Rethinking Subsidies for Employer-Sponsored Insurance, Medicare, and Medicaid

Defined- Contribution Financing for Taxpayer Subsidies

A reform agenda that will both replace Obamacare and fix the flaws of previous health policy begins (but does not end) with a fundamental change in how we publicly finance and subsidize health care. Under current law, whether one’s health coverage is provided through employers, Medicare, or Medicaid, taxpayer subsidies to help finance it are essentially open-ended. They largely insulate insured Americans from the full costs of insurance and health care. The defined-benefit promises under such insurance plans encourage greater use of and higher costs for care. Converting those public subsidies into defined-contribution payments is the first step toward providing beneficiaries with strong incentives to obtain the most value for them.

For almost 70 years, federal tax treatment has favored employer-sponsored group health insurance through a tax exclusion that does not count employer-paid premiums as taxable compensation for workers. This provides employees with a strong incentive to take larger shares of their compensation in the form of more costly and comprehensive health coverage instead of as taxable cash wages.

In Medicare coverage for the elderly and disabled, most beneficiaries participate in the program’s traditional fee-for-service (FFS) insurance arrangement. This allows enrollees to see any licensed health service provider, with few (if any) questions asked, so long as the patient is willing to incur the relatively modest cost-sharing charges intended to limit unnecessary use. Moreover, this initial layer of cost sharing is largely muted because almost 90 percent of Medicare beneficiaries also have supplemental insurance coverage that pays for whatever costs of covered services

Overall Policy Prescriptions:

• Convert taxpayer subsidies for insurance coverage (Medicare, Medicaid, and employer-sponsored insurance) into defined-contribution payments.

• Ensure that private health care consumers and public health program beneficiaries have more direct control over how taxpayer dollars are spent for their health care.

• Provide an enhanced infrastructure of health information and connections to intermediary agents to assist consumers in making their choices more actionable and effective.

• Base more-refined adjustments in levels of support within particular categories of beneficiaries primarily on such factors as income and health risk (and perhaps geography).

Policy Prescriptions for Employer-Sponsored Insurance:

• Clarify and prioritize multiple objectives for private health insurance subsidies.

• As a starting point, switch to flatter, refundable tax credits whose average value is fixed (but subject to some degree of risk adjustment).

(continued on the next page)
that Medicare FFS does not. Hence, the generous taxpayer subsidies for basic Medicare coverage are leveraged even further by supplemental insurance, which encourages use of more services and more intensive treatment—at little or no additional costs to beneficiaries beyond their supplemental insurance premiums. Federal taxpayers pick up most of the extra costs.

How can this work? Current and past Medicare beneficiaries have had a substantial share of their post–age-65 health care costs heavily subsidized by younger taxpayers. For example, Steuerle and Rennane estimate that a two-earner couple earning average wages and retiring in 2011 will receive three times as much in lifetime Medicare benefits ($357,000) as they pay in lifetime Medicare taxes ($119,000), in constant 2011 dollars. (This taxpayer subsidy is at about the same proportionate share of Medicare spending for single Medicare beneficiaries, but somewhat greater for lower-earning ones). Not surprisingly, annual growth in the volume and cost of Medicare spending reflects the fact that, at the point of care, Medicare beneficiaries remain cushioned against the true costs of what they demand and receive.

The Medicaid program's taxpayer subsidies operate in a somewhat different, but still open-ended, manner. The program is financed with a flawed system of federal-state matching payments, with no limit on the amount that states can decide to draw down from the US Treasury each year. For every dollar of Medicaid costs, federal taxpayers pay, on average, 57 percent, and state taxpayers pick up the rest. This open-ended matching grant formula encourages more, rather than less, Medicaid spending. If state officials want to cut their state’s share of Medicaid costs, they have to cut the overall program’s spending by $2.30 to save $1.00 in state funds, because the other $1.30 is returned to the federal government. States are much more likely to devise ways to maximize how much they can get from Washington for Medicaid services while looking for creative ways to contribute the required state portion of the funding without really doing so.

