrictions. Almost immediately upon beginning that research, I was struck by a lack of public and press awareness of the discrepancies between Congress's prescribed scorekeeping methodologies and the laws—particularly those affecting Medicare—that the scorekeeping is ostensibly there to evaluate. Even if one accepted (as I did) the entirety of the Congressional Budget Office's assumptions about the effects of the ACA, the law's passage had unambiguously worsened the federal fiscal outlook when accounting for these discrepancies.

The publication of this information, both in the original Mercatus research paper and in the E21 article reproduced here, unleashed a firestorm. The *Washington Post* published an article about it on page 3 of its print edition, provoking thousands of comments, criticisms from prominent supporters of the ACA, television appearances in which I explained my findings, and even a White House press conference exchange involving President Obama's press secretary, Jay Carney. I had expected some of this and am generally not naive about the passion that suffuses high-stakes policy controversies. It was nevertheless sobering to witness the tenor of much of this discussion. The study hadn't opined on the larger merits or demerits of the ACA, but had focused narrowly on a factual explanation of a congressional scorekeeping quirk that caused a deficit-increasing law to appear to be a deficit-reducing one. Many complaints about my study, even some arising from within academia, had incorrectly assumed that it had written

off some of the ACA's key savings provisions (it hadn't) or that it was motivated by a predisposed hostility to all the ACA's policy goals (it wasn't).

After the smoke cleared, the correctness of the study's central point was acknowledged by more and more sources. Several of the Congressional Budget Office's subsequent publications contained updated language acknowledging the existence of the scorekeeping quirk central to the study's findings. The Committee for a Responsible Federal Budget subsequently recommended that the loophole be closed to inhibit similar deficit-increasing legislation in the future. Tom Price, then the chairman of the House Budget Committee, introduced legislation to do so. By the time Congress began debating repeal-and-replace legislation in 2017, the claim that the ACA was reducing federal deficits had been largely abandoned. The arguments against repeal-and-replace were premised almost entirely on projected coverage declines under repeal, and most reporting acknowledged that repeal legislation would reduce future deficits even if the legislation included substantially expensive replacement provisions.

Life being unpredictable, and scholars being fallible, it's rare for articles venturing projections to look very prescient years after their initial publication. But whatever this article's flaws, the cautions it offered have held up surprisingly well over time. The piece notes a "substantial risk" that the ACA's Independent Payment Advisory Board (IPAB) might never produce its projected savings. In fact, IPAB was never constituted. The piece suggests that the ACA's Cadillac plan tax might produce "far less revenue than currently projected." The tax has since been postponed, weakened, and finally repealed. The piece also warns that the law's health insurance exchanges are "susceptible to future expansion"—and indeed, in the wake of the failure of repeal-and-replace legislation, there have been calls for Congress to further increase federal spending to shore up troubled ACA exchange plans.

Of course, appearing prescient after the fact wasn't the purpose of this piece. It would have been far better if this article had had sufficient influence at the time it was first published and the warnings it contains had been heeded.

**THIS MORNING [APRIL 10, 2012] THE MERCATUS CENTER IS PUBLISHING** my study, "The Fiscal Consequences of the Affordable Care Act," which evaluates the comprehensive healthcare reform law (the ACA) enacted in 2010.<sup>1</sup> In this study, I project that the ACA will add over \$1.15 trillion to net federal spending and more than \$340 billion to federal deficits over the next 10 years, and far more thereafter.

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1. Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Center at George Mason University, Arlington, VA, 2012).

That this law on which so many high hopes were placed will significantly worsen federal finances is an unfortunate but unambiguous result. The finding is based on analyses published by the Congressional Budget Office (CBO) and Centers for Medicare & Medicaid Services (CMS) Medicare Actuary, and it reflects an optimistic fiscal scenario in which all the law's cost-saving provisions work as currently envisioned.

## Quantifying the Fiscal Consequences of Healthcare Reform

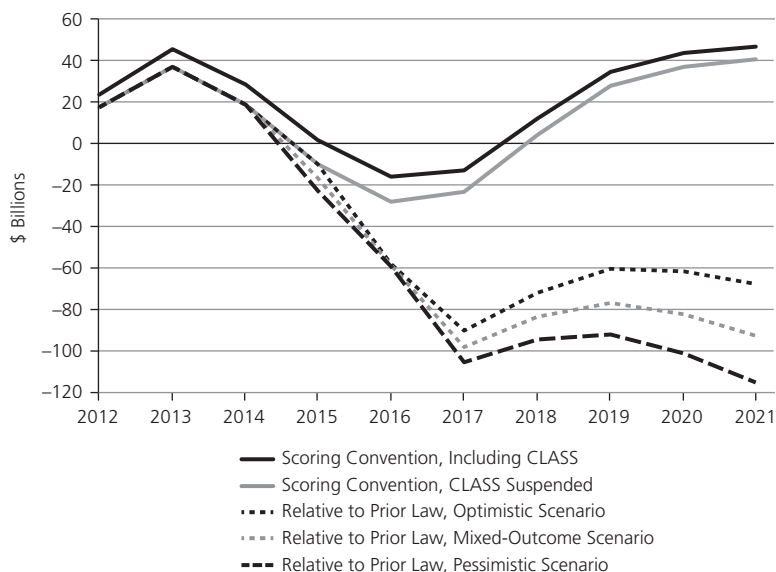
The fiscal stakes of healthcare reform are high. Prior to the law's passage its proponents and opponents disagreed on many things but they agreed on one: rising healthcare cost commitments were a key driver of an unsustainable federal fiscal outlook. Motivations and goals for the 2010 legislation were various, but among the most prominent was the view that such action was necessary to correct the course of federal finances. For this landmark legislation to actually worsen the fiscal situation would represent a substantial failure of governance, and it threatens disastrous consequences if the law is not corrected before its provisions become fully effective.

The ACA unambiguously worsens federal finances. As figure 1 shows, under a variety of possible assumptions (all based on the analyses of CBO and CMS), our annual deficits will be much larger because of the ACA than they would have been under prior law. As visually represented in this picture, up is good and down is bad from a budgetary perspective.

The top two lines on the graph show that the law appears to have a helpful effect on the federal budget under a particular government scorekeeping convention. This is true both as the law was originally scored by CBO and as it was adjusted for last year's suspension of one of its provisions, the CLASS program. The bottom three lines, however, show that the ACA greatly worsens the situation relative to actual previous law.

Under each of the optimistic, mixed-outcome, and pessimistic assumptions concerning the future implementation of the ACA's various provisions, the law would add between \$340 billion and \$530 billion to federal deficits over the next decade. Under the pessimistic scenario—by no means a worst-case scenario, but one assuming that Congress acts in the future according to historical precedent—the law would add over \$100 billion annually to federal deficits by 2021. This suggests that it would add more than \$1 trillion to deficits in its second decade.

Figure 1. Net Annual Budgetary Effect of the Affordable Care Act



Note: The figures above are positive if they improve the budget outlook and negative if they worsen deficits.

Source: Figure 7 in Charles Blahous, “The Fiscal Consequences of the Affordable Care Act” (Mercatus Center at George Mason University, Arlington, VA, 2012). Author’s calculations based on data and projections from the Congressional Budget Office and the Centers for Medicare & Medicaid Services.

There are two important yardsticks for measuring the fiscal effects of healthcare reform. Measuring its effects on federal deficits is one. The other—measuring its effect on total federal healthcare spending—is equally important. This is because under current law, federal healthcare spending commitments are widely acknowledged to be unsustainable. A “solution” that appears to reduce federal deficits while adding to total federal healthcare spending is no solution at all, as it would subject future generations to tax burdens far higher than the American public has ever tolerated. This is why health experts across the ideological spectrum have stressed the necessity not only of reducing federal deficits, but also of “bending the healthcare cost curve” downward.

Unfortunately, the ACA fails this second test by an even wider margin. Under any realistic scenario it would add to federal outlays by more than \$1.15 trillion over the next 10 years.

## The Use of Medicare Savings to Finance a New Health Entitlement

Why are these dire fiscal consequences not more widely understood? A great source of confusion lies in government scorekeeping methods, which compare the effects of legislation to a hypothetical baseline scenario rather than to enacted law. To understand the difference, it is necessary to go briefly into the weeds of Medicare trust fund accounting.

The ACA contains many provisions designed to slow the growth of Medicare spending. This matters because the federal Medicare program is financed in a particular way—from special, separate trust funds. The Medicare Hospital Insurance (HI) Trust Fund in particular is governed under law by certain rules. Medicare HI is only permitted to spend money on benefits as long as there is a positive balance in its trust fund. If that trust fund is depleted, then—under law—benefit payments must automatically be cut to the level that can be financed from incoming tax revenues.

This is relevant to an evaluation of the ACA because the CMS Medicare actuary has projected that, had the ACA not been passed, the Medicare HI Trust Fund would have been depleted in 2016. If that were allowed to happen, Medicare HI payments would have been sharply cut in that year.

Due to the ACA's Medicare cost-saving provisions, however, these automatic spending cuts are no longer projected to begin in 2016. Medicare HI is now projected to remain solvent until 2024, postponing forced outlay reductions until then. In other words, the ACA's Medicare provisions decrease the level of Medicare HI spending prior to 2016, but then increase it from 2016 to 2024 relative to previous law. Considered separately and apart that would be a good thing, but it has inescapable fiscal ramifications in the context of the ACA's other spending expansions.

Here's a simple way to think of it: under law, Medicare is permitted to spend any proceeds of savings in the Medicare HI program. If we cut \$1 from Medicare HI spending in the near term, then an additional \$1 is credited to the HI Trust Fund as a result. The Trust Fund thus lasts longer and its spending authority is expanded, permitting it to spend another \$1 in a later year.

A core fiscal problem with the ACA is that the same \$1 in Medicare savings that expands Medicare's future spending authority by \$1 is also assumed to finance the creation of a large new federal health program. Taken together,

these two expansions of spending authorities—the new health program and Medicare’s solvency extension—far exceed the cost savings in the legislation.

Many people understood this instinctively when the law was originally debated. They wondered how a law could simultaneously extend the solvency of Medicare, provide subsidized health coverage to 30 million new people, and also reduce the deficit. The answer is that it can’t. The cost savings of the ACA are insufficient to both extend Medicare solvency and finance a new health program without adding enormously to the federal debt.

The government scorekeeping conventions now in widespread use are useful and appropriate for many policy purposes, but unfortunately they do not account for this phenomenon. CBO is diligent in carefully noting that these scoring conventions, dating back to the 1985 Deficit Control Act, do not represent actual law.<sup>2</sup> As CBO states, “CBO’s baseline incorporates the assumption that payments will continue to be made after the trust fund has been exhausted, although there is no legal authority to make such payments.” The scorekeeping convention thus ignores the additional spending authority created when the HI trust fund is extended, as occurs under the ACA. Unfortunately, few people read or understand these critical disclosures.

As a result, much of the cost savings attributed to the ACA is actually not net new savings, but rather substitutions for those required under previous law. Under previous law, either Medicare payments would have been suddenly cut in 2016 or lawmakers would have had to enact other Medicare cost savings (indeed, perhaps much like those in the ACA). The difference is that under previous law this all would have happened without also creating an expensive new spending program.

Figure 2 shows the vast difference between the Medicare cost savings attributed to the ACA under the prevailing scoring convention and the much lower amount of actual net new savings.

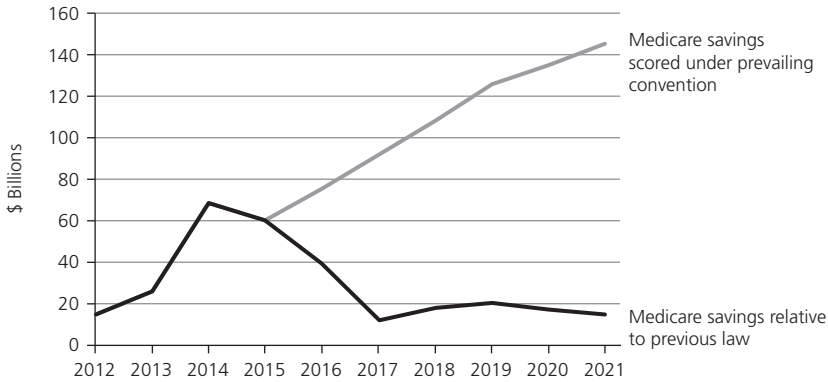
It is critical to understand that this is not merely a presentational matter. It is reflective of something far more important than the dueling press releases of healthcare reform’s proponents and opponents. It means that under law, substantial real additional spending and real additional debt will accrue as a result of the legislation having been passed.

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2. Congressional Budget Office, “The Budget and Economic Outlook: Fiscal Years 2012 to 2022,” January 2012.



Figure 2. Medicare Savings under the Affordable Care Act



Source: Author's calculations based on projections of the Congressional Budget Office (2011) and Centers for Medicare & Medicaid Services Medicare Actuary (2010).

## Alternative Scenarios

The results presented thus far assume that all the ACA's cost-savings provisions work as currently envisioned—even those that would require future Congresses to behave in ways considerably different from historical precedent. Unfortunately, the projected fiscal results of the ACA grow still worse when various plausible legislative scenarios are taken into account.

The ACA contains various provisions that aim to constrain the growing costs of federal healthcare spending, as well as various provisions that would expand its spending commitments. There is a substantial risk that its cost-increasing provisions will cost more than currently projected, and that its cost-containing measures will accomplish less than currently projected.

The law's new health insurance exchanges are particularly susceptible to future expansion. This is generally the case with major federal entitlement programs. The original design of Social Security, for example, did not include cost-of-living adjustments, early retirement options, disability benefits, or today's more generous benefit formula. All of those features were added later as individuals grew more dependent on the program.

The ACA's new health exchange subsidies are currently designed so that their total cost will not grow faster than our gross domestic product (GDP). Because healthcare costs tend to grow faster than the underlying economy, low-income participants in the exchanges will over time shoulder

an increasing share of their healthcare expenses. Will this be politically sustainable, or will lawmakers yield to pressure to expand the subsidies to spare poor participants from these cost increases? Even if participation continues as projected by the CMS Actuary, if it grows afterward by a mere 1% annually, and if the subsidies grow only with healthcare inflation, this will add \$50 billion to their costs in the first 10 years and far more afterward.

On the other hand, the law's cost-saving measures could well produce considerably less savings than now assumed. The law establishes a controversial new Independent Payment Advisory Board, charged with facilitating measures to hold down the growth of Medicare costs over time. There is a substantial risk that its recommendations could be overridden or that the board will be eliminated altogether.

In addition, various new taxes under the law could unleash a dynamic much like the one that now exists with the federal Alternative Minimum Tax (AMT). Under current-law projections, the AMT would bring in dramatically rising federal revenues over time because its income thresholds are not indexed. Each year, Congress acts to raise these thresholds so that rapidly rising numbers of Americans are not newly subject to the AMT. The ACA's "Cadillac plan tax" and 3.8% Medicare surcharge are similarly designed such that they would subject rapidly rising numbers of Americans to these taxes every year. If Congress simply allows the thresholds triggering these taxes to rise with general economic growth, they will produce far less revenue than currently projected.

None of this is intended to suggest that the ACA's various cost-saving measures are necessarily bad policies. But their proceeds cannot safely be spent until they have verifiably accrued.

Under a plausible "pessimistic" scenario in which future Congresses handle such provisions roughly in keeping with historical precedent, the ACA will add nearly \$530 billion to federal deficits over the next 10 years, and far more thereafter.

## Fiscal Corrections

Properly understood, the ACA stands to precipitate dire fiscal consequences. To forestall these, sharp corrections are required before 2014, when millions of Americans would begin to depend on its various new benefits.

To meet the original promise that the legislation would bend the federal healthcare cost curve downward, fully \$1.15 trillion in spending over

the next 10 years would need to be stripped out of the law. This would gut the preponderance of its subsidized coverage expansions, both through the health exchanges and through Medicaid and the Children's Health Insurance Program (CHIP).

A more modest standard would be to require that the law simply not make the federal deficit situation worse under a more pessimistic (but plausible) scenario. This would still allow the law to add to overall federal healthcare obligations, but would at least provide protection against the possibility of accelerating severe federal fiscal problems. Aiming for this weaker standard could allow the law's Medicaid/CHIP expansion to remain in place but would require eliminating roughly two-thirds of the law's health exchange subsidies.

There are many important issues surrounding healthcare reform that my study does not speak to. Among them are the constitutionality of the law's health insurance purchase mandate, the appropriate role of the federal government in facilitating expanded coverage, the long-term viability of the ACA's Medicare cost restraints, how central employer-provided coverage should remain, and the merits of the IPAB concept. My paper instead focuses on a central fiscal question: Does this law improve or worsen the federal government's fiscal predicament?

The answer, unfortunately, is that it greatly worsens the fiscal outlook. Only by considerably scaling back the new spending commitments made under the law, or by finding new financing sources for these commitments, will it make the positive contribution to federal finances that experts across the ideological spectrum agree is required.

# Expanding Medicaid: The Conflicting Incentives Facing States

*This article was originally published at E21 on March 5, 2013.*

As with the previous piece, this article was written to summarize the results of a comprehensive study conducted for the Mercatus Center. The study concerned the conflicting incentives facing states with respect to voluntarily expanding Medicaid per the terms of the ACA, because in 2012 the Supreme Court had affirmed states' prerogatives to accept or reject Medicaid expansion.

The study reached the (in my eyes unremarkable) conclusion that expansion was a very difficult call for states, and that the balance could be tipped by factors ranging from subjective value judgments to a state's unique budgetary circumstances and socioeconomic profile to the results of specific state–federal negotiations. Accordingly, it projected that states would likely make a wide variety of decisions—with some states expanding, others not, and still others attempting to negotiate and implement a middle-ground policy. This is essentially what has happened.

The study's analysis and conclusions might have appeared insignificant were it not for the peculiar political dynamic surrounding Medicaid expansion. After the Supreme Court rendered its decision, a great number of articles asserted that all states would nevertheless expand Medicaid per the ACA's terms, and that only a combination of irrationality and partisan obstructionism could possibly induce states to do otherwise. This was demonstrably untrue if one combed through the complex and conflicting considerations facing the states. Indeed, many of the states were already in difficult fiscal circumstances, making it less practicable for them to take on additional health spending even if the federal government picked up a bigger share of the tab. But the assumption that expansion was a no-brainer nevertheless worked its way into countless publications.

The dynamic of the Medicaid expansion issue is instructive in that it reveals the power of assumptions and value judgments. It is too easy for us to succumb to the illusion that, if other people reach a different conclusion than ours as to what public policies are desirable, they must be motivated by malice. The Medicaid expansion question is an issue where, if one looks openly at the considerations cutting both ways, it quickly becomes obvious why some states would make different decisions than others.

RECENT DECISIONS BY INDIVIDUAL STATES CONCERNING THE Affordable Care Act's now-optional Medicaid expansion have been much in the news of late.<sup>1</sup> Today [March 5, 2013] the Mercatus Center is publishing my comprehensive study of the conflicting incentives facing states as they make their choices about expansion.<sup>2</sup>

The decision facing individual states is complex. Setting aside the larger question of whether the ACA's ambitious coverage expansion is good national policy, several competing factors now bear upon the states' incentives. These include individual state budget circumstances, the 2012 Supreme Court decision,<sup>3</sup> federal Medicaid financing support levels, the federal government's own fiscal problems, and interactions between Medicaid and the ACA's new health exchanges, among many others. Some press coverage has portrayed the current dynamic as a divide between pragmatic governors (choosing to expand) and ideologues (choosing not to).<sup>4</sup> I strongly disagree with that characterization. There are powerful incentives operating against expansion just as there are incentives in favor of it; a diversity of state decisions is to be expected even assuming that all governors behave wholly pragmatically.

Some brief background is in order. Through the ACA, federal lawmakers sought to aggressively expand health insurance coverage, choosing the preexisting Medicaid program as the primary vehicle for covering the previously uninsured poor. The new law expanded the ranks of individuals that state Medicaid programs must cover to include childless adults with incomes up to 133% of the federal poverty level (FPL)—effectively 138% because of a 5% income exclusion. For 2014–2016, the federal government is to finance 100% of the cost of covering the newly eligible population, and this percentage will gradually decline to 90% in the years 2020 and beyond. Last year the Supreme Court ruled that the federal government could not compel the states to expand Medicaid by threatening the withdrawal of their current funding. This decision effectively rendered expansion optional for the states.

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1. "An Offer They Can't Refuse," *The Economist*, March 2, 2013.

2. Charles Blahous, "The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2013).

3. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012).

