SAILING INTO THE PERFECT STORM:
Who will come to the rescue?

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Princeton University

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SAILING INTO THE PERFECT STORM: Who will come to the rescue?

I. LONGTERM TRENDS IN U.S. HEALTH SPENDING
TOTAL REAL HEALTH SPENDING PER CAPITA 1965 – 2004
IN CONSTANT YEAR 2000 DOLLARS (GDP DEFLATOR)

$y = 973.4e^{0.0453x}$

$R^2 = 0.9935$

SAILING INTO THE PERFECT STORM:
Who will come to the rescue?

I. LONGTERM TRENDS IN U.S. HEALTH SPENDING
A. A zoological model of the U.S. health-care sector
Professor of Health Economics beholding it all in amazement

Local Hospital Board

Beats Fiber Optics!

Nice ride!

U. S. President

Venture capitalist, looking for a bite

Employers & Insurers

Congress & State Legislators
SAILING INTO THE PERFECT STORM:
Who will come to the rescue?

I. LONGTERM TRENDS IN U.S. HEALTH SPENDING
   A. A zoological model of the U.S. health-care sector
   B. The 2½-Percent Rule of U.S. health spending
TOTAL REAL HEALTH SPENDING PER CAPITA 1965 – 2004
IN CONSTANT YEAR 2000 DOLLARS (GDP DEFLATOR)

$y = 973.4e^{0.0453x}$
$R^2 = 0.9935$

4.5%/year

TIME PATH OF REAL (INFLATION ADJUSTED) GDP PER CAPITA
UNITED STATES, 1965-2000

\[ y = 15638e^{0.0202x} \]

\[ R^2 = 0.9887 \]

SOURCE: Economic Report of the President 2002; Tables B4 and B34.
THE 2½% RULE:

Over the long haul, the American health system wants to grow about 2.5 percentage points faster than the GDP as a whole.

So far the health system has been able to impose that rule on the rest of the U.S. economy.

The CMS actuaries assume that it will be able to do so also in the decade ahead.
THE LATEST CMS FORECAST:
National Health Expenditures as a Share of GDP 1980 - 2014

Source: CMS, Office of the Actuary, National Health Statistics Group, various years.
SAILING INTO THE PERFECT STORM: Who will come to the rescue?

I. LONGTERM TRENDS IN U.S. HEALTH SPENDING

II. THE PUBLIC-PRIVATE SECTOR MIX
   A. Private-, Federal- and State Spending
PROJECTED SOURCES OF TOTAL HOSPITAL REVENUE 1965 - 2014

- PRIVATE
- FEDERAL
- STATE & LOCAL

SOURCE: CMS.gov
PROJECTED SOURCES OF TOTAL HOSPITAL REVENUE 1965 - 2014

STATE & LOCAL  FEDERAL  PRIVATE

SOURCE: CMS.gov
PROJECTED SOURCES OF TOTAL HEALTH SPENDING IN 2014

- **Private, $1,813b**, 50%
- **State & Local, $490b**, 14%
- **Federal, $1,295b**, 36%

SOURCE: CMS.gov
FEDERAL-, STATE- AND TOTAL SPENDING ON **MEDICAID**, 1965-2014

**SOURCE:** CMS website.
PROJECTED SOURCES OF TOTAL HEALTH SPENDING IN 2014

Federal
$354b, 57%

State & Local, $264b, 43%

SOURCE: CMS.gov
STATE MEDICAID SPENDING AS A PERCENT OF GENERAL FUND EXPENDITURES, 2002

- MEDICAID, 16%
- EDUCATION, 48%
- ALL OTHER, 28%
- TRANSPORTATION, 1%
- PUBLIC ASSISTANCE, 2%
- CORRECTIONS, 7%

SOURCE: Vernon Smith et al., “The Continuing Medicaid Budget Challenge, October, 2004; Fig. 6, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=48004
STATE SPENDING GROWTH FOR MEDICAID vs. NOMINAL STATE GENERAL FUNDS SPENDING, FY2004 - FY2005

The CMS probably underestimates the share of total health spending that must be financed by state governments for two reasons:

1. The employment-based health insurance system is crumbling for low-wage workers;

2. Deficit-driven Federal fiscal policy
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II. THE PUBLIC-PRIVATE SECTOR MIX