The ACA will expand Medicaid even further, beginning in 2014, to all Americans, except undocumented aliens, earning less than 138 percent of the

Policy Prescriptions for Medicare:

• Determine the competitive price for core Medicare benefits in a relevant market for the average Medicare beneficiary.

• Allow the results of annual health plan bids alone to determine the benchmarks for taxpayer subsidies, rather than relying on average costs for traditional FFS Medicare in a given market area as the default setting.

• Apply premium support to earlier cohorts of newly eligible enrollees, and perhaps even current enrollees so that the benefits of competitive cost pressures make a difference before fiscal pressures overwhelm the program another 10 years from now.

Policy Prescriptions for Medicaid:

• Develop a defined-contribution alternative for Medicaid coverage that holds taxpayer costs and program eligibility rules relatively more constant but allows the nature, level, and quality of Medicaid’s health benefits to become more variable.

• Adopt a block-grant or capped-allotment approach to Medicaid reform.

• Develop a clear integration plan with the employer market so that eligible Medicaid beneficiaries with defined contributions can retain their choices even as they move out of pure Medicaid financing into other private coverage financed in part with tax credits.

• Target initially the portion of the Medicaid population below age 65, nondisabled, and looking for a qualitative upgrade from traditional Medicaid coverage.
federal poverty level. (See the “Defined Contributions and State-Level Accountability for Medicaid” section for more on its rules for the federal share of Medicaid financing for those newly eligible for Medicaid under the health law.) In any case, the older federal-state financing share rules will remain in place for the populations eligible for Medicaid before the ACA was adopted in March 2010.

Defined-Benefit Subsidies Encourage Higher-Cost, but Lower-Value, Health Spending. The common characteristic within Medicare, Medicaid, and employer-sponsored insurance—the three dominant defined-benefit insurance arrangements for the vast majority of Americans—is that a large portion of every extra dollar spent on premiums or services is paid by a third party and heavily subsidized by Uncle Sam. Those public subsidy arrangements also mean that the real customers in our health system are not the patients but the big payers of insurance claims filed by doctors and hospitals—namely, the federal government, the states, and the country’s employers. The result is more maddening bureaucracy, redundant paperwork, unaccountable service delivery, and uneven quality.

Defined-benefit financing reinforces the nature of Medicare FFS to encourage fragmented, volume-driven care and rely on across-the-board reimbursement reductions for all health care providers to reduce fiscal pressures. Medicaid’s defined-benefit structure overpromises guaranteed services that it cannot deliver or afford, resulting in overstretched state budgets, below-cost reimbursement to providers, reduced access to care, and isolation from the types of coverage available to other working-age Americans. The open-ended defined-benefit nature of the tax exclusion for employer-sponsored private health insurance has skewed the distribution of tax benefits to higher-income workers, disadvantaged individual (non-ESI) purchasers of health care, and produced disruptions in insurance coverage for workers changing or losing jobs.

Most of all, open-ended financing of taxpayer subsidies for defined-benefit health coverage has produced high levels of health spending. These levels could be lowered if private health care consumers and public health program beneficiaries had more direct control over how taxpayer dollars are spent for their health care and recognized the full costs and consequences of their health care choices instead of assuming they are paid largely with other people’s money. The ACA does little, if anything, to solve this problem. Indeed, its primary objective is to ensure that the uninsured are also enrolled in expansive and heavily subsidized third-party coverage arrangements, which remain at the heart of today’s cost-escalation problem.

The plan to put about 16 million low-income Americans into the Medicaid program starting in 2014 does not include any significant structural changes in how the program operates. Even though Medicaid already is stressing the limited resources of most state governments and failing to compensate physicians and hospitals for their basic costs of care, the proposed expansion will distort future spending levels even more. The new law temporarily increases the federal match for all states to 100 percent for the population of new program participants (also beginning in 2014), which will only encourage state officials to look for additional ways to push even more Medicaid costs off their books and onto the federal budget while they can.