4. David Nather and Jason Millman, "The GOP Split on Obamacare," *Politico*, February 21, 2013.

## Finding 1

For states generally, the expansion decision is a very close call. States now face a value judgment that is anything but trivial. They must weigh the gains of expanded health benefits for their citizens, financed primarily by taxpayers residing elsewhere, against the additional costs expansion would pose on their own state budgets that are already strained in many instances. The particulars render this decision a very close call for most states: we should therefore expect different states to make different decisions reflecting their unique budgetary circumstances, subjective value judgments, and the specific needs of their populations.

Beyond theoretical considerations, we know from states' historical behavior that they weight these competing considerations differently. Historically Medicaid eligibility has varied significantly from state to state; states have long made very different choices about whether to pursue waivers to expand Medicaid coverage, even with the federal government providing the majority of funding for states that have done so.

## Finding 2

States face substantial Medicaid cost increases even before budgeting for the optional coverage expansion. Expanding Medicaid exposes states to additional costs at a time when they are already struggling to budget for projected Medicaid cost increases under pre-ACA law. Though by some estimates average state Medicaid costs would further increase by only 3%–4% if they expand, this would be layered on top of a huge previously projected increase. The latest CMS Medicaid report projects state Medicaid costs to grow by 158% cumulatively over the next decade, assuming all states opt for expansion. (See figure 1.)

Even relative to Medicaid's troubled history of rapid cost growth, these projections point to a coming cost explosion. They embody substantially higher future growth rates than states faced during the last decade. Yet Medicaid already absorbs 24% of state budgets and is described by the bipartisan State Budget Crisis Task Force as "crowding out other needs."<sup>5</sup>

One of the factors driving this rising pressure on state budgets is that states' Medicaid costs were kept artificially low in 2009–2011 through federal

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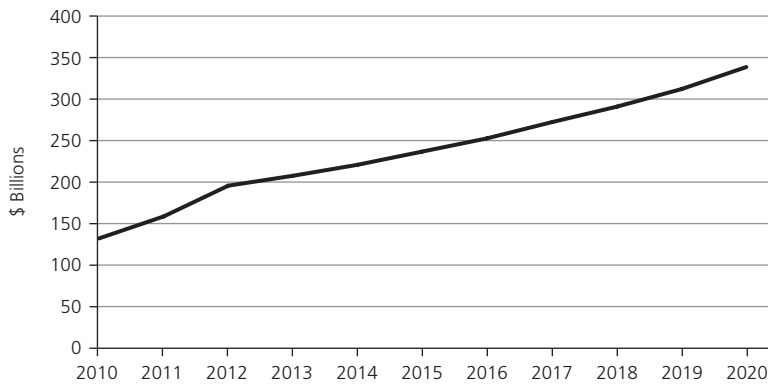
5. State Budget Crisis Task Force, *Report of the State Budget Crisis Task Force*, January 2014.

assistance under the 2009 stimulus law. Thus, even with the generous federal assistance rates under the ACA, states that choose to expand would face not only higher costs but a higher percentage of total Medicaid costs going forward than they faced during the 2009–2011 period. (See figure 2.)

### Finding 3

After the Supreme Court decision, states face a common incentive to decline to cover childless adults with incomes above the FPL under Medicaid. The

**Figure 1. State Medicaid Expenditures (Projected Costs If All Participate in Expansion)**



**Figure 2. State Share of Total Medicaid Expenses**



ACA establishes federal subsidies for individuals with incomes between 100% and 400% of the FPL if they buy health insurance through newly established exchanges. Individuals are only eligible for these subsidies if they are not eligible for Medicaid. Insuring these individuals under Medicaid would require states to bear some of the cost of coverage after 2016. By contrast, the federal government would provide the entirety of the subsidy through tax credits if these individuals' insurance is provided through the exchanges. The states can therefore save money by leaving these individuals uninsured by Medicaid to be insured through the exchanges instead.

Not only would leaving these individuals out of the Medicaid coverage expansion save the states money—it could potentially provide beneficiaries with access to better health services and more generous subsidies. Estimates of the average annual total insurance value under the exchanges are about \$9,500 by 2022, as opposed to a total value for Medicaid coverage of less than \$7,000. Leaving these individuals uncovered by Medicaid thus sets up a potential win-win for state taxpayers and ACA beneficiaries alike.

#### Finding 4

States' toughest decisions pertain to covering childless adults with incomes below the FPL. Some have suggested that states might come out ahead financially if they cover this population under Medicaid with the ACA's generous federal match rates. The data suggest otherwise. Expanding Medicaid would increase this population's health benefits but it would cost states substantial money relative to their current expenditures for financing healthcare for the uninsured.

Taking into account the historical allocation of the costs of the uninsured's health services, as well as differences in health service consumption between Medicaid recipients and the uninsured, federal match rates for the expansion population would probably need to be about 92% over the long term for states to come out ahead. Effective match rates under the ACA are substantially less: probably about 79% on average given the expected blend of those newly eligible and those already eligible but previously uncovered (who would bring the lower pre-ACA match rates) within the expansion population. Because this effective match rate for expansion is well below states' break-even point, expansion is expected to cost the states money.



Further adding to the disincentives here is the fact that HHS announced in December 2012 that states conducting only partial expansions will not receive the ACA's enhanced federal match rate.<sup>6</sup> This further reduces incentives for states to expand Medicaid at all.

## Finding 5

Future federal cost-shifting to states is virtually certain, though the amount is unknown. Given the current state of federal finances, it is unrealistic to assume that the federal government will make all future Medicaid payments now scheduled under law. To return federal spending to historically sustainable norms would require across-the-board spending cuts of roughly 15% relative to current levels, and 25% relative to projected future levels, to avoid all cuts in the growth of Medicaid and in the ACA's new health exchanges. (See figures 3 and 4.)

Every serious bipartisan budget discussion in recent years has envisioned reductions in future federal Medicaid outlays. The bare minimum of required savings appears to be \$100 billion over the next 10 years, with much evidence suggesting that the savings required will be closer to \$200 billion. I do not agree with those who assert that every dollar cut from federal Medicaid expenditures is a dollar of costs necessarily shifted to states. Nevertheless, if states absorb even half of the effects of federal belt-tightening, they will face further additional costs on the same order of magnitude as the Medicaid expansion.

## Finding 6

Given the difficulty of the decision, state negotiations with the federal government could tip the balance. It is clearly against many states' fiscal interests to expand Medicaid unless they are given the latitude to implement fundamental structural reforms to slow the growth of its costs. That said, states need as much relief from the rising cost baseline as they do from the cost of a possible Medicaid expansion. This gives the states ample incentive to use the prospect of expansion as a bargaining chip to get as much relief as

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6. Kathleen Sebelius, "Progress Continues in Setting up Health Insurance Marketplaces," *Health-Care Blog* (HealthCare.gov), December 10, 2012.

Figure 3. Federal Noninterest Spending as a Percentage of GDP (CBO Current Policy Scenario)

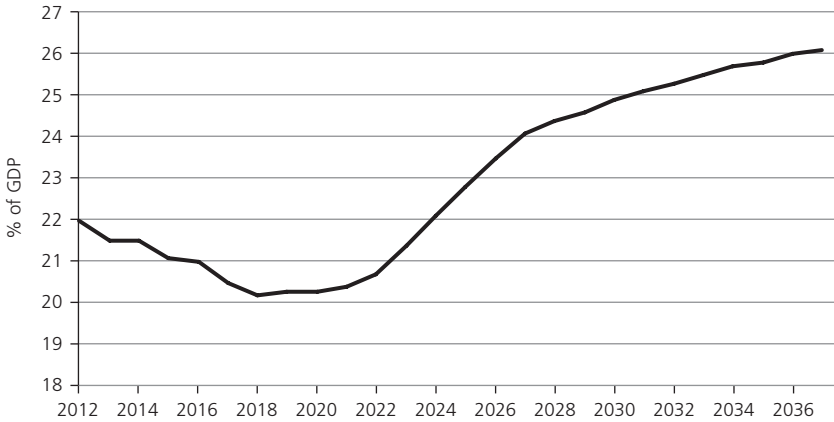
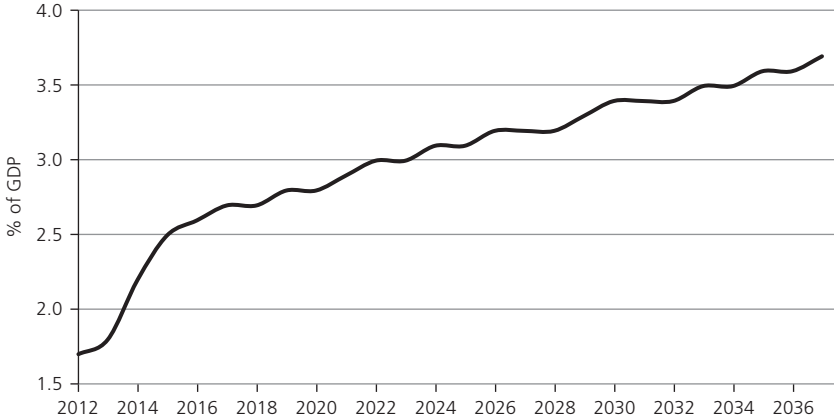


Figure 4. Projected Federal Spending on Medicaid/CHIP, Health Exchanges, as a Percentage of GDP (CBO Current Policy Scenario)



they can from currently projected financing requirements. Whether states are allowed to implement market-based reforms to improve Medicaid efficiencies could be a critical determinant of whether they are able to handle projected caseload increases with or without the expansion. Given this context, it's unsurprising to see a series of divergent, individually negotiated state–federal arrangements.

Excerpt from Charles Blahous, *Decoding the Debates*  
(Arlington, VA: Mercatus Center at George Mason University, 2020).

The bottom line is that Medicaid expansion brings additional federally financed health benefits to the states while exposing state budgets to higher costs. It is reasonable for state governors to reach differing conclusions as to which is the overriding factor. Perhaps the only common incentive clearly facing all states is to shift their childless adults above the FPL from Medicaid to the ACA's new health exchanges and to let the federal government absorb the full cost of their subsidies. Beyond that, much decision-making will depend on whether the states believe they can negotiate satisfactory terms to justify shouldering the costs of expansion, and on how states believe the troubled federal fiscal picture will ultimately be resolved.

# No Grounds for Claim That the ACA Lowers Healthcare Costs

*This article was originally published at E21 on November 25, 2013, as “No Grounds for Claim That Obamacare Lowers Healthcare Costs.”*

Policy experts ill serve their reputations when they compulsively wade into all aspects of an ongoing public policy debate. On occasion, however, an erroneous claim achieves such wide circulation that it essentially obligates those with some expertise to step up and push back before the claim is broadly internalized and becomes difficult to dislodge. Such a dynamic existed about claims that the ACA was successfully holding down growth in healthcare costs—claims first promoted even before the ACA’s core provisions went into effect.

The following piece provides fuller details, but the root of the controversy was that national healthcare cost growth turned out to be slower in the first few years after 2010 than previously projected, and some sought to credit the ACA for this development. These claims didn’t withstand scrutiny for several reasons, among them the fact that the cost slowdown had preceded the ACA’s enactment, as well as the fact that the ACA’s relative effect on national health expenditure projections was to increase them. This piece explained these various factors in greater detail.

**PUBLIC SUPPORT FOR THE AFFORDABLE CARE ACT (ACA) HAS plummeted now that the oft-repeated claim that “if you like your health care plan, you can keep it” is widely understood to be untrue.<sup>1</sup> Despite previous assurances, millions of Americans are now grappling with ACA-triggered cancellations of their health insurance policies. Faced with public anger, ACA supporters are now turning to another argument to promote the law: that the ACA is already working to hold down healthcare cost growth. Unfortunately, some of these claims are just as groundless as the ones that misled so many Americans to believe they would be able to keep their previous coverage.**

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1. “How Low Can It Go? ObamaCare Poll Numbers Drop—Again,” Fox News, November 20, 2013; Glenn Kessler, “Obama’s Pledge That ‘No One Will Take Away’ Your Health Plan,” *Washington Post*, October 30, 2013.

One particularly egregious example is White House adviser David Cutler's op-ed, published November 8, 2013, in the *Washington Post*, titled "The Health-Care Law's Success Story: Slowing Down Medical Costs."<sup>2</sup> This piece contains the following paragraph:

Before he was criticized for his statements about insurance continuity, President Obama was lambasted for his forecasts of cost savings. In 2007, Obama asserted that his health-care reform plan would save \$2,500 per family relative to the trends at the time.<sup>3</sup> The criticism was harsh; I know because I helped the then-senator make this forecast. Yet events have shown him to be right. Between early 2009 and now, the Office of the Actuaries at the Centers for Medicare & Medicaid Services has lowered its forecast of medical spending in 2016 by 1 percentage point of GDP. In dollar terms, this is \$2,500 for a family of four.

To see why this is wrong, it is useful to break down this paragraph's thesis into its component parts. Specifically, it claims that

- the president's previous assertions that his "health-care reform plan" would "save \$2,500 per family" have been "shown" "to be right," and
- this is proved by the fact that the CMS actuaries have lowered, between early 2009 and now, their forecast of medical spending in 2016 by \$2,500 per family.

For this paragraph to be correct, the ACA must be the reason the CMS actuaries have lowered their 2016 health spending projections. That is flatly untrue.

To clear this up, let us take a look at those CMS projections for health spending and examine how and why they have changed since early 2009. Figure 1 shows CMS's February 2009 projections for national health spending, as a percentage of GDP, through 2016.

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2. David Cutler, "The Health-Care Law's Success Story: Slowing Down Medical Costs," *Washington Post*, November 8, 2013. See also Keith Koffler, "Former Obama Advisor: Premiums Could Get 'Very High,'" *White House Dossier*, November 12, 2013.

3. Barack Obama, "Remarks at a Labor Day Rally in Manchester, New Hampshire," American Presidency Project, September 3, 2007, <http://www.presidency.ucsb.edu/ws/index.php?pid=77010#ixzz1zUgBTIKQ>.

Shortly after these projections were made, in June 2009, CMS slightly modified the outlook to take into account subsequent legislation, including the 2009 stimulus law. These modified projections are added on figure 2. These June 2009 projections were the operative baseline projections when the ACA was signed into law in March 2010.

Figure 1. Projected National Health Expenditures, February 2009

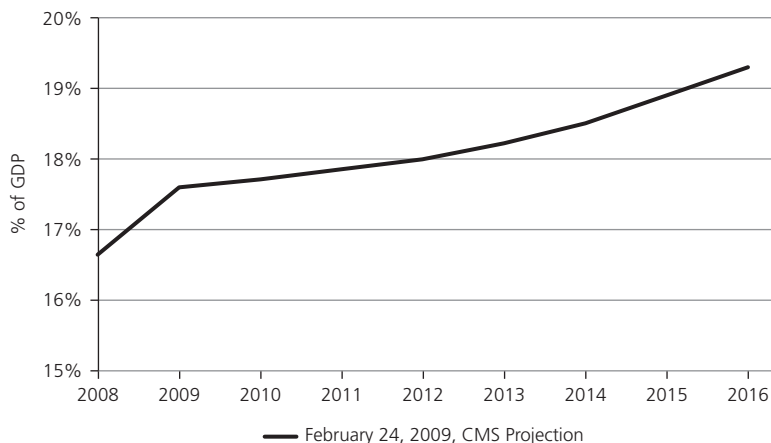


Figure 2. Projected National Health Expenditures, June 2009

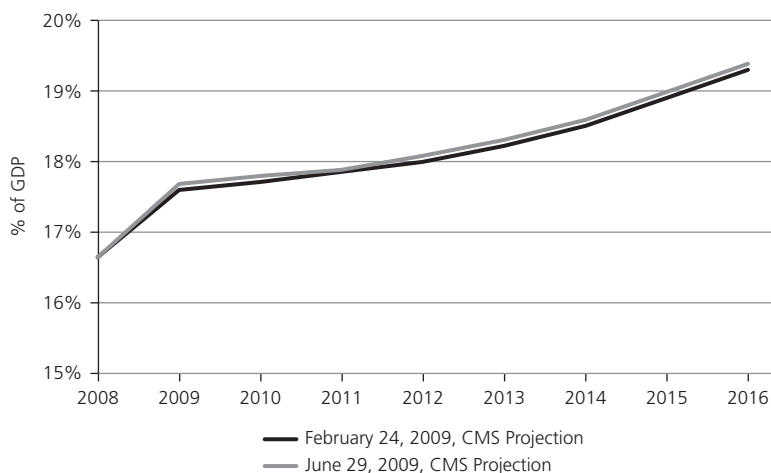
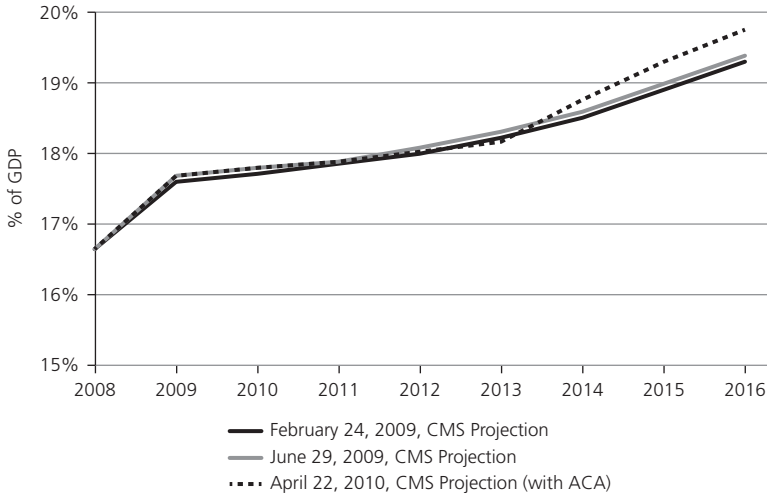


Figure 3. Projected National Health Expenditures, April 2010



Just after the ACA was enacted the following March, CMS released a memorandum in April 2010, explaining how the projections for national health spending would be affected by the new law.<sup>4</sup> Those projections are shown on in figure 3.

The obvious point that leaps out from this graph is that the chief CMS actuary found that the ACA would increase national health expenditures through 2016. Not content to let the tables speak for themselves on this point, CMS was explicit in the text of its memorandum that the ACA increased the near-term cost projections:

The estimated effects of the PPACA on overall national health expenditures (NHE) are shown in table 5. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by \$311 billion or 0.9 percent, over the updated baseline projection that was released on June 29, 2009. Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased

4. Richard S. Foster, chief actuary of the Centers for Medicare & Medicaid Services, memorandum, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” April 22, 2010.

in. . . . The increase in total NHE is estimated to occur primarily as a net result of the substantial expansions in coverage under the PPACA.<sup>5</sup>

The CMS actuaries most recently updated their projections in September 2013. These are the latest projections to which Dr. Cutler refers in his op-ed.<sup>6</sup> These projections are shown in figure 4.

As Dr. Cutler notes, CMS is now projecting slower healthcare expenditure growth than it was in 2009 and 2010. CMS's current projection of 2016 health spending totaling 18.4% of GDP is 1 percentage point lower than its June 2009 estimate (19.4%) and 0.9 points lower than its February 2009 estimate (19.3%).

Why did CMS lower its estimates of future health spending? It wasn't because of the ACA. We know this for a fact because CMS has released a memorandum detailing the reasons for changes in its 10-year outlook since April 2010.<sup>7</sup> Here are the factors CMS cited, and the percentage of the improvement each was responsible for:

- Medicare, Medicaid, and other programs “unrelated to the ACA”: 50.7% of improvement
- Other factors “unrelated to the ACA”: 26.1%
- Updated data on historical spending growth: 21.8%
- Updated macroeconomic assumptions: 6.1%

Now, that adds up to 104.7% of the total improvement. The reason these four factors add to more than 100% is that a fifth factor, the “impact of the ACA,” worked against the improvement. Per CMS, adjusting the

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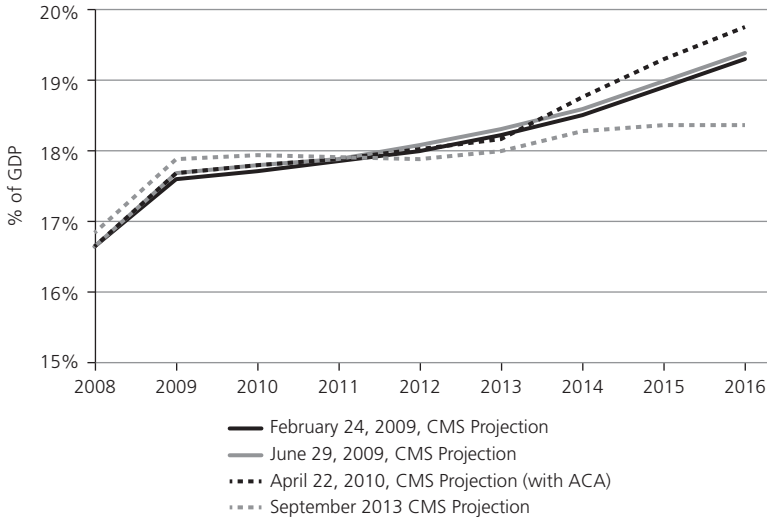
5. Richard S. Foster, Chief Actuary of the Centers for Medicare & Medicaid Services, memorandum, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Passed by the Senate on December 24, 2009,” January 8, 2010.