III. THE FRAYING OF EMPLOYMENT-BASED INSURANCE
DISTRIBUTION OF PREMIUM INCREASES FOR COVERED WORKERS, ALL FIRMS, 2004

PERCENTAGE OF FIRMS IN RANGE

RANGE OF PREMIUM INCREASES, 2004

<table>
<thead>
<tr>
<th>Range of Premium Increases</th>
<th>Percentage of Firms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5%</td>
<td>24.0%</td>
</tr>
<tr>
<td>5.1% to 10%</td>
<td>21.0%</td>
</tr>
<tr>
<td>10.1% to 15%</td>
<td>26.0%</td>
</tr>
<tr>
<td>15.1% to 20%</td>
<td>19%</td>
</tr>
<tr>
<td>More than 20%</td>
<td>10%</td>
</tr>
</tbody>
</table>

SOURCE: www.kff.org/insurance/7148/sections/ehbs04-1-4.cfm
AVERAGE PREMIUM COSTS FOR COVERED WORKERS, 2004

FACT OF LIFE

All fringe benefits granted workers by employers come out of what one may call the workers’ *gross wage base*, that is, the maximum debits the employer could afford to make to payroll expense for those workers and not lose money on employing them.

This is true of employment based health insurance as well, whether the employee pays all or part of the premium through *explicit* deductions from the paycheck or whether the employer formally pays the premium.
One in four workers earns $18,800 a year or less, with few if any benefits. What can be done? (P.58)
How can the low wages and family incomes of these roughly one third of American households absorb the ever rising cost of family health insurance coverage?

How can small business cope with this rowing problem, which is, after all, not really its business?
A NUMERICAL ILLUSTRATION:

Assume:

1. A low-skilled worker’s current wage base is $30,000/yr.

2. That wage base will grow at 3% per year

3. A family health insurance policy now costs $10,000

4. The premium for that policy will rise at either 8% or 10% in the decade ahead, which means it will be $21,000 or $26,000, respectively, 10 years hence.
## GROWTH IN HEALTH INSURANCE PREMIUM RELATIVE TO WAGE BASE, 2004 - 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Wage Base</th>
<th>Premium @ 8% Growth</th>
<th>Premium @ 10% Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'05</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'06</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'07</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'08</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'09</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'10</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'11</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'12</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>'13</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>2014</td>
<td>$30,000</td>
<td>$15,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>
Employers will respond to these ominous trends in two phases:

1. Initially they will shift more and more of the cost of insuring their workers onto the workers themselves. That won’t solve these workers’ problems, of course. For the most part, it will merely shift the costs to each worker’s household budget, especially to the chronically ill, who must then pay the high deductibles year after year.
SAILING INTO THE PERFECT STORM

Employers will respond to these trends in two phases:

1. Initially they will shift more and more of the cost of insuring their workers onto the workers themselves. That won’t solve these workers’ problems, of course.

2. Eventually they will stop providing health insurance to their employees altogether.
The number of uninsured is likely to rise in the decade ahead.

As the economy grew apace in the 1990s, the number of uninsured actually rose!
SAILING INTO THE PERFECT STORM:
Who will come to the rescue?

I. LONGTERM TRENDS IN U.S. HEALTH SPENDING

II. THE PUBLIC-PRIVATE SECTOR MIX

III. THE FRAYING OF EMPLOYMENT-BASED INSURANCE

IV. FEDERAL FISCAL POLICY
PROJECTED FEDERAL ON-BUDGET DEFICITS 2005-2015

SOURCE: Congressional Budget Office, The Budget and Economic Outlook: An Update, September 2004; Summary Table 2 and Table 1-6
Who Stole the Projected Surplus? 2002-11

Source: Robert Reischauer, Urban Institute
Who Stole the 2002-11 Surplus?

Contribution of Policy & Other Factors to the $8.8 Trillion Deficit in the Budget Outlook

- Economic & Technical Re-estimates: 38% ($3.4 T)
- Tax Legislation: 31% ($2.8 T)
- Defense, Homeland, & Int.: 21% ($1.8 T)
- Rx Drugs & Other Entitlement Legislation: 8% ($0.7 T)
- Domestic Disc. Other than Homeland: 1% ($0.1 T)

Source: CBPP, cited by Robert Reischauer, Urban Institute
ALL TAXES AS PERCENTAGE OF GDP

OECD COUNTRIES, 2000

- SWEDEN 54.2%
- FRANCE 45.3%
- EU15 41.6%
- OECD EUROPE 39.9%
- GERMANY 37.9%
- OECD TOTAL 37.4%
- UNITED KINGDOM 37.4%
- CANADA 35.8%
- SWITZERLAND 35.7%
- AUSTRALIA 31.5%
- UNITED STATES 29.6%
- JAPAN 27.1%

The tax cuts of 2001 and 2003 were passed on the (Keynesian) argument that it would put added money into the pockets of taxpayers who would then spend more and, thus, revive the economy.