6. Centers for Medicare & Medicaid Services, “National Health Expenditure Projections 2012–2022.”

7. Centers for Medicare & Medicaid Services, “Analysis of Factors Leading to Changes in Projected 2019 National Health Expenditure Estimates: A Comparison of April 2010 Projections and September 2013 Projections,” 2013.



Figure 4. Projected National Health Expenditures, September 2013



April 2010 projections for the subsequent impact of the ACA shows it further increasing spending over 10 years (equal to and opposite from 4.7% of the total change). CMS analyzes these numbers through 2019, but we can safely say that, through Dr. Cutler’s cited year of 2016, CMS sees the ACA doing even less to hold down cost growth (CMS elsewhere found that 2016 is when the ACA would cause the largest “relative increases” in health spending).

This of course does not prove that the ACA is doing nothing to lower health costs. The ACA contains some provisions (e.g., those expanding health coverage) that clearly increase healthcare costs, as well as other provisions aimed at reducing costs. Reasonable people can argue over which effect will be larger in the long run. Reasonable people can even debate what has transpired to date. But no one can rightly claim that CMS has revised its near-term cost projections downward because of the ACA. That is simply false.

A recent White House Council of Economic Advisers (CEA) report is much more careful in promoting the impression that the ACA is slowing

health cost growth.<sup>8</sup> It fairly notes that health spending has slowed (true), that slower health spending growth carries budgetary and economic benefits (true), that the causes of the slowdown are “not fully understood” (true), and that the ACA contains provisions designed to slow cost growth (true). The report also argues (reasonably) that other recent changes in the healthcare sector, such as increased patient cost-sharing and expiration of drug patents, are by themselves insufficient to explain the cost slowdown. Neither is the Great Recession the full explanation, CEA argues, because the health cost slowdown has outlasted it. Largely by process of elimination, CEA encourages the belief that a root cause of cost-reduction is the ACA “really, really working,” in the words of one especially credulous reader.<sup>9</sup>

But CEA’s case for crediting the ACA is extremely weak. In the first place, the basis on which CEA argues that the Great Recession cannot be solely responsible for the cost slowdown applies with much greater force to the ACA. We are told that the Recession can’t be the sole cause because the cost slowdown has outlasted it. But clearly the ACA cannot be a leading cause either, because the cost slowdown long preceded its 2010 enactment.<sup>10</sup> (See figure 5.)

It may be even more useful to look at these data as adjusted for general price inflation, as shown in figure 6. But whether measured in nominal or real terms, the health spending slowdown clearly predated the ACA. Still, we do not hear anyone arguing that the slowdown was brought about by implementing the Medicare prescription drug benefit in 2005.

The CEA report acknowledges that the ACA will cause healthcare spending “to grow at an elevated rate for a few years” because of the massive coverage expansion at the core of the law.<sup>11</sup> CEA argues that this burst of healthcare spending will eventually be followed by cost reductions. Given the countless problems that have arisen with ACA implementation so far, this is far from a reliable bet, much less a demonstration that the ACA is successfully bringing costs down already.

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8. Jason Furman, “New Report from the Council of Economic Advisers: The recent Slowdown in Health Care Cost Growth and the Role of the Affordable Care Act,” White House, November 20, 2013.

9. Paul Krugman, “Real Entitlement Reform,” *New York Times*, November 21, 2013.

10. Centers for Medicare & Medicaid Services, National Health Expenditures tables.

11. Furman, “New Report from the Council of Economic Advisers.”

Figure 5. Annual Percentage Growth in National Health Expenditures

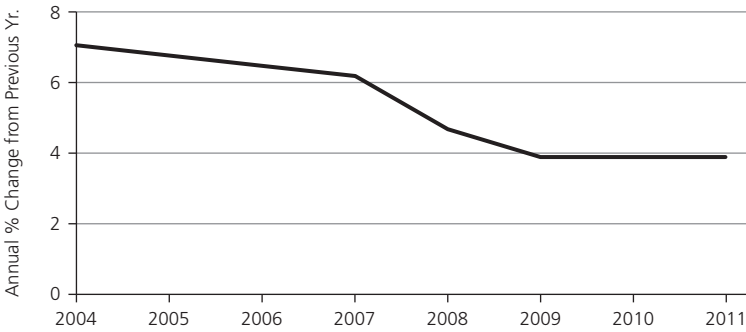
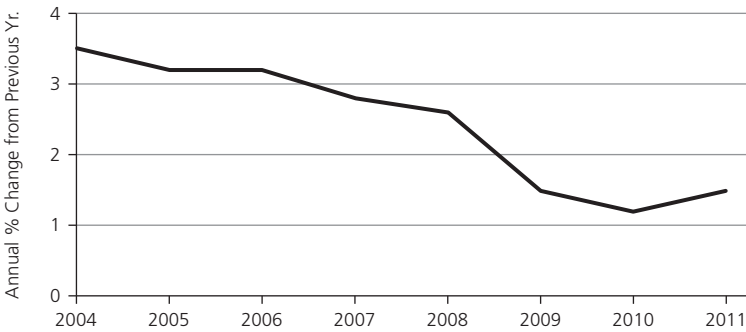


Figure 6. Annual Percentage Growth in Real National Health Expenditures



Public confidence in the ACA took a beating when it was revealed that millions would lose health coverage that they had been told they could keep. Now the public is being told that the ACA is responsible for government actuaries’ improved health spending projections, when an examination of those projections clearly shows that not to be so. If the supporters of the ACA want to win back public support and confidence, they will need to find a stronger case for the virtues of the law.

# The ACA Lowers Employment, and That's Terrible News

*This article was originally published at E21 on March 3, 2014.*

Soon after the ACA was passed, a particular effect of the law began to draw greater attention: the fact that it substantially reduces labor force participation. Economist Casey Mulligan was one of the first prominent voices to draw attention to this problem, and it was later recognized by CBO as well as substantiated in employer surveys.

Like all legislation, the ACA has upsides and downsides, depending on one's subjective value judgments. It significantly increased health insurance coverage, while at the same time greatly increasing government spending and tax burdens as well as reducing economic growth and workforce participation. It should be acceptable to argue that the law's health insurance coverage expansion justifies its problematic effects on government finance and on the labor force, or alternatively that it does not. But each side of that argument should acknowledge the real adverse effects that accompany the adoption of its policy position.

With particular respect to CBO's recognition that the ACA would depress labor force participation, there was a temptation for some to argue that this wasn't such a bad thing, either because it was a matter of workers voluntarily leaving work rather than being fired by employers or because individuals who left their jobs would be freed to make other lifestyle choices. This piece was intended to show why, irrespective of whether one favors or disfavors the ACA, its adverse effect on workforce participation is a real problem that must not remain uncorrected.

**ON FEBRUARY 4, 2014, THE CBO RELEASED A REPORT THAT INSTANTLY** became a focus of intense controversy.<sup>1</sup> The report found that the ACA would reduce US employment by the equivalent of 2 million full-time workers by 2017, 2.5 million by 2024. This news was received in the context of the polarizing politics surrounding the ACA, with commenters choosing sides over the report according to their attitudes toward the healthcare law itself.<sup>2</sup>

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1. Congressional Budget Office, "The Budget and Economic Outlook: 2014 to 2024," February 2014.

2. Mike Flynn, "CBO: Obamacare Will Kill 2.5 Million Jobs," *Breitbart*, February 5, 2014.

When CBO's findings are instead viewed from the standpoint of our larger economic policy challenges, it becomes clear that this consequence of the ACA is unequivocally bad, irrespective of one's general attitude toward healthcare reform. To clarify this, let's step back from the debate over the ACA for a moment and examine the current state of our economy.

Our prosperity derives from two factors: the first is how much Americans work, the second is how productive we are while working. Perhaps America's biggest current economic problem is that workers are leaving the labor force by the millions. Part of the worker drain is due to population aging and was a widely anticipated problem. But other factors have also arisen to make the exodus much worse than foreseen.

In 2007, we knew we had a significant problem coming when the baby boomers would begin to leave the workforce. The growth of our labor force would slow and our economic growth would slow along with it. (The data in figures 1 and 2 come from annual Social Security trustees' reports.)

Unfortunately the labor force has shrunk much more than anticipated. The number of workers dropped through the floorboards, and economic growth fell alongside it. (See the 2009 plunge in figures 3 and 4.)

Part of the explanation is that the Great Recession arrived, causing unemployment to rise just as many boomers were starting to retire. But other phenomena also entered the picture.

Figure 1. Past/Future Labor Force Growth as Projected in 2007

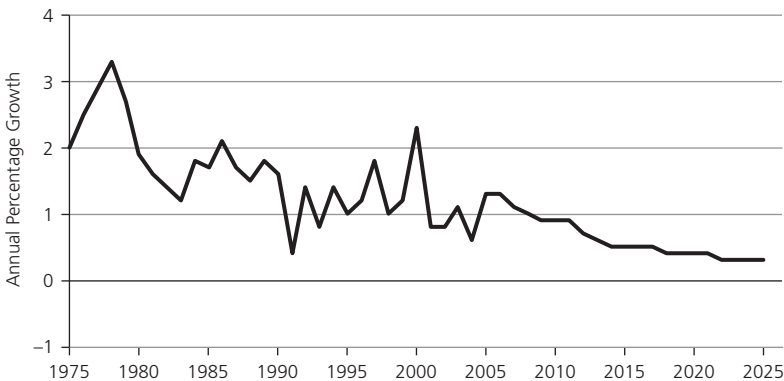


Figure 2. Past/Future Real GDP Growth as Projected in 2007

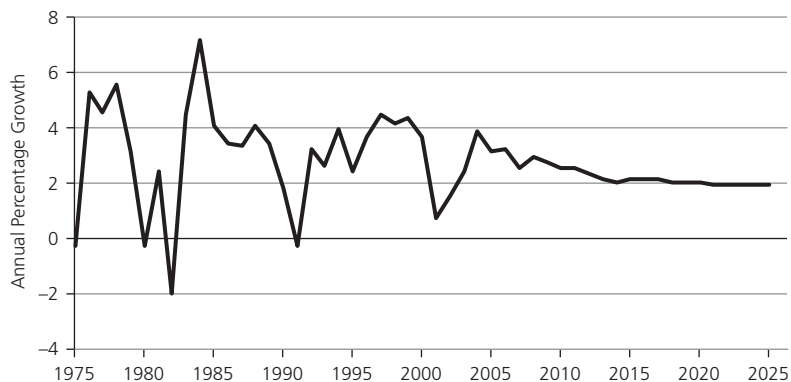
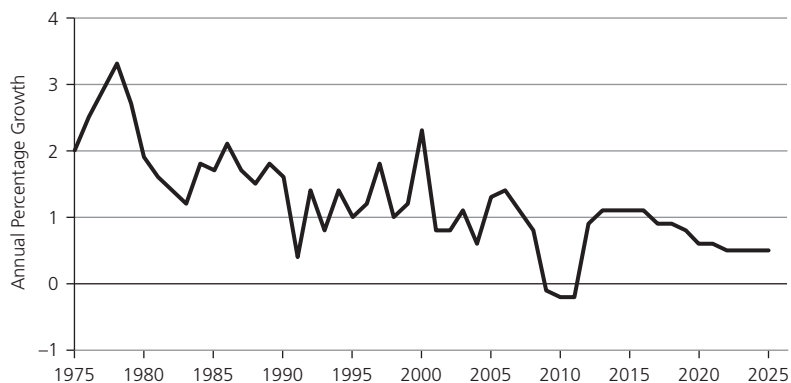


Figure 3. Past/Future Labor Force Growth as Projected in 2013



One is that Social Security disability benefit awards skyrocketed, as often happens (albeit usually to a lesser extent) during a recession. This means that many who otherwise would have continued to look for work are now extremely unlikely to ever return to the labor force. (See figure 5.)

Our sagging economy also caused net immigration to plummet, further depressing the ranks of workers. People are much less likely to join—whether legally or illegally—an economy in which it is tough to find work. Recently

Figure 4. Past/Future Real GDP Growth as Projected in 2013

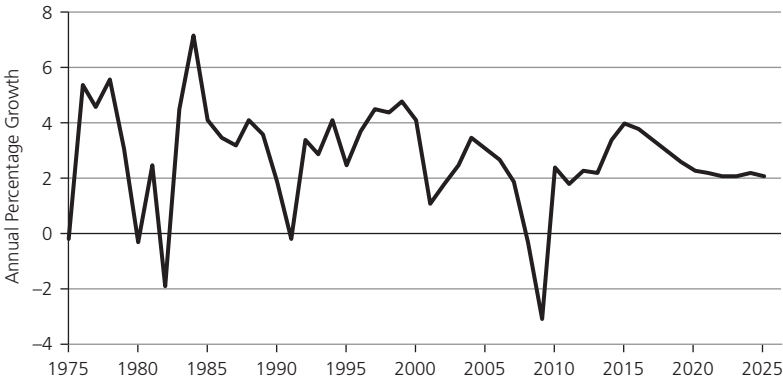
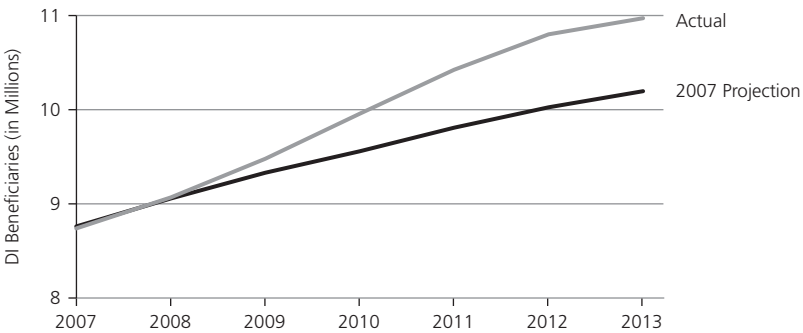


Figure 5. Social Security Disability Beneficiaries: Projected vs. Actual

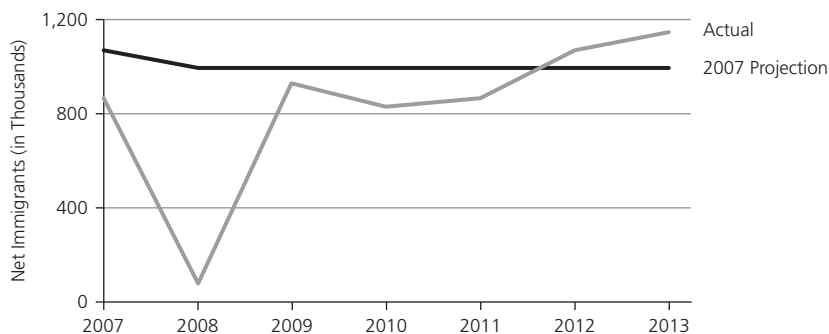


immigration has recovered, but not enough to replace the immigrants lost from 2007–2011. (See figure 6.)

On top of all that, there is a deeply concerning phenomenon of “discouraged workers”—those who have simply given up finding work. Put all these factors together, and we now have an economy with far too few workers.<sup>3</sup>

3. Floyd Norris, “A Dire Economic Forecast Based on New Assumptions,” *New York Times*, February 27, 2014.

Figure 6. Net Immigration: Projected vs. Actual



CBO’s latest projections for labor force participation are sobering indeed. (See figure 7.)

Inadequate labor force participation has long been a central concern of economists on both sides of the political aisle. The problem of individuals heading into permanent retirement undesirably early has prompted efforts by myself, Peter Orszag, Jeff Liebman, Jason Fichtner, and many other esteemed economists to correct flawed work incentives facing middle-aged Americans.<sup>4</sup>

Those who leave the workforce at younger ages constitute an even more serious problem. The left-leaning Center for American Progress encapsulated these widely shared concerns:

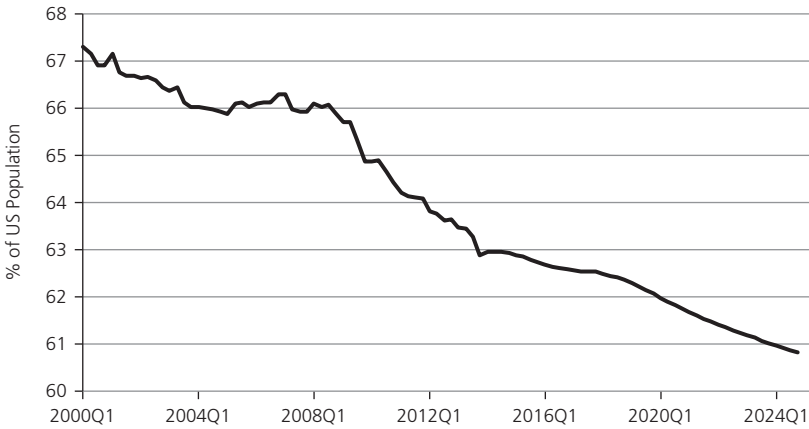
According to our analysis, a young person who experiences a six-month period of unemployment can expect to miss out on at least \$45,000 in wages—about \$23,000 for the period of unemployment and an additional \$22,000 in lagging wages over the next decade due to their time spent unemployed.<sup>5</sup>

4. Charles Blahous, “Social Security and Work,” *National Affairs*, 2009; Peter Orszag, “Should a Lump-Sum Payment Replace Social Security’s Delayed Retirement Credit?,” *An Issue in Brief*, no. 6 (April 2001); Jeffrey B. Liebman and Erzo F. P. Luttmer, “The Perception of Social Security Incentives for Labor Supply and Retirement: The Median Voter Knows More than You’d Think,” *Tax Policy and the Economy* 26, no. 1 (2012); Jason J. Fichtner (acting deputy commissioner of Social Security), interview transcript, *Retirement Revolution*, February 19, 2009; Andrew G. Biggs, Aspen Gorry, and Sita Nataraj Slavov, “Improving Work Incentives and Fairness in Social Security and Medicare” (panel, American Enterprise Institute, March 28, 2013).

5. Sarah Ayres Steinberg, “America’s 10 Million Unemployed Youth Spell Danger for Future Economic Growth,” Center for American Process, June 5, 2013.



Figure 7. Historical/Projected US Labor Force Participation



Until the recent CBO report, the Obama White House had also been a part of the bipartisan consensus that employment is the key to economic advancement. National Economic Council Director Gene Sperling said this at a January 6, 2014, press conference:

I think there's no question over the last 50 years things have been done wrong, but I think we've learned from lessons. I think that both Democrats and Republicans have learned you have to look at—to make sure about the incentives you're creating and that policies are better if they are designed to reward work. One of the reasons the earned income tax credit has been so important is that it's an incentive for work.<sup>6</sup>

The ACA did not by itself cause our declining labor force problem, though it is now understood to be making it worse. Importantly, this is not—as some have claimed—a desirable, necessary side effect of ending “job lock.”<sup>7</sup> Alternative reform proposals would have enhanced health insurance

6. White House, Office of the Press Secretary, “Press Briefing by Press Secretary Jay Carney and Director of the National Economic Council Gene Sperling 01/06/14,” January 6, 2014.

7. White House, Office of the Press Secretary, “Statement by the Press Secretary on Today's CBO Report and the Affordable Care Act,” February 4, 2014.

portability without having anti-employment effects; examples include proposals by President George W. Bush and Senator John McCain.<sup>8</sup>

Given the central role of the ACA in our national political dialogue, it's inevitable that advocates would try to spin the recent CBO report according to how they want the ACA to be perceived. But when the spinning is put aside, there's no avoiding reality: we simply cannot afford to be implementing policies that drag our sagging labor force participation even further downward.

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8. Edward Lazear, "Bushcare," *Politico Magazine*, February 18, 2014; Nina Owcharenko and Robert Moffit, "The McCain Health Care Plan: More Power to Families," *Backgrounder*, no. 2198, October 15, 2008.

# I Was Right about the ACA

*This article was originally published at E21 on June 30, 2014.*

Rarely have I been more reluctant to submit a piece for publication than when I submitted this one, with its self-congratulating headline. But there had recently been a brief flurry of news developments documenting several instances of my previous research making correct predictions. The developments confirming these predictions hadn't received nearly the same level of press coverage as had contrary predictions made to promote the ACA. It seemed that the fulfillment of the predictions wouldn't be widely noted unless it was specifically written about, and it seemed inappropriate to ask someone else to do it.