An economist would find it hard to argue with this theory. It is standard fare in macro-economic policy and it works.
That same theory, however, also predicts that added government spending — be it on health care, education, roads, or mass transit — revives the economy as well.

For example, without the rapid growth of health spending during the 1980s and the jobs it added, the Reagan recovery of that decade would not have been nearly as robust.
TAX CUTS VERSUS ADDED HEALTH SPENDING

continued

Every added dollar of health spending diffuses quickly throughout the entire US and, most importantly, stays at home. Hardly any of it leaks abroad.

By contrast, good parts of a major tax cut may leak abroad in the form of offshore investments or spending on consumer goods made abroad.
The construction of new hospital facilities or of new golf resorts both are scored as “investments” in the national GDP accounts.

We always pretend that building golf courses boosts the economy, while building hospitals is a drag on the economy.

Does that make sense to you?
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V. CAN “CONSUMER-DRIVEN HEALTH CARE” BAIL US OUT?
   A. “Consumer Driven Health Care” defined
In the current debate on U.S. health policy, the term “Consumer-Directed Health Care” and its acronym CDHC has come to mean mainly the following:

1. Health insurance policies with very high-deductibles (anywhere from $2,000 to $15,000 per year per family) and often high coinsurance rates thereafter (25% to 35%)

2. Personally held Health Savings Accounts (HSAs), also known as Medical Savings Accounts (MSAs), into which individuals or families can make annual deposits out of pretax income and from which deductibles or coinsurance can be paid

President Bush, for example, would allow these HSAs only if they were coupled with a high-deductible insurance policy with specified minimum deductibles.
THE GENERAL IDEA OF HIGH DEDUCTIBLE HEALTH INSURANCE

THE FAMILY’S ANNUAL HEALTH SPENDING

YEARS

ANNUAL DEDUCTIBLE

Catastrophic insurance

HSA
HDHI+HSA arrangements come in two quite distinct flavors that should never be confused:

1. HDHI policies offered by employers through an insurance carrier, coupled with a tax-preferred HRA that is effectively owned by the employer, i.e., it is not portable from job to job.

2. HDHI policies offered in the individual market for insurance – e.g., via the internet-based broker eHealthInsurance.com – coupled with a personally owned, portable, tax-preferred HSA that is managed by a bank.
I. LONGTERM TRENDS IN U.S. HEALTH SPENDING

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IV. FEDERAL FISCAL POLICY

V. CAN “CONSUMER-DRIVEN HEALTH CARE” BAIL US OUT?
   A. “Consumer Driven Health Care” defined
   B. Employment-based CDHC
For doctors and hospitals this could mean added bad debt expense, although that bad debt might be offset by higher fees.
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   A. “Consumer Driven Health Care” defined
   B. Employment-based CDHC
   C. Individually purchased HSA policies
eHealthInsurance.com is an Internet-based farmers market, so to speak, for individually sold health insurance policies.
In the following examples, I pretended to be a single woman, like this lady, in her mid 30s with three children under age 10 living in either Los Angeles (Zip code 90040) or Dallas, Texas (Zip code 75202).