During the editing process for this piece, my original title—"Who Was Right about the ACA?"—was changed to the more aggressive version reproduced here. I acquiesced to this change because the original was, I admit, disingenuously coy.

The piece simply listed a few realities that showed conventional wisdom to have been wrong. Among these were the fact that states were making a wide variety of decisions about Medicaid expansion, the fact that expansion was proving quite costly to states, and the fact that the fiscal effects of the ACA were proving problematic, in large part because several of its cost-saving provisions were not being successfully implemented.

AROUND AND AFTER THE TIME THAT THE AFFORDABLE CARE ACT WAS enacted, many analysts identified problems with claims being made about the law, and we offered explanations of its likely actual effects. Too often these were brushed aside amid efforts to promote the ACA in the face of growing public opposition.<sup>1</sup> But, four years into the ACA, it is remarkable how well our predictions have been borne out.

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1. Frank Newport, "Americans Tilt against Democrats' Plan If Summit Fails," *Gallup*, February 25, 2010.

Below I will resurrect five of my own specific predictions about the ACA, contrast them with what many ACA advocates had said, and review what subsequent events have shown.

### Prediction 1: States Will Make a Variety of Decisions with Respect to Expanding Medicaid

*What I predicted:* “In contrast with some statements made by both supporters and opponents of the ACA, the complexities of these decisions suggest that states should be expected to make a wide variety of policy choices.”<sup>2</sup>

*ACA advocates’ claims:* “All these states will opt in. Every one” (Jennifer Granholm).<sup>3</sup> “The deal the federal government is offering states on Medicaid is too good to refuse. And that’s particularly true for the red states. If Mitt Romney loses the election and Republicans lose their chance to repeal the Affordable Care Act, they’re going to end up participating in the law. They can’t afford not to” (Ezra Klein).<sup>4</sup>

*What has happened:* As of June 2014, the Kaiser Family Foundation lists 27 states (including Washington, DC) as “implementing expansion,” 21 as “not moving forward at this time,” and 3 in “open debate.”<sup>5</sup>

### Prediction 2: Expanding Medicaid Will Cost the States Money, in Part Because of the “Woodwork Effect”

*What I predicted:* “Projections indicate that . . . covering newly eligible individuals as well as increased numbers of those previously eligible (but yet uncovered) would add substantially to state budget costs. Effective [federal support] rates associated with expansion will be lower than those expressly provided for in the ACA because of the ‘woodwork effect’ of previously eligible individuals being brought under Medicaid.”<sup>6</sup>

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2. Charles Blahous, “The Affordable Care Act’s Optional Medicaid Expansion: Considerations Facing State Governments” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, March 2013), 36.

3. Jennifer Granholm, “Why All Gobs Will Opt into ‘Obamacare,’” *Politico*, July 11, 2012.

4. Ezra Klein, “The Affordable Care Act’s Big Giveaway to Stungy Red States,” *Washington Post*, July 3, 2012.

5. “Status of State Action on the Medicaid Expansion Decision,” Kaiser Family Foundation, accessed June 2014, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act>.

6. Charles Blahous, “The ACA’s Optional Medicaid Expansion: Considerations Facing State Governments” (Research Summary, Mercatus Center at George Mason University, March 2013), 2.

*ACA advocates' claim:* "There has been some concern in state capitals surrounding this proposal given the possible increase in state Medicaid expenditures that could result. . . . The move to greater insurance coverage would likely result in substantial savings for state and local governments. Rather than harming the budget situation of the states, health insurance reform would improve it" (CEA, Obama White House).<sup>7</sup>

*What has happened:* "At least a couple of states have already cited higher-than-expected costs. . . . California officials on Tuesday said the woodwork population is expected to grow 60 percent more than what they had expected, costing the state [an] additional \$1.2 billion. Rhode Island is now expecting to pay \$52 million more than previously projected over two years after Medicaid sign-ups beat expectations by more than double. . . . This graph from a December 2012 NASBO report shows how Medicaid has been taking a greater portion of state general funds, while education spending has decreased."<sup>8</sup>

### Prediction 3: The ACA Will Significantly Worsen the Federal Budget Deficit

*What I predicted:* "The Affordable Care Act (ACA) enacted in 2010 will significantly worsen the federal government's fiscal position relative to previous law. . . . These adverse fiscal effects are not everywhere understood because of widely circulated analyses referencing scoring conventions of the Congressional Budget Office (CBO) . . . which compare the health care reform legislation to a baseline scenario that differs from actual law."<sup>9</sup>

*ACA advocates' claim:* "According to the official Administration and Congressional scorekeepers, the Affordable Care Act will reduce the deficit: its costs are more than fully paid for" (White House blog).<sup>10</sup>

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7. Executive Office of the President, Council of Economic Advisers, "The Impact of Health Insurance Reform on State and Local Governments," September 15, 2009, <https://obamawhitehouse.archives.gov/administration/eop/cea/Impactofhealthinsurancereform>.

8. Jason Millman, "Medicaid Enrollment Is Growing Faster Than Expected in Some States. It's Going to Cost Them," *Washington Post*, May 14, 2014. The graph cited is from Michael A. Fletcher, "States Face Double Fiscal Whammy: Federal Aid Cuts and Spiraling Healthcare Costs," *Washington Post*, December 14, 2012.

9. Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2012).

10. Jeanne Lambrew, "Official Sources Agree: The Affordable Care Act Reduces the Deficit," White House, April 9, 2012.

*What has happened:* Two months after my study was published, CBO’s next long-term budget outlook clarified explicitly that I was correct. CBO’s baseline comparison that appeared to show the ACA reducing the deficit did not reflect how it changed actual law: “Projections in this report are consistent with a statutory requirement that CBO, in its baseline projections, assume that benefit payments will continue to be made after trust funds have been exhausted, even if there is no legal authority to make such payments.”<sup>11</sup>

#### Prediction 4: Expanding Health Insurance Coverage Will Increase Health Service Consumption and Costs

*What I predicted:* “The same report found that the uninsured received only about 55 percent of the total medical care received by the insured population and that, if covered, per-person health spending for the uninsured would increase by 39 percent. . . . Thus, taking important relevant factors into account, including both the higher amount of health services received by the uninsured and the woodwork effect of newly covering those previously eligible, it appears likely that expanding Medicaid coverage would add substantially to state budget costs.”<sup>12</sup>

*ACA advocates’ claim:* “It is deficit-neutral; it bends the cost curve; it covers 30 million Americans who don’t have health insurance . . . to make sure that people are getting the care they need and the checkups they need and the screenings they need before they get sick—which will save all of us money and reduce pressures on emergency rooms all across the country” (President Obama).<sup>13</sup>

*What has happened:* “As the health-care law expands Medicaid to cover millions more Americans, a new Harvard University study finds that enrollment . . . significantly increases enrollees’ use of emergency departments.”<sup>14</sup>

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11. Congressional Budget Office, “The 2012 Long-Term Budget Outlook,” June 2012.

12. Blahous, “Affordable Care Act’s Optional Medicaid Expansion,” 27.

13. White House, Office of the Press Secretary, “Remarks by the President after Meeting with Senate Democrats,” December 15, 2009.

14. Sarah Kliff, “Study: Expanding Medicaid Doesn’t Reduce ER Trips. It Increases Them,” *Washington Post*, January 2, 2014.

## Prediction 5: There Was a Substantial Risk That Cost Savings Projected for Several ACA Provisions Would Not Fully Materialize

*What I predicted:* “The legislation employs comparatively uncertain cost-saving measures as budgetary offsets for comparatively certain cost-increasing provisions. . . . The proceeds of such cost-savings cannot safely be spent until they have verifiably accrued.”<sup>15</sup>

*ACA advocates’ claims:* We can expect “\$750 billion in reliable revenues and savings,” “\$145 billion saved . . . by phasing out overpayments to . . . Medicare Advantage,” “\$69 billion in penalties paid by employers and individuals who choose not to purchase insurance,” “\$32 billion raised by taxing very expensive (‘Cadillac’) health insurance policies. . . . The numbers on this list do not represent ‘hoped-for’ savings. . . . These are firm estimates that CBO was able to ‘score’ with some confidence, based on known facts and solid historical data.”<sup>16</sup>

*What has happened:* The employer and individual mandates have not been enforced and there is mounting pressure for repeal.<sup>17</sup> Planned Medicare Advantage cuts have been scaled back.<sup>18</sup> The Cadillac plan tax has not yet taken effect and labor unions are mobilizing against its implementation.<sup>19</sup>

While I got this basic story right, I did miss some details. In 2012 I predicted that ACA provisions such as the Cadillac plan tax, Independent Payment Advisory Board, and Unearned Income Medicare Contribution would face obstacles to implementation, but did not anticipate similar blocking of the employer and individual mandates and the Medicare Advantage cuts.<sup>20</sup>

15. Blahous, “Fiscal Consequences,” 11.

16. Maggie Mahar, “How the Affordable Care Act Pays for Itself and Cuts the Deficit” (report, Century Foundation, New York, 2011).

17. Sarah Kliff, “Obamacare’s Employer Mandate Keeps Getting Delayed. What Happens If It Gets Killed?,” *Washington Post*, February 11, 2014; Linda J. Blumberg, John Holahan, and Matthew Beuttgens, “Why Not Just Eliminate the Employer Mandate?,” Urban Institute, May 2014.

18. Jay Hancock, “Obama Administration Retreats on Private Medicare Rate Cuts,” *Kaiser Health News*, April 8, 2014.

19. Ned Resnikoff, “Why Unions Are Turning on Obamacare,” *MSNBC*, August 5, 2013.

20. Blahous, “Fiscal Consequences.”

## Conclusion

In any event, the first years of ACA implementation have unfolded essentially as I anticipated in my 2012 and 2013 studies.<sup>21</sup> The point is not that I am omniscient or that I have a special gift for anticipating unknowable outcomes. Rather, these statements resulted from straightforward, common-sense analysis of easily predictable effects.

While we cannot erase past policy mistakes, going forward we should make better use of predictive information widely available to lawmakers, press, and the public than was done in the case of the ACA.

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21. Blahous, “Fiscal Consequences”; Blahous, “Affordable Care Act’s Optional Medicaid Expansion.”



# Five Lessons of the Cadillac Plan Tax Failure

*This article was originally published at E21 on December 22, 2015.*

Although I believed from the start that the ACA's Cadillac plan tax was of flawed design and uncertain political staying power, I supported a central aim of its designers: to limit the tax preference for employer-sponsored health insurance that is a prime driver of healthcare cost inflation. In that context, and looking back after the fact, it was a good choice to make this piece about the broader lessons to be learned from the Cadillac plan tax's unraveling, rather than focusing on critiquing the tax itself.

The piece lays out five lessons to be learned from the failure of the tax, but they all in some way relate to two of its sentences: "Legislators have a long history of enacting laws that require spending certain funds right away, purportedly to be financed by less-certain savings scheduled to take effect later. This rarely works as advertised."

**THE OMNIBUS SPENDING BILL RECENTLY PASSED BY CONGRESS AND** signed into law by President Obama delays the onset of the Affordable Care Act's so-called Cadillac plan tax for two years.<sup>1</sup> The new law also weakens the effect of the tax (assuming it's ever collected) by making it deductible, as noted by my Mercatus Center colleague Brian Blase.<sup>2</sup> I agree with former Office of Management and Budget director Peter Orszag's observation that the delay may simply be a first instance of a "rolling permanent deferral" of the Cadillac plan tax.<sup>3</sup>

The tax has long been on shaky political ground and the new law considerably reduces the chances of its ever taking effect. It is worth understanding what caused the unraveling of the tax, and what lessons can be drawn from this.

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1. Lisa Mascaro, "President Obama Signs Massive Year-End Tax Cut and Spending Package," *Los Angeles Times*, December 18, 2016.

2. Brian Blase, "Delaying and Weakening Obamacare's Cadillac Tax Is a Move in the Wrong Direction," *Forbes*, December 16, 2015.

3. Amy Goldstein, "Congress to Delay ACA's Cadillac Tax on Pricey Health Plans until 2020," *Washington Post*, December 16, 2015.

The Cadillac plan tax is (was) a 40% excise tax on the amount by which health insurance plan costs exceeded annual thresholds of \$10,200 (individuals) or \$27,500 (families), starting in 2018.<sup>4</sup> These thresholds were indexed to grow more slowly than historical health cost growth, so that over time more and more plans would be subject to the tax, producing escalating federal revenues necessary to help fund the ACA's ambitious health entitlement expansion. A key policy intent of the tax was to offset the damaging effects of the longstanding federal tax preference for employer-sponsored insurance, one of which is to drive excess healthcare cost inflation.<sup>5</sup>

## Lesson 1: Save Before You Spend

After the ACA was enacted, I expressed concern that “the legislation employs comparatively uncertain cost-saving measures as budgetary offsets for comparatively certain cost-increasing provisions.”<sup>6</sup> My observation was hardly original, nor was the concern applicable only to the ACA.<sup>7</sup> Legislators have a long history of enacting laws that require spending certain funds right away, purportedly to be financed by less-certain savings scheduled to take effect later. This rarely works as advertised.

Regardless of one's view about whether the ACA's particular savings measures were ever likely to pan out, my other observation from the same paper remains a broadly applicable legislative principle: “The proceeds of such cost-savings cannot safely be spent until they have verifiably accrued.”<sup>8</sup> This principle was not heeded with the ACA.

## Lesson 2: Don't Assume a Favorable Future Political Alignment

The ACA was passed during a rare historical moment in which Democrats held the White House, the House, and a wide majority in the Senate. The long-term fate of the ACA's individual provisions was always likely to be a

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4. Gary Claxton and Larry Levitt, “How Many Employers Could Be Affected by the Cadillac Plan Tax?” (Issue Brief, Kaiser Family Foundation, August 25, 2015).

5. Charles Blahous, “Distinguishing Policy from Politics in the Cadillac Plan Tax,” E21 (Manhattan Institute for Policy Research), October 5, 2015.

6. Charles Blahous, “The Fiscal Consequences of the Affordable Care Act” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2012), 11.

7. Medicare and Social Security: The Facts, Hearing before the Committee on the Budget, 112th Congress. 112-13 (2011).

8. Blahous, “Fiscal Consequences,” 43.

function of how a differently constituted future Congress might view them. As Orszag has noted, even congressional Democratic support for the tax collapsed after Congress switched hands.<sup>9</sup>

The writing was on the wall for the Cadillac plan tax as soon as it was enacted. I noted in 2012 that “it did not survive its initial clash with political pressures; the form of the tax enacted with the ACA was almost simultaneously amended in accompanying reconciliation legislation, changes that both postponed the effective date and increased the thresholds below which the tax would not apply.”<sup>10</sup> Thus, “to assume that the tax will always be applied to the letter of current law is to assume that political actors in the future will be far more committed to this tax than even the original authors of ACA were.”<sup>11</sup>

Lesson 2 is closely related to lesson 1’s admonition about fiscal prudence because it’s much easier for an incoming party majority to attack a previously enacted tax than it is to repeal benefits on which people have become dependent. In any case, no successful legislative strategy can be built on the assumption that a rare political majority will persist.

### Lesson 3: Be Transparent

A key policy purpose of the Cadillac plan tax was to “offset some of the excessive spending that economists attribute to the longstanding tax preference for employer-provided insurance.”<sup>12</sup> The most direct and transparent way to address that problem would have been to scale back that tax preference. But instead of straightforwardly attacking the distortion and its damaging effects, the Cadillac plan tax constituted an opaque attempt at devising a countervailing distortion.<sup>13</sup>

This opacity received negative attention when videos surfaced of ACA architect Jonathan Gruber asserting that he and other proponents engaged in “mislabeling” to invisibly achieve the Cadillac plan tax’s policy goals.<sup>14</sup> But apart from ethical considerations, deliberate opacity is often a tactical mistake. A transparent debate over scaling back the employer-sponsored

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9. Peter R. Orszag, “Democrats Attack a Pillar of Obamacare: Ending the Cadillac Tax Would Undermine Efforts to Contain Health-Care Costs,” *Bloomberg Opinion*, December 10, 2015.

10. Blahous, “Fiscal Consequences,” 35.

11. Blahous, 36.

12. Orszag, “Democrats Attack a Pillar.”

13. Blahous, “Distinguishing Policy from Politics.”

14. Jake Tapper, “Obamacare Architect in 6th Video: ‘Mislabeling’ Helped Us Get Rid of Tax Breaks,” *CNN*, November 14, 2014.

insurance tax preference would undoubtedly have been contentious, but those who supported such a provision would thereafter have been publicly invested in the objective. But instead of reflecting a growing bipartisan consensus on the necessity of attacking tax preferences, what we wound up with was a new tax that had few friends.<sup>15</sup> The opacity created a situation in which support was largely confined to a small community of experts who had bought into the tax's purpose,<sup>16</sup> while powerful constituencies on both sides of the aisle rose in opposition.<sup>17</sup>

#### Lesson 4: Partisan Victories Can Be Short-Lived

Politically difficult measures like the Cadillac plan tax are much easier to defend if enacted with bipartisan support. If, on the other hand, legislation is passed over the strong and unified objections of one of the two major parties, it's often only a matter of time before that party has an opportunity to repeal strongly disliked parts of that legislation. Had the Cadillac plan tax (and other parts of the ACA) been bipartisan, its political staying power would likely have been greater.

Contrast the ACA dynamic with, for example, bipartisan legislation such as the 1983 Social Security reforms. Those controversial reforms were extremely difficult to enact,<sup>18</sup> but once they were enacted, negotiators on opposite sides were heavily invested and thus disinclined to revisit the legislation—even when tough measures like taxing Social Security benefits and raising the retirement age were taking effect.

#### Lesson 5: Don't Campaign against Necessary Policy Steps

The ACA was enacted after presidential candidate John McCain had been successfully attacked for his proposal to scale back the employer-sponsored

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15. Donald B. Marron, "Cutting Tax Preferences Is Key to Tax Reform and Deficit Reduction" (Testimony before the Senate Committee on the Budget, Urban-Brookings Tax Policy Center, Washington, DC, February 2, 2011).

16. Letter to Orrin G. Hatch, Paul D. Ryan, Ron Wyden, and Sander M. Levin, October 1, 2015, [https://www.cbpp.org/sites/default/files/atoms/files/cadillac\\_tax\\_letter.pdf](https://www.cbpp.org/sites/default/files/atoms/files/cadillac_tax_letter.pdf).

17. Bob Herman, "New Lobbying Group to Grease Wheels for 'Cadillac' Tax Repeal," *Modern Healthcare*, July 15, 2015.

18. Charles Blahous, "Is It Becoming Too Late to Fix Social Security's Finances?," E21 (Manhattan Institute for Policy Research), August 31, 2012 (republished in this collection).

insurance tax preference<sup>19</sup>—even though experts on both sides understood his basic idea to be a necessary policy step.<sup>20</sup> When this happens, those elected to office find themselves with a bad choice between breaking their word and furthering large policy problems. A core reason we now lack an effective mechanism to constrain the drivers of excess health cost inflation is that, prior to the ACA, it was not adequately presented to voters what that might involve. While it's inevitable that candidates for office will want to present their platforms in the most salable light, they would do well to campaign in a manner consistent with how they need to govern. And voters, for their part, should be scrutinizing candidates to determine whether their promises can realistically be upheld if they are elected to office.

## Conclusion

The apparent demise of the Cadillac plan tax contains many object lessons for legislative strategists. Crafting a more effective brake on health cost inflation will require that we learn from them.

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19. Ben Smith, "Obama Attacks 'Radical' McCain Health Plan," *Ben Smith Blog (Politico)*, October 4, 2008.

20. Ryan Hill, "Reforming the Employer-Sponsored Insurance Tax Exclusion," American Action Forum, August 2, 2012; Paul N. Van de Water, "Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform: Universal Coverage May Be Out of Reach Otherwise," Center on Budget and Policy Priorities, June 4, 2009.

# Why the ACA's Medicaid Expansion Needs to Be Fixed

*This article was originally published at E21 on March 13, 2017, as "Why Obamacare's Medicaid Expansion Needs to Be Fixed."*

This and the remainder of the articles included in part 1 were written and published in the heat of intense national debate over congressional efforts to repeal and replace the ACA. Many aspects of this debate involved subjective value judgments that individuals will inevitably make differently even when they are looking at identical information, and these pieces do not address those issues. Instead they (and some other pieces I published around the same time) narrowly highlight one of the ACA's most clearly problematic features: its inflated federal match rate for covering the Medicaid expansion population.

Lawmakers were then in a bind: if repeal-and-replace legislation responsibly normalized Medicaid match rates to treat all beneficiaries equally (an action that would be consistent with longstanding historical practices), CBO would project states to have Medicaid cover millions fewer individuals than would be covered under the ACA. CBO's projection contributed to challenging political obstacles that the sponsors of such legislation proved unable to overcome.

Regardless of these political challenges, it is important for policymakers and the public to be aware of the significant and mounting problems—from inequities in the treatment of Medicaid's most vulnerable beneficiaries to enormous cost overruns—being caused by the ACA's inflated Medicaid match rate. These problems will persist until corrections are made.

**CONGRESSIONAL REPUBLICANS, HAVING MOVED THEIR ACA repeal-and-replace bill through committee, are hearing the inevitable criticisms from both sides of the aisle as to what should be done differently. These disparate opinions are only useful insofar as they enable Senate and House leadership to finalize a bill that attracts the votes necessary to pass both chambers and get to the president's desk.**

One of the issues in contention is what to do with the ACA's Medicaid expansion.<sup>1</sup> Medicaid provides health insurance for the poor and is jointly funded by the federal and state governments. The ACA departed from the historical distribution of government financing obligations, providing inflated federal matching payment rates specifically to cover those brought newly under Medicaid.<sup>2</sup> The federal government covered 100% of these costs from 2014 to 2016, scheduled to phase to 90% from 2020 onward.

The House bill would leave the ACA's match rates in place until 2020, thereafter reverting to Medicaid's historical matching formula, through which the federal government provided 57% of funding on average.<sup>3</sup> The expansion population enrolled before 2020 would be grandfathered in; the federal government would permanently fund these individuals at the ACA's elevated (90%) match rates. After 2020, federal payment growth per Medicaid enrollee would be limited to national health cost inflation.

The issue of how rapidly to reform the ACA's inflated Medicaid payment rates has divided congressional Republicans. Fiscal conservatives are concerned the bill does not do enough to scale back the ACA's expansion costs.<sup>4</sup> Other Republicans, as well as governors in expansion states, resist even the gradual cost-containment provisions in the House bill.<sup>5</sup>

The following explanation is not intended to provide guidance as to what schedule will produce the critical mass of votes necessary to pass legislation. Rather, it is an attempt to explain the substantive problems created by the ACA's inflated match rate. It's important that these problems be corrected. While the precise timetable must be determined by the vote-counting, the bill's sponsors are right to be taking this on.

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1. Jeremy Diamond, "In Major Shift, White House Privately Backing Earlier Rollback of Medicaid Expansion," *CNN*, March 10, 2017.

2. Charles Blahous, "The Affordable Care Act's Optional Medicaid Expansion: Considerations Facing State Governments" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2013).

3. See the section-by-section summary at House Committee on Energy and Commerce, "Energy and Commerce Republicans Release Legislation to Repeal and Replace Obamacare," press release, March 6, 2017.

4. John T. Bennett, "Trump Might Be Open to Earlier Freeze of Medicaid Expansion," *Roll Call*, March 10, 2017.

5. Jessie Hellmann, "Four GOP Senators Pledge to Vote against Rolling Back Medicaid Expansion," *The Hill*, March 6, 2017; Benjy Sarlin, "Why Medicaid Is So Hard for Republicans," *NBC News*, March 10, 2017.

## Problem 1: The ACA Medicaid Expansion Payment Rate Is Inequitable

The only convincing way the ACA's inflated Medicaid payment rate can be justified is in terms of a political negotiation between the federal government and the states. Otherwise the ACA's match rate makes little policy sense. Consider the information about current federal Medicaid support payments in table 1.<sup>6</sup>

It is extremely difficult to explain or even understand this arrangement from a policy standpoint. The federal government has been covering 100% of costs for childless adults above the poverty line, but only 57% for children in poverty. A childless woman above the poverty line receives 100% support; her pregnant sister receives 57% support. An able-bodied adult above the poverty line receives 100% support; a disabled individual in poverty receives 57% support. This defies policy sense.

So why has this happened? It happened because the ACA was originally drafted to conscript states to expand Medicaid to cover childless adults up to 138% of the poverty line. The only way to overcome state objections to this was to have the federal government pick up virtually all the costs. After the Supreme Court rendered the ACA's Medicaid expansion optional for states, this elevated match rate thereafter became a lure for states to cover a population they would otherwise decline to spend significant resources to cover.<sup>7</sup>

Had states made a priority of covering childless adults above the poverty line, they would have previously sought federal waivers to do so at historical Medicaid match rates—but generally they did not.<sup>8</sup> The ACA's elevated Medicaid match rate for the expansion population, by design, distorted state coverage decisions relative to the results of their own prior policy deliberations.

## Problem 2: The ACA's Medicaid Expansion Creates Access Challenges for Vulnerable Populations

There is an understandable tendency to treat the ACA's Medicaid expansion as an unalloyed gain for vulnerable populations. It is assumed that

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6. Blahous, "Affordable Care Act's Optional Medicaid Expansion," 1–2, 8.

7. *NFIB v. Sebelius*, 567 U.S. 519 (2011).

8. John Holahan and Irene Headen, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL" (report, Kaiser Commission on Medicaid and the Uninsured, Washington, DC, May 2010).



**Table 1. Federal Medical Assistance Percentages for Different Beneficiary Populations**

Percentage of costs covered by the federal government for pregnant women and children under 6 below 133% of the poverty line, children ages 6–18 in poverty, and elderly or disabled individuals on SSI assistance (average among all states)	57%
Percentage of costs covered by the federal government for childless adults from 100% to 138% of the poverty line	100% from 2014–2016, phasing to 90% in 2020

compassion must be unambiguously on the side of Medicaid expansion. This is not necessarily so.

There would be winners and losers from repealing the ACA's inflated Medicaid match rates. The losers would be childless adults with incomes between 100% and 138% of the poverty line (assuming they do not move into superior coverage), as well as state governments. The winners would be federal taxpayers and, potentially, the most vulnerable populations—poor children, poor pregnant women, and poor aged and disabled individuals.

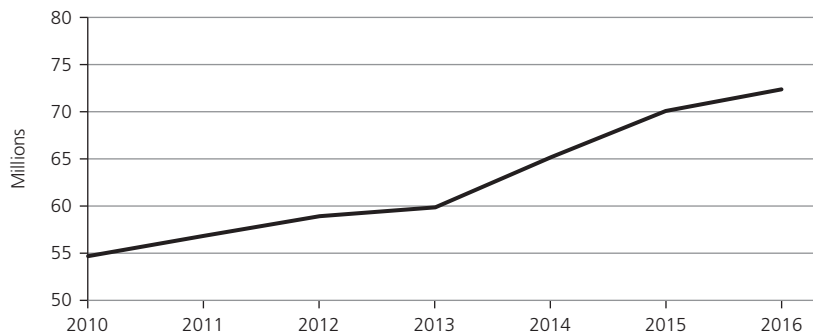
Recall that the ACA's principal effect on Medicaid was to expand financing support, enrollment, and thus the demand for services. From 2013 to 2016, competition for such services increased from fewer than 60 million individuals to more than 72 million—an enrollment increase of over 20%. (See figure 1.) As the National Academy of Science's Institute of Medicine has noted,

As a result of the recent Medicaid expansion and the number of patients who are now insured through state exchanges, a shortage has developed in the supply of primary care physicians in some areas of the country relative to the demand.<sup>9</sup>

The ACA attempted to counteract this problem by increasing the supply of physicians willing to take Medicaid, via a fee increase for participating

9. Gary Kaplan, Marianne Hamilton Lopez, and J. Michael McGinnis, eds., *Transforming Health Care Scheduling and Access: Getting to Now* (Washington, DC: National Academies Press, 2015), 20.

Figure 1. Total Medicaid Enrollment



doctors.<sup>10</sup> There is an ongoing argument about whether access to care for Medicaid participants was made better or worse by the ACA, on balance.<sup>11</sup> That said, unless the supply of Medicaid services expanded proportionally with higher enrollment, it is virtually certain that part of the cost of expansion was paid by previously enrolled—and more vulnerable—individuals, in the form of increased competition for limited services.

Repeal of the ACA's inflated Medicaid match rate would not mean childless adults between 100% and 138% of the poverty line couldn't still be covered. It would simply end the federally imposed preference for covering this population over concentrating benefits on more vulnerable individuals. Applying the standard federal payment rate equally to the historic population and the expansion population would permit states to more accurately weigh the tradeoffs associated with expanded Medicaid coverage.

### Problem 3: The ACA Medicaid Expansion Payment Rate Is Fueling a Cost Explosion

Medicaid has long struggled with financial stewardship issues due to its hybrid structure in which states do not bear the full costs of their own program

10. Michelle Yè Hee Lee, "Paul Ryan's Claim That 'More and More Doctors Just Won't Take Medicaid,'" *Washington Post*, February 1, 2017.

11. Molly Candon, "The Doctor Will See You Now: Appointment Availability for Medicaid Patients," Penn LDI blog, March 17, 2017; Deane Waldman, "ObamaCare's Dangerous Wait Lines," *The Hill*, December 5, 2016.

management decisions. The ACA worsened that problem by having the federal government pick up 100% of the bill for any cost-increasing decisions the states make. The predictable result has been a cost explosion in covering the newly eligible population.

Table 2 shows the CMS Medicaid actuary's evolving estimates for the per capita costs of covering newly eligible adults. Note, for example, that 2015 annual per capita costs, estimated at less than \$4,000 in the 2013 report, came in at over \$6,365, a full 60% higher.

It wasn't supposed to be this way. The Medicaid actuary initially expected that per capita costs for newly eligible adults would be much lower than for previous eligibles, based on the reasonable expectation that the expansion population would have better health and income while having fewer high-cost health conditions. The warped incentives of the ACA, however, have induced states to set payment rates for the expansion population far higher than for the needier historic Medicaid population.

The specific politics of Medicaid, as well as the general politics of ACA repeal, are inordinately complex. The Medicaid match rate issue, however, is substantively straightforward. While reasonable people can differ about whom Medicaid should cover, there is little in the way of a sensible policy rationale for the federal government providing greater support for the ACA's Medicaid expansion population than it does for everyone else in the program. Timetable aside, it's a problem warranting correction and the bill's sponsors deserve credit for addressing it.

**Table 2. CMS Medicaid Actuary Estimates of Per Capita Costs of Newly Eligible Adults**

Year	2014	2015	2016
2013 Report	\$4,636	\$3,976	\$3,625
2014 Report	\$5,517	\$4,281	\$3,606
2015 Report	\$5,488	\$6,366	\$5,910
2016 Report	\$5,511	\$6,365	\$5,926

# Lawmakers Can't Afford to Give Up on Fixing the ACA

*This article was originally published at E21 on April 3, 2017, as "Lawmakers Can't Afford to Give Up on Fixing Obamacare."*

Although the title of this piece was adapted to emphasize its relevance to the ongoing repeal-and-replace debate, it actually summarizes "The Fiscal Effects of Repealing the Affordable Care Act"—a comprehensive 2017 study performed for the Mercatus Center as a bookend to the 2012 study "The Fiscal Consequences of the Affordable Care Act." The 2017 study found that, just as the passage of the ACA had worsened federal finances, its repeal would improve them.

This finding received considerably less press attention than the finding of the 2012 study, likely because the topic of debate had largely shifted from the ACA's fiscal effects to its coverage effects. ACA supporters mostly conceded that repeal would lower the federal deficit, and were instead expressing concern about reduced coverage levels under potential repeal. Another factor was that repeal-and-replace sponsors had chosen not to touch the ACA's major Medicare cost-containment provisions, thereby obviating potential controversies over any double-counting in the scorekeeping.

The 2017 study, and this accompanying article, pointed to numerous instances of the ACA's cost-saving provisions failing to be implemented. This ongoing failure suggested that the savings realized from repealing the ACA might be substantially greater than the amount apparent under conventional scoring. At the same time, however, CBO made aggressive assumptions about how Medicaid enrollment would proceed if the ACA remained on the books—assumptions that, when considered separately, might suggest a possible overstatement of both the coverage reductions and the budget savings under potential repeal. I originally believed, owing to the failure of the ACA's cost-saving provisions, that actual savings upon repeal would be greater than the central estimate. However, after further reviewing CBO's baseline Medicaid participation assumptions, I have come to believe that the central estimate was probably the best one, because sources of projection error in both directions are likely to roughly cancel each other out.

IN MARCH 2017 CONGRESSIONAL EFFORTS TO REPEAL AND REPLACE THE Affordable Care Act came to a screeching halt when the House leadership couldn't muster the votes to pass the American Health Care Act (AHCA).<sup>1</sup> While it's unclear how long lawmakers will put the effort aside, they cannot afford to simply abandon the objective.<sup>2</sup> As my latest study (published this morning by the Mercatus Center) analyzes in detail, the fiscal damage being caused by the ACA is simply too great to leave uncorrected.<sup>3</sup>

Healthcare policy involves difficult tradeoffs with implications affecting the health and income security of millions of people; its effect on federal finances is only one factor lawmakers must consider. But fiscal implications cannot be ignored, as we are reminded by the Congressional Budget Office's latest projections of unsustainable federal debt accumulation.<sup>4</sup>

The fiscal damage caused by the ACA is of such a magnitude that many members of the press and policy commentariat continue to have difficulty wrapping their minds around it.<sup>5</sup> Before President Obama took office, federal debt held by the public stood at less than 50% of GDP and there was a solid expert consensus that federal health spending growth constituted a dire threat to long-term fiscal stability.<sup>6</sup> And yet the ACA added further to this fastest-growing part of federal spending, even under the most optimistic projections for the law.<sup>7</sup> Today federal debt held by the public is 77% of GDP and growing, while federal health spending obligations are greater than ever before.<sup>8</sup>

Many of the provisions initially designed to pay for the ACA's dramatic expansion of federally subsidized health insurance coverage have been repealed, suspended, postponed, weakened, or otherwise not implemented. In my 2012 study, "The Fiscal Consequences of the Affordable Care Act," I

1. "Live Coverage: House Pulls ObamaCare Repeal Bill," *The Hill*, March 24, 2017.

2. Peter Sullivan and Jessie Hellmann, "House GOP Insists: We're Not Giving Up on ObamaCare Repeal," *The Hill*, March 28, 2017.

3. Charles Blahous, "The Fiscal Effects of Repealing the Affordable Care Act" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, April 2017).

4. Congressional Budget Office, "The Budget and Economic Outlook: 2017 to 2027," January 2017.

5. Catherine Rampell, "Reports of Obamacare's Demise Are Greatly Exaggerated," *Washington Post*, October 13, 2016.

6. Congressional Budget Office, "Budget and Economic Data," <https://www.cbo.gov/about/products/budget-economic-data>; Henry Aaron et al., "Busting the Budget: Healthcare Costs of Entitlement Programs?" (panel, Committee for a Responsible Federal Budget, September 15, 2008).

7. Douglas W. Elmendorf, Letter to Speaker of the House Nancy Pelosi, March 20, 2010.

8. Congressional Budget Office, "Budget and Economic Outlook," 5.

anticipated some, but not nearly all, of this fiscal slippage.<sup>9</sup> The 2012 study correctly anticipated that the ACA's Cadillac plan tax might not produce the full amount of revenues projected, and that its cost-containing Independent Payment Advisory Board might prove too controversial to ever become operational.<sup>10</sup> But the subsequent deterioration of the ACA's financing proved more severe than even these pessimistic predictions, due to the suspensions of the ACA's health insurance fees and medical device tax, the postponement and weakening of its individual and employer mandate penalties, and the repeal of the CLASS long-term care program (which had been projected to produce a surplus over Congress's 10-year budget window).<sup>11</sup>

Table 1 shows how key ACA financing mechanisms have deteriorated relative to initial projections. CBO initially scored the ACA as reducing federal deficits by \$124 billion from 2010 to 2019 relative to Congress's budget baseline. That scorekeeping method effectively mandated that the ACA's Medicare Hospital Insurance (HI) cost savings be doubly counted—once to extend the solvency of the HI trust fund, and a second time to finance the ACA's coverage expansion (further details on this technical, but critical, point are available in my study).<sup>12</sup> Adjusting for this scoring quirk, I projected in 2012 that the ACA would add \$346 billion to federal deficits from 2012 to 2021.<sup>13</sup> At the bottom line, the ACA's finances have turned out worse than projected, relative to either baseline.

Regardless of what has happened to date, what matters now are the choices going forward. My latest study explores the fiscal ramifications of repealing and replacing the ACA, while detailing various factors that could cause the savings to be either more or less than currently projected.<sup>14</sup>

The most encouraging news from the study is that the fiscal benefits of repeal may well be substantially larger than can be gleaned from any CBO report.<sup>15</sup> This result has nothing to do with any fault of CBO's, and indeed lawmakers should resist the temptation to attack CBO if they disagree with

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9. Charles Blahous, "The Fiscal Consequences of the Affordable Care Act" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2012).

10. Blahous, "Fiscal Consequences."

11. Charles Blahous, "How to Repair ObamaCare's Fiscal Damage," *Wall Street Journal*, March 16, 2017.

12. Blahous, "Fiscal Effects."

13. Blahous, "Fiscal Consequences."

14. Blahous, "Fiscal Effects."

15. Blahous, "Fiscal Effects."

Table 1. Deterioration of Key ACA Financing Provisions

Provision	Estimated financing contribution, 2010–2019 (\$B)	Current status
Fees on medical manufacturers and insurers	\$107	Medical device and health insurance fees suspended until 2018
CLASS program	\$70	Repealed
Employer mandate penalties	\$52	Suspended for smaller employers and relaxed for larger employers until 2016
Cadillac plan tax	\$32	Delayed until 2020
Individual mandate penalties	\$17	Hardship exemptions expanded

its estimates. CBO has certain charges it must meet: it must make a single best-guess estimate even when there is a wide range of projection uncertainty. And CBO must also project the effects of the ACA as currently written—not as it has been, or is likely to be, implemented.

For example, CBO must assume that, going forward, the ACA's Cadillac plan tax, health insurance fees, and medical device tax will together produce escalating streams of federal revenue—even though to date legislators' tendency has been to suspend or postpone these taxes, while adding the resulting revenue loss to the deficit. The ACA, whose finances depend greatly on these taxes, thus threatens to add far more to federal deficits than a hypothetical replacement plan that does not depend on these taxes.

A number of factors—ranging from the policy choices made in repeal legislation to assumptions for economic variables and counterfactual legislative behavior—could plausibly push the 10-year savings from repealing the ACA's full array of spending and taxes up above \$1 trillion over 10 years.<sup>16</sup> The fiscal improvement could approach this magnitude if one recognizes

16. Blahous, "Fiscal Effects."

that many of the ACA's various taxes might never be collected anyway, if lawmakers include repeal of the ACA's various insurance market rules, and if government forecasters are continuing to underestimate the per capita costs of the ACA's Medicaid expansion (see table 2).

On the other hand, the savings could be less than currently projected if CBO is continuing to overestimate future participation in the ACA's exchanges or if, as some have argued, CBO is overestimating the decline in Medicaid coverage under repeal-and-replace legislation (see table 3 and figure 1).<sup>17</sup>

Another factor lawmakers should be aware of is that repeal of the ACA's Medicare provisions would accelerate Medicare HI trust fund depletion. The acceleration would be most sudden if the ACA's Medicare HI cost-containment provisions are repealed (which the AHCA would not have done). But there would still be some acceleration of HI insolvency from repealing the ACA's Medicare payroll tax increase or its restraints on disproportionate share hospital payments (which the AHCA would have done).

Stepping back from recent efforts to repeal and replace the ACA is a setback from some perspectives, but also affords lawmakers more time to get the policy right. A key decision in this respect is how best to replace the ACA's Cadillac plan tax, ideally with an alternative policy that scales back the damaging effects of the longstanding tax distortion favoring employer-sponsored health benefits over take-home pay.<sup>18</sup> In addition, care should be applied to the contours of any replacement provisions aimed at maintaining health insurance coverage, lest they perpetuate the fiscal problems the ACA created.

Regardless of how these and other policy dilemmas are resolved, lawmakers cannot afford to give up on enacting fiscal corrections to the ACA. A comprehensive analysis of the situation shows that the fiscal stakes are far too high.<sup>19</sup>

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17. Avik Roy, "Four Critical Problems with the CBO's Latest Obamacare Repeal Estimates," *Forbes*, January 17, 2017.

18. Charles Blahous, "Distinguishing Policy from Politics in the Cadillac Plan Tax," E21 (Manhattan Institute for Policy Research), October 5, 2015.