**“I just work week to week”**

<table>
<thead>
<tr>
<th>Family Profile:</th>
<th>Ellen is a single mom with three daughters at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment:</td>
<td>Ellen works in a print shop</td>
</tr>
<tr>
<td>Location:</td>
<td>Baltimore, MD</td>
</tr>
<tr>
<td>Annual Income:</td>
<td>$24,960 (136% of the federal poverty level)</td>
</tr>
<tr>
<td>Health Insurance:</td>
<td>Parent: Uninsured Children: Medicaid/SCHIP</td>
</tr>
<tr>
<td>Monthly Budget:</td>
<td>$1,736</td>
</tr>
<tr>
<td>Company</td>
<td>UNICARE Life &amp; Health Insurance Company</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Plan Name</td>
<td>HSA Compatible Plan 3 (Family)</td>
</tr>
<tr>
<td>Policy Form Number</td>
<td>TXIHDPWP0304/TXIAPL1203</td>
</tr>
<tr>
<td>Plan Type</td>
<td>PPO</td>
</tr>
<tr>
<td>Estimated Monthly Cost</td>
<td>$129.00</td>
</tr>
<tr>
<td>Deductible</td>
<td>$10,000</td>
</tr>
<tr>
<td>Coinurance</td>
<td>0%</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$10,000</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$5 Million</td>
</tr>
<tr>
<td>HSA Eligible</td>
<td>YES</td>
</tr>
<tr>
<td>Company</td>
<td>UniCare</td>
</tr>
<tr>
<td>--------------</td>
<td>---------</td>
</tr>
<tr>
<td>Plan Name</td>
<td>HSA Compatible Plan 3 (Family)</td>
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<tr>
<td>Policy Form Number</td>
<td>TXIHDHPWP0304/txiapl1203</td>
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<tr>
<td>Plan Type</td>
<td>PPO</td>
</tr>
<tr>
<td>Estimated Monthly Cost</td>
<td>$129.00</td>
</tr>
<tr>
<td>Deductible</td>
<td>$10,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>Out-of-Pocket Limit</td>
<td>$10,000</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$5 Million</td>
</tr>
<tr>
<td>HSA Eligible</td>
<td>YES</td>
</tr>
<tr>
<td><strong>Company</strong></td>
<td>Blue Cross and Blue Shield of Texas, A Division OF Health Care Service Corporation</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Plan Name</strong></td>
<td>PPO Select Saver</td>
</tr>
<tr>
<td><strong>Policy Form Number</strong></td>
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</tr>
<tr>
<td><strong>Plan Type</strong></td>
<td>PPO</td>
</tr>
<tr>
<td><strong>Estimated Monthly Cost</strong></td>
<td>$162.00</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$5,000 individual/$15,000 family</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>25%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Limit</strong></td>
<td>$8,000 individual/$24,000 family</td>
</tr>
</tbody>
</table>
It is not clear to me how high deductibles and coinsurance of this sort are compatible with the already very low income of the roughly bottom third of families in the nation’s income distribution.
DISTRIBUTION OF FAMILY INCOME, UNITED STATES, 2002
Average income $66,970 (Median about $50,000)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250,000 and more</td>
<td>1.7%</td>
</tr>
<tr>
<td>$200,000 - $249,999</td>
<td>1.3%</td>
</tr>
<tr>
<td>$150,000 - $199,999</td>
<td>3.5%</td>
</tr>
<tr>
<td>$100,000 - $149,999</td>
<td>11.3%</td>
</tr>
<tr>
<td>$75,000 - $99,999</td>
<td>13.4%</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>21.0%</td>
</tr>
<tr>
<td>$35,000 - $49,999</td>
<td>15.3%</td>
</tr>
<tr>
<td>$25,000 - $34,999</td>
<td>11.7%</td>
</tr>
<tr>
<td>$15,000 - $24,999</td>
<td>11.2%</td>
</tr>
<tr>
<td>$10,000 - $14,999</td>
<td>4.3%</td>
</tr>
<tr>
<td>Less than $10,000</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

= 33%

The problem is exacerbated by the fact that CDHC with high deductibles inevitably shifts more of the financial burden of ill health away from chronically healthy to chronically sick Americans, who often are to be poor because they are chronically ill.
PERCENT OF TOTAL HEALTH SPENDING ACCOUNTED FOR BY DECILE AMONG PRIVATELY INSURED AMERICANS, 2001

SOURCE: MEPS Data, provided by Kenneth Thorpe, Emory University
More than half of health care spending is on behalf of people with multiple chronic conditions

Percent of total health care spending by number of chronic conditions*
(Percent of population)

- 1 chronic condition: 21% (23% of population)
- 2 chronic conditions: 18% (11% of population)
- 3 chronic conditions: 15% (5% of population)
- 4 chronic conditions: 12% (3% of population)
- 5+ chronic conditions: 14% (2% of population)
- 0 chronic conditions: 22% (56% of population)

SOURCE: Martin Spikoff, “Health Plans Begin to Address Chronic Care Management,” Managed Care, December 2003.
A major effect of HDHI will be to redistribute the fiscal burden of health care from the chronically healthy to the chronically sick.

**MEAN PER CAPITA SPENDING IN DECILE**

**DECILE OF PRIVATELY INSURED POPULATION**

**SOURCE:** MEPS Data for 2001, provided by Kenneth Thorpe, Emory University
FOR THE CHRONICALLY ILL, THE HDHI CONSTRUCT WOULD WORK OUT LIKE THIS

THE FAMILY’S ANNUAL HEALTH SPENDING

YEARS

ANNUAL DEDUCTIBLE

Catastrophic insurance
At the moment, many state governments seek to reform their Medicaid programs in the direction of CDHC schemes.

The most clearly articulated version of this idea is emerging in Florida.

That the federal government is likely to endorse this type of reform can be inferred form the composition of the Medicaid Commission recently appointed by the U.S. Secretary of Health and Human Service.