19. Blahous, "Fiscal Effects."



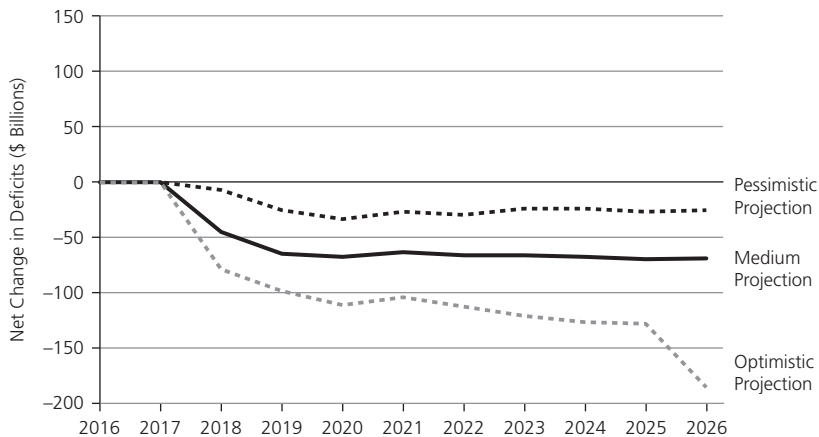
**Table 2. Successive CMS Medicaid Actuarial Report Estimates of Per Capita ACA Expansion Costs**

Year	2014	2015	2016
2013 Report	\$4,636	\$3,976	\$3,625
2014 Report	\$5,517	\$4,281	\$3,606
2015 Report	\$5,488	\$6,366	\$5,910
2016 Report	\$5,511	\$6,365	\$5,926

**Table 3. Range of Projected Deficit Reduction If ACA Spending and Taxes Are Repealed, Effective 2018**

	Pessimistic projection	Medium projection	Optimistic projection
Federal deficit reduction, 2017–2026	\$228 billion	\$586 billion	\$1,070 billion

**Figure 1. Net Projected Change in Federal Deficits If ACA Spending and Taxes Are Repealed, Effective 2018**



# Who Should Pay to Cover Pre-existing Conditions?

*This article was originally published at E21 on April 30, 2017.*

This article falls into the “you never can tell” category. I had expected it to appeal to only a very limited audience, because it describes a complex policy problem, outlines multiple approaches to dealing with the problem, and shies away from opining on the best solution. Yet I probably received more compliments upon the publication of this piece, from sources covering a wider range of the political spectrum, than for any other piece published over the previous couple of years.

When things turn out differently than we expect, we have an opportunity to learn. I’ve tried to learn something from the relative success of this piece. One possible lesson is that there is a greater audience than previously realized for writing that merely tries to explain the basic directional choices facing policy-makers without attempting to focus the reader on any particular conclusion.

If there is one takeaway point from this piece readers should internalize, it’s that paying for the care of those with pre-existing health conditions isn’t an insurance issue per se, even though we tend to treat it as such in our national policy discussion. Insuring people against a problem they might someday have, as opposed to helping them to pay for a problem they already do have, are two very different things, and need to be clearly distinguished if we are to make informed policy choices.

**AMONG THE MOST VEXING OF OUR NATIONAL HEALTHCARE POLICY** challenges is the question of who should pay (and how) for the medical care of those with pre-existing health conditions. Advocates propose a broad array of answers to this question, explanations of which rapidly grow complicated. The purpose of this column is to simplify as much as to explain—to provide a cursory, thumbnail guide to the basic value judgments underlying these complex proposals.

Disagreement over how to handle pre-existing conditions is a big part of how we came to our current impasse over national healthcare policy. The promise that the Affordable Care Act would guarantee coverage for those with pre-existing conditions was one of the most popular provisions of an

otherwise unpopular law, and a central motivation for its passage.<sup>1</sup> Donald Trump, while a candidate for president, expressed support for maintaining a pre-existing condition coverage guarantee even as he opposed the ACA as a whole.<sup>2</sup> More recently, congressional Republicans have been working to bridge internal differences over how to handle pre-existing conditions in a repeal-and-replace bill, resulting in the draft MacArthur amendment to the AHCA.<sup>3</sup>

We have a tendency to use “pre-existing conditions” as a euphemism for “expensive healthcare needs,” but the two aren’t quite the same. If you and I are both healthy today, and both participating in the same insurance plan, the pricing of our insurance should already factor in the probability that one of us will someday face a health problem requiring expensive treatment—and the plan should be able to handle it when we do. But sick people without insurance (or looking to change plans) are in a different situation; their need for health treatment is a certain problem rather than a merely possible one, and hence the average expected cost is much higher. Technically, what they need is not insurance against a possible, unknown problem, but rather help paying for a certain, known problem.

There’s no way around a simple truth: treating an expensive health condition costs (someone) lots of money. There are four basic approaches that can be taken to this problem.

1. Leave sick people to face the costs of their own treatment, whether out of pocket or through high-cost insurance, no matter how ruinous those costs become.
2. Mandate that other, healthier people overpay for the value of their own health insurance so that sick people can underpay for the value of theirs.
3. Spread the costs of paying expensive health bills throughout society, for example by having taxpayers pick up the tab.
4. Require a targeted group to shoulder the costs.

Let’s summarize these approaches in turn.

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1. Patricia Zengerle, “Most Americans Oppose Health Law but Like Provisions,” *Reuters*, June 24, 2012.

2. “Donald Trump on Health Care,” *On the Issues*, March 10, 2017.

3. The American Health Care Act of 2017, H.R. 1628, amendment.

## Approach 1

Leave sick people to face the costs of their own treatment, no matter how high they get. Theoretically (albeit callously) we could leave people with expensive health conditions to their fates, forcing many to first bankrupt themselves and later be denied essential care. The cost of insuring against such expenses would be enormously high, so the sick would face a choice between paying their bills out of pocket without insurance or carrying far more expensive insurance than everyone else. American society appears to wholeheartedly reject this approach, which suggests we must find an alternative.<sup>4</sup>

## Approach 2

Force other, healthier people to carry insurance and overpay for its value, so that sick people can underpay for the value of theirs. This is, in effect, the approach taken under the ACA. The ACA sought to mandate that everyone carry insurance and to impose “modified community rating”—i.e., an individual’s health history could not be the basis for charging him or her a different premium amount.

This approach requires that healthy people pay far more than the value of the health services they expect, while sick people pay far less than the value of the services they expect. The key word here is “expect.” Under all insurance, people who make more claims receive more value for their premiums than those who make fewer. But more typically, the individual only chooses to carry the insurance in the first place if he believes that the likelihood of his making a claim is such that it justifies paying the assessed premium amount. Community rating and mandatory coverage by contrast create a very different dynamic—forcing many people to pay premiums well in excess of the expected value of their claims, so that others can pay premiums that are far less than the expected value of theirs.

The value judgment made in the ACA is a defensible one. Simplified, it is like saying, “We want to ensure that those in our society facing ruinous health-care costs are shielded from those costs. We are choosing to have this done through our health insurance system. Paying for their treatments will cost money. So, all the rest of you will pay extra for your own health insurance,

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4. Ashley Kirzinger, Bryan Wu, and Mollyann Brodie, “Kaiser Health Tracking Poll: Health Care Priorities for 2017” (report, Kaiser Family Foundation, Washington, DC, January 6, 2017).

to cover not only your own average expected healthcare costs but theirs as well. We believe this is the right thing for a compassionate society to do.”

Had this fundamental value judgment of the ACA been forthrightly explained to voters, it might have sustained more popular support. Instead, however, Americans were repeatedly told that the ACA would simultaneously provide for the sick while lowering everyone else’s insurance costs, reducing the federal deficit, and extending Medicare solvency at the same time.<sup>5</sup> When people realized they were being forced to bear additional costs through their own insurance—and when some of these people were hit much harder than others due to patterns in their particular markets—they felt misled and grew angry in a way they perhaps might not have if they had agreed to this tradeoff from the beginning.<sup>6</sup>

### Approach 3

Spread the costs throughout society, for example by having taxpayers pick up the tab. An alternative approach is to straightforwardly say, “We want to help sick people meet their health expenses. There’s no particular policy rationale for hiding these expected costs in insurance premiums, since this isn’t really an insurance problem so much as one of straightforward financial support. Therefore, we’ll just have taxpayers pay for it directly.”

There are a lot of ways this could be done. One option is through “high-risk pools”—coverage programs funded by states specifically to finance such costs, and a model Republicans are considering as a successor to the ACA.<sup>7</sup> And while the ACA generally reflected approach 2 above, it also featured taxpayer-provided subsidies per approach 3, in the form of tax credits for low-income individuals to offset their insurance premiums. Other examples of approach 3 include the support taxpayers provide for both the ACA and non-ACA portions of Medicaid, and for much of Medicare as well (though none of those programs specifically targets people with pre-existing conditions).

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5. J. B. Wogan, “No Cut in Premiums for Typical Family,” *PolitiFact*, August 31, 2012; Charles Blahous, “Repealing Obamacare Would Lower Federal Deficits,” *CMSNews.com*, June 22, 2015; James C. Capretta, “Blahous and Capretta: Exposing the Medicare Double Count,” *Wall Street Journal*, May 1, 2012.

6. Reuters, “Obamacare Premiums for 2017 Jumped 25% on Healthcare.gov,” *Fortune*, October 25, 2016.

7. Karen Pollitz, “High-Risk Pools for Uninsurable Individuals,” Kaiser Family Foundation, February 22, 2017.

Some advocates are concerned about taking approach 3 because they believe government funding will be inadequate to cover the costs of treating pre-existing conditions.<sup>8</sup> Another potential objection is the argument that all participants in the healthcare system should share in these costs, not just those who pay income taxes.

## Approach 4

Require a targeted group to shoulder the costs. This is just another way of saying “find someone else to pay, other than the sick individual, the taxpayer, or other mandated participants in the insurance pool.” Possibilities are theoretically endless, though few of them would have a compelling policy rationale.

One of the few potentially interesting versions of this approach would be to require insurance companies to shoulder the costs by grandfathering in guaranteed issue and modified community rating for those with pre-existing conditions who gained coverage under the ACA, while relieving other participants of the coverage mandate and associated penalties. For those with pre-existing conditions, this approach would implement President Obama’s promise that “if you like your healthcare plan, you can keep it.”

This would destabilize these plans and force insurance companies (and, by extension, investors in them) to accept substantial losses. To the extent that insurers withstand these losses and continue to operate, voters might regard this outcome as preferable to, or a useful amelioration of, shifting these costs to taxpayers and healthy participants. The ACA permitted insurers to pursue the upside of a potentially lucrative bet—participating in the ACA’s insurance marketplaces so long as the new coverage mandate led to additional profits, but pulling out if the marketplace plans proved unprofitable. Approach 4 would effectively force insurers (and their investors) to accept the realization of downside risk from having made that bet.

Regardless of who shoulders the costs of caring for the uninsured, someone will bear those costs unless that care is denied. The complexities of the various policy options facing lawmakers should not obscure a more fundamental societal value judgment that must be made: specifically, who should bear those costs.

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8. Harris Meyer, “Why High-Risk Pools Won’t Crack the Pre-existing Condition Dilemma,” *Modern Healthcare*, February 13, 2017.

# Medicaid Scare Tactics Are Irresponsible

*This article was originally published at E21 on June 22, 2017.*

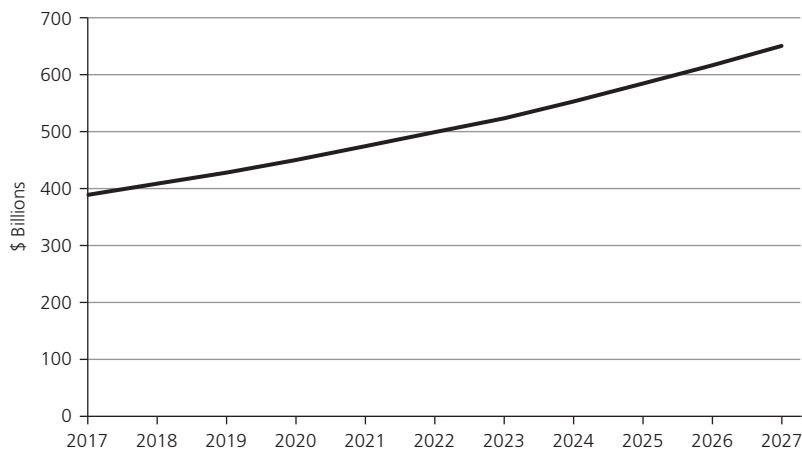
This piece caught the eye of contacts at the *Washington Post*, leading to the publication of a similar piece in the *Post* a few days later that made many of the same points in abbreviated form. The inspiration for it was a flurry of publications suggesting that the most vulnerable Medicaid beneficiaries—for example, children with pre-existing conditions and seniors needing nursing home care—were threatened by pending legislation to repeal and replace the ACA. Not only was this perspective adopted in the writings of many advocates, but it underlay a large chunk of news reporting. The widespread circulation of these charges subjected lawmakers to visceral and often vitriolic expressions of opposition.

There was no basis for the scare pieces, as the following piece explains. Without taking a position for or against the repeal-and-replace legislation, nearly all the budget savings attributed to it pertained to CBO's projections for what would happen to Medicaid expansion under the legislation. None of those effects would have adversely affected the vulnerable populations who depended on Medicaid before the ACA, and indeed might well have benefited them. However, this piece was unable to dislodge the misconception that those vulnerable Americans' benefits would be at significant risk, which persisted throughout the 2017 legislative debate.

**IF WE WANT TO MAKE HEADWAY ON IMPROVING PUBLIC POLICY** discourse, a good place to start might be with how we're debating Medicaid policy, in particular how it might be affected by pending legislation to repeal and replace the Affordable Care Act, including legislation presented on June 22, 2017, by Senate Republicans.

Medicaid has long been on an unsustainable cost growth trajectory. This was true long before the ACA was passed in 2010, though the ACA exacerbated the problem. Annual federal Medicaid spending is currently projected (see figure 1) to grow from \$389 billion in 2017 to \$650 billion in 2027. The biggest problem with that growth rate is that it's faster than what's projected

Figure 1. Projected Annual Federal Medicaid Spending



Source: Congressional Budget Office, January 2017 baseline.

for our economy as a whole. As with Social Security and Medicare, Medicaid costs are growing faster than our ability to finance them.

Medicaid serves a sympathetic low-income population. This purpose, however, does not lessen the necessity of placing the program on a financially sustainable course. Nor does it eliminate lawmakers' obligation to prioritize how Medicaid dollars are spent; to the contrary, it magnifies it. Lawmakers face the conflicting pressures of targeting Medicaid resources at where they are most needed while also limiting aggregate spending growth to a sustainable level.

This situation creates irresistible political opportunities for those inclined to exploit them. Whenever lawmakers take on the unenviable job of moderating cost growth to sustainable rates, these can be and are described as heartless "cuts" relative to existing law—even though existing Medicaid law cannot be maintained indefinitely. This creates a catch-22: the existence of an untenable Medicaid cost growth baseline both mandates responsible action to repair it and establishes a warped basis for comparison that amplifies the political hazards of doing so.

We have seen this dynamic operate with full force in the recent public debate over efforts to repeal and replace the ACA, including its Medicaid provisions. Countless editorials and news articles have portrayed an intent by



Congress to “gut” Medicaid to pay for “tax cuts for the rich.”<sup>1</sup> This intensifying drumbeat has led to disturbing vitriol and threats against legislators, based on gross mischaracterizations of the implications of pending legislation.<sup>2</sup> Consider for example an op-ed recently published in the *New York Times*:

Imagine your mother needs to move into a nursing home. It’s going to cost her almost \$100,000 a year. Very few people have private insurance to cover this. Your mother will most likely run out her savings until she qualifies for Medicaid. . . . Many American voters think Medicaid is only for low-income adults and their children—for people who aren’t “like them.” But Medicaid is not “somebody else’s” insurance. It is insurance for all of our mothers and fathers and, eventually, for ourselves. The American Health Care Act that passed the House and is now being debated by the Senate would reduce spending on Medicaid by over \$800 billion, the largest single reduction in a social insurance program in our nation’s history. . . . Many nursing homes would stop admitting Medicaid recipients and those who don’t have enough assets to ensure that they won’t eventually end up on Medicaid. Older and disabled Medicaid beneficiaries can’t pay out of pocket for services and they do not typically have family members able to care for them. The nursing home is a last resort. Where will they go instead? . . . Draconian cuts to Medicaid affect all of our families. They are a direct attack on our elderly, our disabled and our dignity.<sup>3</sup>

Most anyone reading such an editorial would come away with the fear that pending legislation would threaten the access of the elderly and disabled to Medicaid services. It wouldn’t. The elderly and the disabled who were eligible for Medicaid before the ACA would remain eligible after its proposed repeal. The ACA’s Medicaid expansion population involved childless adults under the age of 65, a different category of beneficiaries altogether.

The large projected expenditure reduction under the AHCA (the House’s repeal-and-replace bill) actually has nothing to do with disabled or elderly Medicaid beneficiaries, but rather with changes in projected enrollment for

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1. E. J. Dionne Jr., “Dionne: Senate’s McConnell Is Gutting Health Care in Darkness,” *Mercury News*, June 15, 2017; Mark Trahan, “The Secret Republican Health Care Plan: Cutting Taxes & Destroying Medicaid,” *Native News Online*, June 21, 2017.

2. Sergio Bichao, “‘Hunt’ Republicans, Says Union County Democrat in Response to Shooting,” *New Jersey* 101.5, June 15, 2017.

3. David Grabowski, Jonathan Gruber, and Vincent Mor, “You’re Probably Going to Need Medicaid,” *New York Times*, June 13, 2017.

the ACA's expansion population. Doug Badger estimated in a recent paper that 82% of the Medicaid savings projected for the AHCA by CBO arose from changes to projected enrollment patterns—not from anything that would undermine care for the person profiled in the *New York Times* op-ed.<sup>4</sup> The story is likely to be quite similar under the recently unveiled Senate bill.

The Chief CMS Actuary recently weighed in with its own estimate of 10-year cost savings of \$383 billion over 10 years from the House bill's Medicaid provisions—less than half the savings projected by CBO.<sup>5</sup> A primary difference between the two estimates has to do with what CMS and CBO respectively believe would happen if the ACA remains on the books. CMS projects that under a continuation of the ACA, the proportion of the potentially newly-Medicaid-eligible population living in Medicaid-expansion states would remain at its current 55%. CBO, by contrast, assumes that additional states would expand Medicaid if the ACA remained law.<sup>6</sup> CBO further assumes that many fewer people will participate in Medicaid if the ACA is repealed, even if they remain fully eligible to participate. The bottom line is that the essential difference between these two assumptions has nothing to do with people now on Medicaid losing their access to coverage.

It is fair to be concerned that fewer people would receive Medicaid coverage in the future under pending legislation than under the ACA. However, current projections bear no resemblance to a picture in which people historically dependent on Medicaid would lose their benefits. To the contrary, CMS estimates (see figure 2) that Medicaid enrollment would stay roughly constant at current levels under the AHCA, while still being substantially higher than projected before the ACA was passed. Indeed, CMS finds that many states would still cover some of the ACA expansion population even if lawmakers do away with the ACA's inflated federal matching payment rates. This would mean expanded coverage relative to pre-ACA levels, and also more equity than under the ACA.<sup>7</sup>

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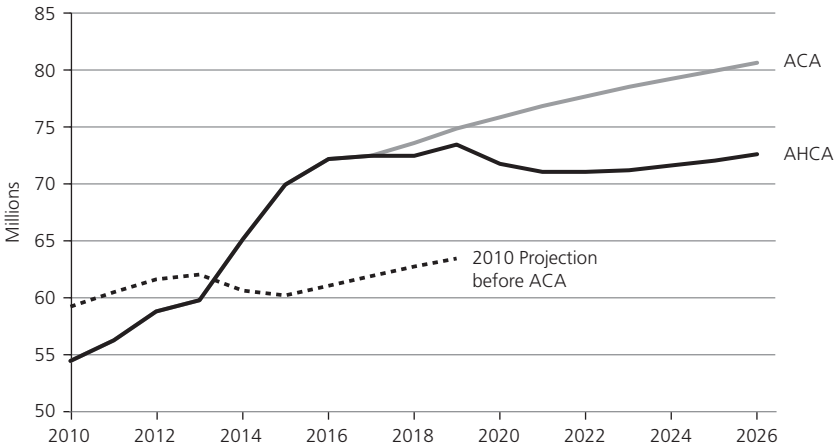
4. Doug Badger, "Dire Predictions about the Effects of AHCA's Per Capita Allocations Find No Support in the CMS Data," *Galen Institute*, June 15, 2017.

5. Paul Spitalnic, "Estimated Financial Effect of the 'American Healthcare Act of 2017,'" Department of Health & Human Services, Centers for Medicare & Medicaid Services, June 13, 2017.

6. Congressional Budget Office, "American Healthcare Act," Congressional Budget Office Cost Estimate, March 13, 2017.

7. Charles Blahous, "Why Obamacare's Medicaid Expansion Needs to Be Fixed," E21 (Manhattan Institute for Policy Research), March 13, 2017 (republished in this collection as "Why the ACA's Medicaid Expansion Needs to Be Fixed").

Figure 2. Medicaid Enrollment Projections



Source: Centers for Medicare and Medicaid Services Chief Actuary.

It is also fair to wonder about the long-term effects of per capita growth caps proposed under both the AHCA and the Senate bill—though not relative to unsustainable promises under current law, but rather to an alternative method of attaining financial sustainability. But no one should associate figures such as \$800 billion in cuts with these proposed caps. As previously described, most of CBO’s projected cost reduction is unrelated to the concept, while CMS’s estimate of the caps’ budgetary effects is well under 10% of that amount.

It is perfectly appropriate for there to be a vigorous, even impassioned debate about whose proposals would provide the best way forward for the Medicaid program. But we ill serve the public with misleading, incendiary rhetoric about vulnerable elderly people being ejected from nursing homes so that cruel politicians can provide tax cuts to the rich, when nothing under consideration can be fairly described as doing any such thing. If advocates want their health policy arguments to be taken seriously, and to usefully inform the American public, groundless hyperbole should be shelved in favor of a focus on what existing proposals would actually do.

# The Spurious “People Will Die” Claim

*This article was originally published at E21 on June 29, 2017.*

Like the previous article, this piece was more about the poor quality of the public debate than about the substance of healthcare reform. As I wrote recently in another context, “intolerance arises when we become so persuaded of our own analytical and moral infallibility that we cannot interpret disagreement other than as evidence of another person’s sinister motivations.” Our national political dialogue suffers from a surfeit of this regrettable tendency.

With sufficiently tenuous reasoning, any of us could portray the adoption of our preferred economic policy views as literally a matter of life and death. After all, more prosperous people tend to live longer, so a stand we believe will lead to greater economic well-being could theoretically be equated with a stand for life itself, with opponents being little better than murderers. Most mature adults recognize that it is absurd to frame policy arguments in this way, as it runs far afield of any reasonable assessment of our own capacity for error, to say nothing of the countless factors bearing upon whether each of us lives or dies. Yet, sadly, we seem to be seeing this style of argument more and more, with the recent debate over repealing and replacing the ACA displaying the tendency at its worst.

The attached piece walks through in some detail how the “people will die” charges leveled during the recent debate were spurious, overzealous, and lacked a rigorous basis.

**PASSIONS ARE HIGH IN THE NATIONAL HEALTHCARE DEBATE. SOME** supporters of the Affordable Care Act have taken to asserting that hundreds of thousands of “people will die” if it is repealed or significantly altered.<sup>1</sup> These claims do not withstand scrutiny, and those who wish their policy arguments to be taken seriously would be well advised to avoid them.

These sensational claims rest on fallacious reasoning, which I’ll describe later in this piece. But first let’s acknowledge that not I, you, or anyone else has any idea how many Americans will live or die under alternative federal

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1. Richard Eskow, “How Many People Will Die for Each Rich American’s Trumpcare Tax Cut?,” *Huffpost*, May 5, 2017.

healthcare policies. It’s an inherently fruitless exercise to attempt to quantify these effects. However, if one seriously wished to attempt it, one would not do so via the methods now being employed to promulgate the “people will die” claim.

The claims are based on extolling a single effect of the ACA: increasing health insurance coverage, which is said to reduce mortality.<sup>2</sup> Of course, the ACA didn’t magically produce its coverage increase out of thin air. To finance it, the law included several features that likely have countervailing effects on mortality. Below is a partial list of such effects, provided with the caveat that it would be just as silly to charge the ACA with killing people as it is to attribute deaths to its possible repeal:

- CBO found the ACA to reduce economic growth, meaning that as a nation we are collectively poorer because the ACA is on the books.<sup>3</sup> Longevity correlates with income, as lower-income people have shorter lives.<sup>4</sup> Repeal would increase national wealth, which correlates with greater longevity.<sup>5</sup>
- CBO also found the ACA to reduce workforce participation.<sup>6</sup> Although there is a fierce national debate over the effects and causes of unemployment, there is broad understanding that unemployment correlates with worsened health.<sup>7</sup>
- The ACA imposed substantial taxes on medical devices and drugs, inhibiting their development and use.<sup>8</sup> We do not know how many lives these products would otherwise have saved.

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2. Ann Crawford-Roberts et al., “Coverage Losses under the Senate Health Care Bill Could Result in 18,100 to 27,700 Additional Deaths in 2026,” Center for American Progress, June 22, 2017.

3. Congressional Budget Office, “Budgetary and Economic Effects of Repealing the Affordable Care Act,” June 2015.

4. Raj Chetty, Michael Stepner, and Sarah Abraham, “The Association Between Income and Life Expectancy in the United States, 2001–2004,” *JAMA Network* (JAMA Special Communication, Volume 315, April 26, 2016): 1750–66.

5. Congressional Budget Office, “Budgetary and Economic Effects of Repealing the Affordable Care Act,” June 2015.

6. Edward Harris and Shannon Mok, “How CBO Estimates the Effects of the Affordable Care Act on the Labor Market” (Working Paper 2015-09, Congressional Budget Office, Washington, DC, December 2015).

7. George Gilder, “The Feminist Economy,” *National Review*, January 23, 2017; “How Does Employment, or Unemployment, Affect Health?,” Robert Wood Johnson Foundation, March 2013.

8. “Obamacare Medical Device Tax,” *Obamacare Facts*, last updated November 14, 2014, <https://obamacarefacts.com/obamacare-medical-device-tax/>; Kat Lucero, “Critics Eye Repeal of Obamacare Prescription Drug Tax,” *The Hill*, January 24, 2017.

- Most of the ACA's coverage expansion occurred through Medicaid, which has a limited supply of providers and services. Those who gained Medicaid coverage via the ACA gained access to subsidized health services. But unless the number of providers, facilities, and services accessible through Medicaid grew at least as fast as enrollment did, there has been a corresponding reduction in health service availability to people previously on Medicaid.

But even a balanced attempt to weigh the ACA's net effects on longevity would be inherently problematic using the methods currently being employed to estimate them. The widely circulated figures for deaths supposedly caused by replacing the ACA are extrapolated from a study of the Massachusetts health reform experience.<sup>9</sup> That study found that post-reform (2007–2010) mortality rates in Massachusetts improved relative to pre-reform (2001–2005) mortality rates more than was the case in other US counties after controlling for demographic and economic conditions. The study is credible, interesting, and suggestive, but does not offer any generalizable proofs of the effects of national health policy on longevity. To the contrary, the authors state that “Massachusetts results may not generalize to other states.”

The study merely shows that longevity improved within Massachusetts after health legislation, more than can be accounted for by economic and demographic trends. This indeed might plausibly have happened because of Massachusetts's particular health reforms, but—as the authors acknowledge—the situation could also have arisen from any of countless factors specific to Massachusetts. Indeed, a similar study of Oregon's experience with Medicaid expansion “did not detect clinical improvements other than depression reduction.”<sup>10</sup> In any case, the Massachusetts study only tells us what *didn't* cause its longevity improvement; it cannot definitively explain what *did*.

But the biggest problem with the “people will die” claim is that it rests on a fundamental logical fallacy. It is related to the familiar “fallacy of

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9. Crawford-Roberts et al., “Coverage Losses”; Benjamin D. Sommers, Sharon K. Long, and Katherine Baicker, “Changes in Mortality after Massachusetts Health Care Reform: A Quasi-experimental Study,” *Annals of Internal Medicine*, no. 160 (May 6, 2014): 585.

10. Katherine Kaicker et al., “The Oregon Experiment—Effects of Medicaid on Clinical Outcomes,” *New England Journal of Medicine*, no. 368 (May 2, 2013): 1713–22; Crawford-Roberts et al., “Coverage Losses.”

composition,” which any discerning interlocutor will call you on if you commit.<sup>11</sup> An oft-cited example of the fallacy is that the fact that a standing spectator can see a baseball game better than the patrons seated near him doesn’t imply that everyone will see better if they all stand up.

The application of the fallacy to health insurance is straightforward. One cannot leap solely from the observation that “having health insurance . . . results in better health” to the conclusion that “the more we expand health insurance, the healthier we all will be.”<sup>12</sup> Health insurance reduces the out-of-pocket costs individuals face when they buy health services. Expanded insurance coverage increases health service consumption, which, considered by itself, should improve health. But it also increases cost growth, an effect widely recognized in health expenditure forecasting.<sup>13</sup> People with insurance feel this cost growth through rising premiums, but the cost inflation is felt especially keenly by the uninsured, who must pay more whenever they buy health services (or receive less care for what they pay).

Thus, even if health insurance did absolutely nothing to improve national health outcomes, we’d still expect the insured to be healthier than the uninsured. Thus, the observation that the insured are relatively healthier doesn’t by itself imply that expanding coverage will save lives.

There are countless potential examples of the fallacy in operation. For example, consider the current tax preference for employer-sponsored insurance. Those who receive health insurance through their employer enjoy an advantage in these benefits’ exemption from taxation. This tax preference steers additional health benefits to these individuals. However, this does not mean improved health for the nation as a whole. To the contrary, the employer-sponsored insurance tax preference is widely recognized as a driver of health market inefficiency, reducing the value of health services relative to dollars spent.<sup>14</sup>

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11. The Logical Place, “Fallacies of Composition and Division,” accessed June 2017, <https://yandoo.wordpress.com/2014/04/07/fallacies-of-composition-and-division/>.

12. Crawford-Roberts et al., “Coverage Losses.”

13. Medicare Board of Trustees, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, June 22, 2016.

14. Yevgeniy Feyman and Charles Blahous, “Replacing the Cadillac Tax: Options and Considerations” (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2017); Jonathan Gruber, “The Tax Exclusion for Employer-Sponsored Health Insurance” (NBER Working Paper No. 15766, National Bureau of Economic Research, Cambridge, MA, February 2010).

Here's an even simpler example: the government could easily add to the wealth of 10 individuals by sending them each a million-dollar check. It is a non sequitur to infer from this that the national wealth would be increased by the government's sending a million-dollar check to every American.

In short, the "people will die" argument is premised on an easily recognized logical fallacy. Don't use it if you want to convince others to adopt your healthcare policy views. If you do, the only thing certain to die will be your credibility.



# The Fiscal Implausibility of Medicare for All

*This article was originally published at E21 on August 5, 2018.*

The research described in this piece, concerning the federal budget costs of enacting single-payer health insurance along lines proposed by Senator Bernie Sanders (I-VT), has thus far been the most widely read work I have ever conducted. Within a few months of its initial publication, more than 100,000 people downloaded the original research study—an astounding number of readers for a 24-page technical paper.

The publication of the research was fortuitously timed: the paper was released just as a number of electoral candidates around the nation were embracing the Medicare for All slogan. Associated Press published an exclusive report previewing the study, from which the lower-bound estimate of \$32.6 trillion in additional federal budget costs over 10 years rapidly became part of standard press descriptions of Medicare for All. The study itself did not opine on whether Medicare for All was good or bad policy, or indeed on any of the subjective value judgments associated with the proposal. The wide circulation of the findings may have occurred in part because the study stayed out of the policy and political debates, instead simply providing data, which advocates on various sides could use to make their various policy arguments. And, indeed, opposing policy advocates did exactly that.

Some have credited (or blamed) the study for a decline in support for Medicare for All after its publication. Again, if the study had this effect, this is not because it made any particular policy argument. Rather, it is in the nature of things that people are more favorably disposed to receiving something when its cost is not discussed. When the costs associated with a policy are presented, there will always be some who decide that the costs are not worth paying.

One tidbit from the study seems to have achieved particular resonance: the fact that even if all federal individual and corporate taxes were doubled going forward, federal revenue would still be insufficient to finance the costs of enacting Medicare for All. This observation, along with the lower-bound cost estimate of \$32.6 trillion for Medicare for All, made its way into much reporting and commentary.

IN JULY 2018 THE MERCATUS CENTER PUBLISHED MY ESTIMATES OF THE cost of the Medicare for All (M4A) bill introduced in the US Senate by Senator Bernie Sanders (I-VT) and 16 cosponsors.<sup>1</sup> Although my work on the study had begun several months before that, the moment of its publication was fortuitous, coinciding with the embrace of M4A by several political candidates across the country. As a result, the level of press attention and public commentary on the study has been overwhelming. AP provided the initial coverage on July 30,<sup>2</sup> leading to several other good articles, such as one in *The Hill*.<sup>3</sup> On August 1 I published a summary of the results in the *Wall Street Journal*.<sup>4</sup> Countless pieces have been published about the study, including particularly insightful ones from Megan McArdle in the *Washington Post* and Chris Deaton in the *Washington Examiner*.<sup>5</sup>

In this article I will summarize the key findings of the study, provide simplified explanations of the derivations, and finally touch on a few issues that have arisen since its publication.

## The Aggregate Costs of Medicare for All

First, a brief description of M4A itself. Despite its name, the legislation would bring nearly all Americans into a national single-payer health insurance system that differs from Medicare in key ways. It would provide first-dollar coverage of a widened range of healthcare services (including, for example, dental, hearing, and vision services) while stipulating (with a few exceptions) that “no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, be imposed on an individual.”<sup>6</sup> To grossly simplify the bill: instead of Americans paying for their healthcare through a combination of

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1. Charles Blahous, “The Costs of a National Single-Payer Healthcare System” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, July 2018). The bill was called the Medicare for All Act of 2017, S. 1804, 115th Cong. (2015).

2. Ricardo Alonso-Zaldivar, “Study: ‘Medicare for All’ Projected to Cost \$32.6 Trillion,” Associated Press, July 30, 2018.

3. Nathaniel Weixel, “New Study Ignites Debate over Cost of ‘Medicare for All,’” *The Hill*, July 31, 2018.

4. Charles Blahous, “Even Doubling Taxes Wouldn’t Pay for ‘Medicare for All,’” *Wall Street Journal*, August 1, 2018.

5. Megan McArdle, “Medicare for All Comes with a Price Tag—and Hard Choices,” *Washington Post*, August 1, 2018; Chris Deaton, “Behind the Debate over ‘Medicare for All,’” *Washington Examiner*, July 31, 2018.

6. Medicare for All Act of 2017, S. 1804.

private insurance, other government insurance programs, and out-of-pocket payments as we do now, we would instead send that money to Washington as tax or premium payments, and the federal government would pay for nearly all the health services we use, right from the very first dollar.

Unsurprisingly this proposition turns out to be very expensive, at least for federal taxpayers. The primary estimate presented in the study is \$32.6 trillion over the plan's first 10 years of full implementation (which, if enacted this year, would be 2022–2031 due to the legislation's phase-in period). Important context should be attached to that number. First, \$32.6 trillion would not be the federal government's total costs, but its new costs over and above what it already spends on healthcare programs and other subsidies. Total annual federal health spending under M4A would be \$4.2 trillion in 2022 and would rise to \$6.9 trillion by 2031. Second, the cost estimate is based on the literal language of the bill without regard to whether its intended outcomes are probable, as this article will further explain. Actual federal cost increases under M4A are likely to be substantially higher than the estimated \$32.6 trillion over its first 10 years.

How best to understand the real-world magnitude of such an eye-popping number? The annual marginal cost of enacting M4A starts out at around 10.7% of GDP and rises to 12.7% of GDP within the first 10 years, continuing to grow beyond that. As the study explains, even a doubling of all projected individual and corporate income taxes would be insufficient to finance these added federal costs.

We have never undertaken a sudden, permanent expansion of government of this size. Total federal spending under M4A on healthcare alone would equal 17.9% of GDP in 2022 and would rise to 20.8% of GDP by 2031. For context, consider that *all* US government spending this year totals 20.6% of GDP. And it bears repeating: even these numbers understate the likely cost of M4A.

## Breaking Down the Cost Estimate

Estimating the price tag of M4A essentially involves estimating the costs for which the federal government would be responsible under the plan, and comparing those to current federal obligations. An important step is estimating healthcare utilization. There is an extensive economics literature demonstrating that the more medical care insurance finances, the more

people consume. This is true separately and apart from the services' value and efficacy: people consume more of both necessary and unnecessary services if insurance pays for them. M4A would therefore fuel a substantial increase in healthcare demand through its provision of first-dollar coverage of a widened range of services.

The utilization increase under M4A would of course be greatest among the currently uninsured, but it would also be substantial for other populations, including current Medicare participants who lack supplemental coverage, and current holders of private insurance whose consumption is presently constrained, at least somewhat, by the requirements of deductibles and copayments.

As we as a nation grapple with how to contain rising healthcare costs, it's important to understand the extent to which insurance itself drives costs upward. The increased demand that would arise under M4A's expanded coverage is substantial—adding an estimated \$5.7 trillion to projected national health spending during 2022–2031, all other things being equal, an increase of more than 11%. That number is probably understated for reasons that go beyond the scope of this article.

Against that topline cost increase, M4A contains provisions designed to bring costs down. Its language directs the HHS Secretary, for example, to “promote the use of generic medications to the greatest extent possible.”<sup>7</sup> Interpreting the “greatest extent possible” very literally as achieving 100% penetration of generics in prescription drugs, one arrives at an estimate of \$0.8 trillion saved during 2022–2031 in lower drug prices. This estimate does not account for other possible, less desirable effects, such as lessened pharmaceutical innovation, nor does it allow for less-than-perfect success in replacing brand-name drugs with generics. Accordingly, it should be thought of as an upper-bound estimate of the savings possible from the bill's drug provisions.

The estimates also assume M4A would have lower administrative costs than private health insurance. I used fairly aggressive assumptions of seven percentage points for the administrative costs saved by bringing those now covered by private insurance under M4A. My study as well as a previous Urban Institute analysis explains why this is likely the upper limit of potential

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7. Medicare for All Act of 2017, S. 1804.

administrative cost savings under the plan.<sup>8</sup> The savings projected under this assumption are roughly \$1.6 trillion over 2022–31.

Now we come to an important comparison. While it is sometimes said that M4A's elimination of private-sector profit and overhead would bring national health costs down, that is not what the numbers indicate; more specifically, to the extent lower administrative expenses do reduce total costs, these would be more than offset by the higher service demand under M4A. Even under the fairly aggressive cost-saving assumptions outlined above, the potential savings from lower administrative costs and lower drug prices combined are less than half the additional costs expected to arise from expanding the scope of insurance.

This is where the factor of provider payment rates comes in. The text of the M4A bill specifies that healthcare providers will be paid at Medicare payment rates, which are roughly 40% lower than the rates paid by private insurance. Previous studies published by the Urban Institute as well as by Emory University professor Kenneth Thorpe (prior to the bill's introduction) assumed this would not be possible, because such dramatically reduced payment rates would be well below providers' reported costs of delivering services.<sup>9</sup> My study took first a literal interpretation of the bill's text: that these dramatic provider cuts would be implemented immediately.

It need hardly be said that cutting provider payment rates by roughly 40% for those now working through private insurance—down to below their reported costs of providing services—while at the same time increasing service demand by 11% would have potentially dire and unforeseeable effects on the availability, timeliness, and quality of healthcare. Understand, these are not gradual cuts in the manner of the Affordable Care Act, but rather immediate cuts upon implementation of M4A. We simply do not know what would happen if the literal text of the M4A bill were carried out. But obviously, if we assume provider payments are suddenly cut by 40%, national health expenditures would naturally fall relative to current projections.

In recognition of the unlikelihood of such dramatic provider cuts being implemented as written, the study contains an alternate scenario in which

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8. John Holahan et al., "The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending" (Research Report, Urban Institute, May 2016).

9. Holahan et al., "Sanders Single-Payer Health Care Plan"; Kenneth E Thorpe, "An Analysis of Senator Sanders Single Payer Plan," January 27, 2016.

payments to providers remain unchanged as a national average. Under that scenario, national health expenditures under M4A would rise even faster than under current law, and the price tag for federal taxpayers would rise to \$38 trillion.

Some have suggested that the study provides evidence for the view that replacing for-profit private health insurance with administratively efficient single-payer insurance will enable more people to receive better benefits for less money.<sup>10</sup> That is incorrect or, at best, an incomplete interpretation. Per above, my study found instead that the potential administrative efficiencies of M4A could only save much less than the induced additional service utilization would cost. It is not the single-payer system itself, but rather cutting payments to hospitals, doctors, and nurses that would produce a scenario showing lower national health spending. Without those payment cuts, projections for M4A show not only dramatically higher federal costs but higher national costs as well. Moreover, even with such payment cuts assumed, we still couldn't say that Americans would get better benefits for less money under M4A, because we simply do not know how many providers would continue to provide services once their income is cut so sharply.