Several members of the Commission are enthusiasts for CDHC.
It can fairly be asked, however, how readily a concept that relies on very substantial cost sharing by patients and, on top of it, on an Interned based information infrastructure can be applied to the Medicaid population.

After all, the concept has not really been tried even on middle and upper income Americans who are much better endowed with ability to pay high cost sharing and who also have greater facility with IT.
My sense is that state governments would be much better off if they relied even more heavily than they have hitherto on Medicaid managed care for comprehensive coverage with the (necessarily somewhat maternalistic) health and health-care management that goes with it.
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V. CAN “CONSUMER-DRIVEN HEALTH CARE” BAIL US OUT?

VI. WILL PRIVATIZING MEDICARE AND MEDICAID BAIL US OUT?
The short answer is that the coordinated care and disease management that well-run managed-care companies can offer can help getting more value (better outcomes) for the tax dollar.

Another advantage is that they offer the government up-front closure on budgets for public insurance programs.
But it is a pipe dream that privatizing can yield major cost savings for taxpayers, other than shifting costs onto the shoulders of Medicare or Medicaid recipients.

1. Research by The Lewin Group has shown that Medicaid managed care actually is somewhat cheaper than treating the same patients in the open-ended, unmanaged Medicaid system, and the quality of care is better.

2. By contrast, privatizing Medicare costs taxpayers MORE. It can be a source of cost savings for taxpayers only by shifting more costs onto Medicare beneficiaries.
Medicare Disadvantaged And The Search For The Elusive ‘Level Playing Field’

What the changes to Medicare really mean for competition and the future of the program.

by Robert A. Berenson

**ABSTRACT:** The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) raised payment levels for established Medicare Advantage (private) local plans and would-be regional preferred provider organizations (PPOs). Even though plans on average receive about 108 percent of what would have been spent for the same beneficiaries in traditional Medicare, the Centers for Medicare and Medicaid Services (CMS) added another 2.3 percent in 2004 and 4.0 percent in 2005 in its implementation of risk-adjusted payments. Although MMA gives a clear preference to private plans to start a fundamental restructing of Medicare, the question remains whether Congress will maintain overpayments to private plans when faced with the pressure to reduce budget deficits.

February 2, 2004

Honorable Jim Nussle
Chairman
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman,

CBO’s baseline budgetary projections released in the *Budget and Economic Outlook* include $395 billion in outlays over 2004 to 2013 for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173). That amount is identical to CBO’s scoring of the bill when passed. In contrast, the Administration estimates that additional outlays resulting from
Medicare Advantage: The Administration’s estimate is $32 billion higher ($46 billion vs. $14 billion)

- The Administration assumes much higher participation (32 percent of Medicare beneficiaries enrolled in Medicare Advantage (MA) plans vs. CBO’s estimate of 9 percent).¹

Both estimates assume that many of the participants in MA plans are in areas where the payments to MA plans and beneficiaries (through premium rebates) would exceed what it would cost if those beneficiaries were in the fee-for-service (FFS) sector. Most of the additional participants in the Administration’s estimate are in relatively low-cost, low-density areas where the payments to MA plans and beneficiaries would be substantially higher than the cost of those beneficiaries in the FFS sector.
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VI. WILL PRIVATIZING MEDICARE AND MEDICAID BAIL US OUT?

VII. CONCLUDING THOUGHTS
For all their laments over Medicaid and SHIP spending, state legislators must realize that they buy health services for the poor on the cheap.

It is well known in official statistics that Medicaid does not cover the full average cost of providing health care to the poor and, for physicians, not even incremental costs.
PAYMENT-TO-COST RATIOS FOR AMERICAN HOSPITALS

Aggregate Hospital Payment-to-Cost Ratios for Private Payers, Medicare and Medicaid, 1980-2003

a/ Includes Medicaid Disproportionate Share payments.

While it has been great for the states to get such a bargain under our social contract, paying prices far below the full cost booked by providers of care carries with it certain ethical risks of which state legislators should be conscious.

In economics we teach students that the prices people offer for something signals the value they attach to it.
What, then, are state legislators communicating to, say, pediatricians, when Medicaid pays pediatricians $20 or so to see a poor child on Medicaid or SCHIP, but as much as $80 to see their own children?

Aren’t legislators implicitly telling pediatricians that the social value of the pediatrician’s work varies by the economic status of the children they treat?
A FUNDAMENTAL QUESTION FOR STATE LEGISLATORS:

As a matter of national policy, should the social value of giving health care to any of these little ones be the same?