Returning to the derivations, the net federal cost is determined by comparing federal costs under M4A to those the federal government would carry under current law. This calculation requires adjustments reflecting M4A's stipulations that the federal government wouldn't pay for absolutely all national health spending. (As one example, the M4A bill requires that states continue to fund current long-term supports and services—LTSS—through Medicaid, and also allows out-of-pocket payments for LTSS to continue.) The resulting federal costs under M4A are compared with current federal healthcare subsidies, including not only direct spending on programs like Medicare and Medicaid but also subsidies delivered through the tax code, such as the tax preference for employer-sponsored insurance.

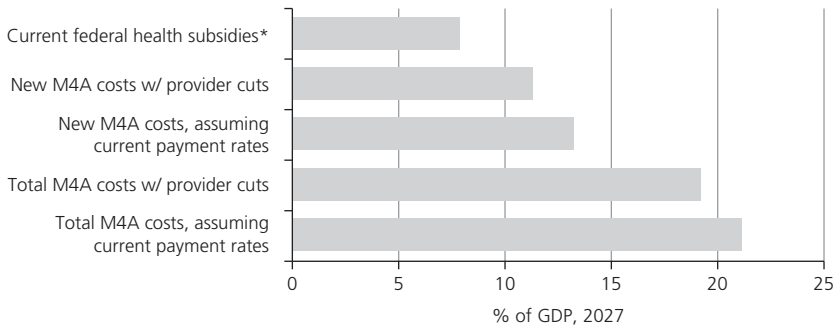
Figure 1 attempts to simplify and contextualize the results, using the year 2027 as an example. The graph shows the net additional costs of M4A, as well as the total federal costs of M4A, both with and without the assumption of roughly 40% provider payment cuts.

As can be readily seen from figure 1, enacting M4A would be an unprecedented expansion of federal spending. Figure 2 compares both the additional

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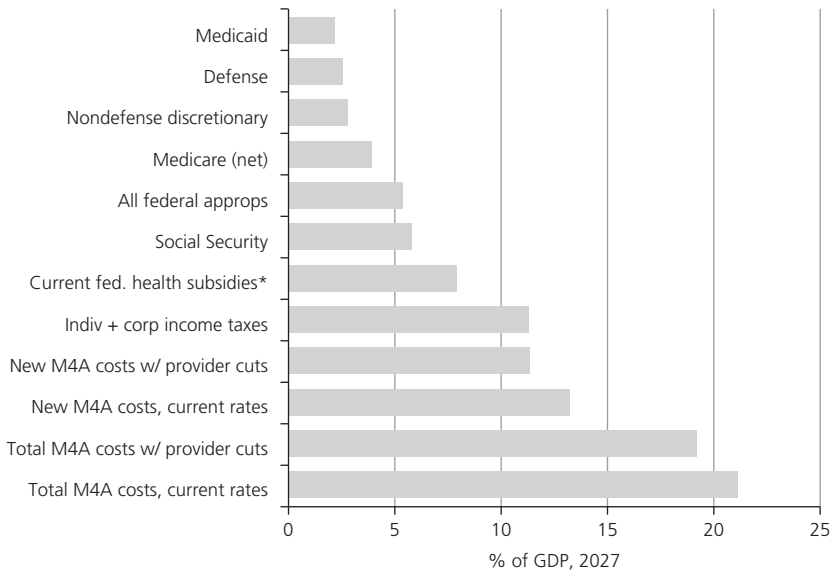
10. Matt Bruenig, "Even Libertarians Admit Medicare for All Would Save Trillions," *Jacobin*, July 30, 2018.

**Figure 1. Federal Health Spending without/with Medicare for All (M4A)**



\* This category includes tax subsidies such as the tax preference for employer-sponsored insurance.

**Figure 2. Medicare for All (M4A) vs. Other Federal Budget Categories**



\* This category includes tax subsidies such as the tax preference for employer-sponsored insurance.

and total federal costs of M4A with those projected for various other categories of the federal budget. There are several striking comparisons in this graph, but a few stand out: even assuming the dramatic provider payment cuts, net new costs under M4A would exceed all projected (individual and corporate) federal income taxes, as well as being more than four times as large as the entire defense budget.

## How Should People React to These Findings?

These numbers are intended to provide information that members of the public can use to inform their thinking about M4A. How people receive the numbers is up to them. My own reactions to these findings needn't determine the reactions of others.

Information about M4A's costs is nevertheless important to have, irrespective of whether one supports or opposes M4A. Those who are concerned about federal finances and skeptical of M4A should know the extent to which their concerns are well founded. M4A proponents, too, should know the costs of making their vision a reality, and understand the questions it raises about whether financing M4A is feasible. Perhaps even more importantly, undecided citizens should have an opportunity to understand the cost implications before becoming invested in one position or the other.

If healthcare utilization rises under M4A, it means more people are getting care that they need. That's good. But the other side of the coin is more health spending, as well as additional utilization of less-effective and less-necessary services, creating more competition among patients for access to care—especially if the supply of healthcare providers proves inadequate to meet increased demand.

M4A's effect on federal finances and its effect on national health expenditures are both important considerations. Some commentators have implied that the potential benefit of a (slight) reduction in national health expenditures (even if driven exclusively by provider payment cuts) is all that really matters, irrespective of the strain on federal finances. Most readers will understand why that interpretation is impracticably narrow. After all, the federal government must be able to finance its operations. If it cannot handle the extra burden of financing \$33 trillion to \$38 trillion in spending over 10 years, it doesn't really matter whether that federal spending would have



brought about a 4% acceleration or a 4% deceleration in national health spending. What matters first is whether the federal government can even do it.

A primary effect of M4A would be to replace private spending on health-care with government spending financed by federal taxpayers. Americans would pay for no deductibles or cost-sharing, but they would pay much higher taxes. This change dwarfs any projected changes in national health spending, which in turn are a highly contingent, unpredictable function of whether and how deeply provider payments are cut. The observation that Americans are already paying for most of these expenses, while technically true, by itself glosses over the important question of whether they are willing to have their taxes raised sufficiently to have the government pay for them.

An analogy might help frame the choice. Suppose, for example, that a government representative came to your door and said, “We’ve totaled up all the money you spend each year on food. We think you’re wasting money paying for restaurants’, grocery stores’, and farms’ costs of doing business, as well as for the costs of others in the food industry. We think we can do this more efficiently. So we’re going to raise your taxes by that amount of money, and we’ll provide all your food to you for free. And we’ll also be able to take care of those Americans who don’t have enough access to food. We’re planning to cut all payments to restaurants, grocery stores, farms, and other food providers by about 40%, and if we do that we might be able to cut 3%–4% off your total food bill.” Would Americans take this deal?

Maybe some would. But it’s nearly certain many would not. First, it’s a huge amount of money to turn over to the government. Even if they were shown how much they were already spending, it doesn’t necessarily follow that Americans would want to pay that much in additional taxes. The potential for a 3%–4% reduction in their food costs might not make up for surrendering all control over how they spend on food. Second, they would be correct not to trust the government to follow through with those 40% payment cuts, once lobbyists for the food industry enter the picture—and if the government didn’t do so, then their food costs would rise at the same time that they lost a great deal of control. Third, if the payment cuts do go through, Americans might worry that their favorite restaurant would close and that they’d not be able to eat there anymore. They might also worry about the lines that would form at grocery stores and restaurants as 40% cuts send many of those establishments out of business. Finally, some may

simply not want to give up their remaining power to choose how much to spend on food, no matter how the numbers shake out.

An important thing for Americans to know is that financing M4A would require more funds than doubling all projected individual and corporate federal income taxes would generate, and indeed that the actual financing required would likely be significantly greater even than that, depending on how deeply the government is willing to cut payments to doctors, nurses, hospitals, and other healthcare providers. On the other side of the coin, Americans would be excused from paying for healthcare in the many ways they currently do. As the idea of M4A is discussed, financing the unprecedented federal cost should be considered whenever and wherever there is a discussion of its potential benefits.

# Questions and Answers about Medicare for All's Costs

*This article was originally published at E21 on August 21, 2018.*

Press and social media coverage of major public policy issues or events tends to play out in stages. Initial descriptions and commentary may draw from the primary information source, but thereafter much of the subsequent reporting and discussion references previous commentary rather than the original source. This happened with my Medicare for All study. First there was an initial burst of straight press reporting on the study, but soon the social media conversation was dominated by policy advocates commenting on it. During that subsequent conversation various themes, questions, and points of confusion arose, necessitating clarification from time to time. The piece reproduced here attempted to elucidate some of those issues.

Some Medicare for All advocates mistakenly asserted that the study showed that Medicare for All, despite its enormous additional costs for the federal government, would actually slow the growth of national health spending. The study didn't actually say that or show it. It did present a lower-bound estimate in which various favorable assumptions would bring about that result, but I made clear throughout that this was a lower-bound estimate, and that the range of likely outcomes encompassed substantially higher projected national costs. This misunderstanding resulted in Medicare for All advocates being corrected by several fact-checker sites, an unforced error that hurt their policy case. This piece devoted considerable space to citing numerous passages from the original study that were drafted specifically to preempt such confusion.

Other controversies dealt with in this piece concerned the magnitudes of provider payment cuts that Medicare for All would impose and whether the widely cited estimates represented total Medicare for All costs or just the incremental costs above and beyond current federal health-related spending. (Answer: the latter.)

**MY JULY 2018 ESTIMATE OF THE FEDERAL COSTS OF MEDICARE FOR ALL (M4A) received widespread public and press attention.<sup>1</sup> The ongoing discus-**

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1. Charles Blahous, "The Costs of a National Single-Payer Healthcare System" (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, July 2018). For examples of attention it has received, see Brian Riedl, "No, 'Medicare for All' Is Still Not Plausible," Foundation for Economic Education, August 13, 2018; *Washington Post*, "The Cosmically Huge 'If' of Medicare for All," August 12, 2018.

sion prompted a number of common questions about the study, which this article attempts to answer.

**Q:** Does the estimate account for what the federal government is already spending on healthcare?

**A:** Yes. The study's federal cost projection of \$32.6–\$38.0 trillion over 10 years<sup>2</sup> is an estimate of *additional* federal healthcare obligations, above and beyond current federal expenditures on programs such as Medicare and Medicaid, as well as current tax code–based subsidies such as those for employer-sponsored and Affordable Care Act insurance policies. Total federal costs under M4A would be substantially greater (\$54.6–\$59.9 trillion) than the study's projections of the additional federal costs alone.

**Q:** How much would the M4A bill cut payments to providers?

**A:** The M4A bill specifies that healthcare providers would be paid at Medicare payment rates, which are substantially lower than those paid by private health insurance.<sup>3</sup> The study analyzes the projected results of this specification, explaining its problematic implications for patients' access to care, the unlikelihood that such drastic cuts would be immediately implemented as written, and the fiscal outcomes if they were not. The CMS Medicare actuary documents that hospital payment cuts would average roughly 40% at first and grow steeper over time, for treating patients now covered by private insurance.<sup>4</sup> Assuming M4A is fully implemented by 2022, physicians would initially be reimbursed at rates averaging about 30% lower than they would have been paid by private insurance, and those cuts would also grow to exceed 40% within the first 10 years.<sup>5</sup> Because all providers would be reimbursed at Medicare rates, this would (obviously) not mean payment reductions for services already covered by Medicare. The study also explains that the imposition of Medicare payment rates would produce a temporary increase in payments for physician services now provided through Medicaid, but those too would eventually turn into net payment cuts and become more severe over time.<sup>6</sup>

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2. Blahous, "Costs of a National Single-Payer Healthcare System."

3. Medicare for All Act of 2017, S. 1804, 115th Cong. (2015).

4. Figure 1 in John D. Shatto and M. Kent Clemens, Office of the Actuary, Centers for Medicare & Medicaid Services, memorandum, "Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers," June 5, 2018.

5. See figure 2 in Shatto and Clemens, memorandum, 8.

6. Blahous, "Costs of a National Single-Payer Healthcare System."

**Q:** Does the cost estimate reflect a particular policy perspective, or is it generally in line with estimates put forward by others?

**A:** Credible studies of M4A's costs tend to produce qualitatively similar results. My estimates are generally in line with those generated by other experts spanning a wide range of affiliations and policy views. Such differences as there are arise primarily because different studies examine different years, and because studies that were completed prior to the M4A bill's introduction needed to make speculative assumptions about provider payment rates and long-term care provisions.

The M4A bill introduced in the Senate has a four-year phase-in period, which means that if it were enacted today M4A's first 10 years of full implementation would be 2022–2031. My study's estimates of \$32.6–\$38.0 trillion in additional federal costs would have been smaller (\$25.2–\$28.9 trillion) during 2017–2026 if M4A had been fully effective during those years, as assumed in prior studies, because healthcare costs tend to grow over time. Adjusting for implementation dates and alternative payment rate assumptions, my estimates closely resemble those generated by the Urban Institute,<sup>7</sup> the Center for Health and Economy,<sup>8</sup> and Emory University professor Kenneth Thorpe,<sup>9</sup> who has characterized his own estimate of spending on the previously uninsured as being “likely low.”<sup>10</sup> (See table 1.)

**Q:** Would eliminating private health insurance profit and administrative overhead produce enough savings to finance the coverage expansion under M4A?

**A:** No. The study makes a very aggressive assumption for national administrative cost savings under M4A (\$1.6 trillion over 10 years).<sup>11</sup> Nevertheless, these potential savings are but a fraction of the projected additional health spending M4A would precipitate by covering the currently uninsured and by expanding the scope and generosity of coverage for the currently insured (\$5.7 trillion).

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7. John Holahan et al., “The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending” (Research Report, Urban Institute, May 2016).

8. “Medicare for All: Leaving No One Behind,” Center for Health and Economy, May 1, 2016.

9. Kenneth E Thorpe, “An Analysis of Senator Sanders Single Payer Plan,” January 27, 2016.

10. Kenneth E Thorpe, “Why Sanders’s Single-Payer Plan Would Cost More Than His Campaign Says,” *American Prospect*, February 29, 2016.

11. Blahous, “Costs of a National Single-Payer Healthcare System.”

**Table 1. Alternative Estimates of First 10-Year Federal Costs of M4A, If the First 10 Years of Full Implementation Had Been 2017–2026**

Study	Estimate
Urban Institute (without long-term care)	\$29.1 trillion
Blahous (without provider cuts)	\$28.9 trillion
Center for Health and Economy	\$27.3 trillion
Blahous (with provider cuts)	\$25.2 trillion
Thorpe	\$24.7 trillion

Sources: John Holahan et al., “The Sanders Single-Payer Health Care Plan: The Effect on National Health Expenditures and Federal and Private Spending” (Research Report, Urban Institute, May 2016); Charles Blahous, “The Costs of a National Single-Payer Healthcare System” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, July 2018); “Medicare for All: Leaving No One Behind,” Center for Health and Economy, May 1, 2016; Kenneth E Thorpe, “An Analysis of Senator Sanders Single Payer Plan,” January 27, 2016.

**Q:** Aren’t we paying for most of these costs already, in other ways? Even if Americans’ federal taxes had to rise to pay for M4A, wouldn’t Americans save money on the other end by no longer having to pay for things like employer-provided health insurance, state-funded programs, and out-of-pocket healthcare expenses out of their take-home pay?

**A:** Yes, and the study discusses these offsetting effects.<sup>12</sup> But, while Americans are already shouldering the vast majority of these costs in other ways, it does not necessarily follow that they would be comfortable with transferring virtually all these personal and societal resources to the federal government to redistribute in the form of health benefits. Among other considerations, there is the sheer magnitude of the change, which would expand federal government obligations to such an extent that even doubling all projected federal individual and corporate income taxes could not adequately fund it. The federal government also has yet to demonstrate it can successfully finance the future budget commitments scheduled under current law,<sup>13</sup> let alone added costs of this unprecedented magnitude. How

12. Blahous, “Costs of a National Single-Payer Healthcare System.”

13. Congressional Budget Office, “The Budget and Economic Outlook: 2018 to 2028,” April 11, 2018.

Americans may weigh these various considerations is beyond the scope of the study.

**Q:** Did your study find that M4A would reduce national healthcare costs by \$2 trillion over 10 years?

**A:** No, as various fact-checking articles have pointed out.<sup>14</sup> This is made clear by contrasting the specific language and findings of the study with the claim of \$2 trillion in savings.<sup>15</sup> More specific details are provided below, but the correct reading of the study is that such savings would be highly unlikely to materialize.

The study's purpose was to produce a federal budget cost estimate, this being a critical factor that would guide legislative procedures in the event lawmakers attempt to enact M4A. The study included a federal cost estimate of \$32.6 trillion over 10 years, emphasizing repeatedly that this was a lower-bound estimate and that actual costs would likely be substantially greater. (To further illustrate this potential variance, the study also included a \$38.0 trillion estimate.) The following quotations from the study are representative of how the \$32.6 trillion figure is presented.

- “It is likely that the actual cost of M4A would be substantially greater than these estimates.”<sup>16</sup>
- “Conservative estimates”;<sup>17</sup> “conservative estimates.”<sup>18</sup>
- “It is likely that the actual cost of M4A would be substantially greater.”<sup>19</sup>
- “These cost estimates essentially represent a lower bound.”<sup>20</sup>
- “Actual savings (from lower drug prices) are likely to be less than assumed under these projections.”<sup>21</sup>
- “This is an aggressive estimate of administrative savings that is more likely to lead to M4A costs being underestimated than overestimated.”<sup>22</sup>

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14. Glenn Kessler, “Democrats Seize on Cherry-Picked Claim That ‘Medicare-for-All’ Would Save \$2 Trillion,” *Washington Post*, August 2, 2018; Ricardo Alonso-Zaldívar, “AP Fact Check: Sanders Spins Savings in Medicare Plan,” AP, August 8, 2018.

15. Blahous, “Costs of a National Single-Payer Healthcare System.”

16. Blahous, “Costs of a National Single-Payer Healthcare System,” abstract.

17. Blahous, abstract.

18. Blahous, 3.

19. Blahous, 3.

20. Blahous, 4.

21. Blahous, 14.

22. Blahous, 14.

- “The resulting implicit estimates of national and federal spending on LTSS should be regarded as conservative.”<sup>23</sup>
- “This study’s assumption of no net increase in LTSS benefit utilization . . . is an additional factor contributing to these projections’ being more likely to underestimate costs than to overestimate them.”<sup>24</sup>

The study contains other passages detailing some of the reasons why the \$32.6 trillion figure likely represents a substantial underestimate:

The adoption of Medicare payment rates would represent a substantial reduction in provider reimbursements for care provided to everyone now covered by private insurance. . . .

. . . It is not precisely predictable how hospitals, physicians, and other health care providers would respond to a dramatic reduction in their reimbursements under M4A. . . . By 2019, over 80 percent of hospitals will lose money treating Medicare patients—a situation M4A would extend, to a first approximation, to all US patients. Perhaps some facilities and physicians would be able to generate heretofore unachieved cost savings that would enable their continued functioning without significant disruptions. However, at least some undoubtedly would not. . . .

Anticipating these difficulties, some other studies have assumed that M4A payment rates must exceed current-law Medicare payment rates to avoid sending facilities into deficit on average. . . .

. . . The resulting cost estimates would be substantially larger.<sup>25</sup>

Some M4A proponents are hopeful that having the federal government take on this enormous cost burden might produce a broader societal benefit of a net reduction in national health spending, and have sought accordingly to convert the study’s federal cost estimate into an estimate of national health expenditure savings.<sup>26</sup> However, if the study’s framing were to change from a cost estimate to a savings estimate, then all the study’s other descriptions

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23. Blahous, 17.

24. Blahous, 17.

25. Blahous, 10–13.

26. Kessler, “Democrats Seize on Cherry-Picked Claim.”



must also flip accordingly. The lower-bound cost estimate would become an upper-bound savings estimate, and the study's finding that "the actual cost of M4A would be substantially greater" would become a finding that "actual savings would be substantially less." Such accuracy is especially important in this context, for the study makes clear that total national health spending under M4A would be much more likely to increase than to decrease relative to current law. This can be seen by noting that the \$2 trillion in proponents' hoped-for national expenditure savings could not be achieved without more than \$6 trillion in provider payment cuts and drug price reductions—savings the study describes as uncertain at best.<sup>27</sup>

Of course, none of this should inhibit M4A proponents from exercising their prerogative to believe and to argue that M4A can achieve net national cost savings—to argue, in effect, that the best-case fiscal scenario of massive provider payment cuts and drug price reductions would actually come to pass—provided, of course, that this conclusion is not attributed to the study. The study states throughout that the actual costs of M4A would likely be substantially greater, in which case the purported \$2 trillion in savings would not materialize.

I hope that these answers and clarifications further public understanding of the estimated costs of M4A.

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27. Blahous, "Costs of a National Single-Payer Healthcare System."