The other major component of the ACA’s coverage expansion involves benefits provided through the law’s state-based insurance exchanges and federally mandated insurance regulations. If the ACA’s individual
mandate and related insurance requirements survive future congressional attempts to repeal or revise them, the concept of defined-benefits health care will be cemented even further into federal law. They will be accompanied by sweeping rules for what must be covered by most insurance plans sold in the United States and what kind of cost sharing insurers and health plans sponsors can impose on enrollees. The upcoming ACA regime for “private” health insurance would elevate the importance of political lobbying far above that of contractual negotiation by health care providers, consumers, and other private payers.

Everyone needs to start seeing more of the real price tags in more competitive and accountable health care markets again, instead of the fake ones at the government discount store.

The ACA does not directly challenge the defined-benefit nature of current Medicare FFS coverage as an open-ended legal entitlement for beneficiaries. Instead, it reduces the future rate of growth in Medicare spending as a way to finance the ACA’s expansion of other kinds of subsidized defined-benefit coverage for the below-65 population (in the state exchanges and in Medicaid).

Despite a handful of limited demonstration projects and rhetorical lip service regarding health delivery system reform in Medicare, the ACA achieves its Medicare spending cuts the old-fashioned way—through across-the-board reimbursement reductions in the level of its formula-driven administered prices for thousands of health services and products in FFS Medicare, plus related reductions in payments to private Medicare plans. Of course, such deep reductions in payments for services will only exacerbate already-strong incentives in FFS Medicare for providers to make up for low payments by increasing the volume of defined-benefit services that they deliver to beneficiaries and charge primarily to taxpayers.

As long as defined health benefits are treated as open-ended legal entitlements whose costs seemingly are paid with other people’s money, they will continue to place mounting pressure on federal and state government budgets while distorting the nature and structure of health care decisions. How would a more sustainable, market-based, and patient-oriented version of health reform avoid the chronic conditions of taxpayer support of health coverage through a defined-benefits structure?

**Defined- Contribution Financing Realigns Incentives to Lower Costs and Improve Quality.** Currently, various mechanisms launder, hide, and redirect the amount and nature of defined-benefit promises through third-party intermediaries. Switching to defined-contribution financing for health coverage will ensure that beneficiaries receive their taxpayer subsidies more directly.

Why? Direct payment in the form of defined-contribution subsidies would empower and encourage consumers and patients to make better health care choices. The subsidies would stimulate more innovative and accountable competition among health care providers. And they would encourage us all to save and invest so that we are able to pay more for health care when it delivers more value but redirect our resources elsewhere when it delivers less.

This integrated transition to defined-contribution payments should apply to Medicare, Medicaid, and ESI. Switching taxpayer support for them to defined contributions would help make the limits of public financing more transparent, renegotiable, and fairly allocated. Levels of defined-contribution support from taxpayers should vary, depending primarily on the needs and nature of the population in question. For example, Medicaid and Medicare beneficiaries are likely to present more costly health-risk challenges and need more extensive health services than will most working-age beneficiaries of the current tax exclusion. Other, more-refined adjustments in levels of support within particular categories of beneficiaries...
should be based primarily on such factors as income and health risk (and perhaps geography).

Limiting taxpayer support through defined contributions would not restrict spending of additional private (or personal) dollars to enhance or expand coverage. The better version of defined-contribution health benefits would place initial control and choice of how to spend those taxpayer subsidies in the hands of beneficiaries. Then, it would follow through by providing an enhanced infrastructure of health information and connections to intermediary agents to assist them in making their choices more actionable and effective.

In short, federal government budgeting would be more manageable and rational with a cap on taxpayer liabilities, but the biggest payoff will come in better health care, better health, and more sustainable support for insured Americans.

**Defined-Contribution Reform of Open-Ended Tax Subsidies for Private Health Insurance**

The tax exclusion for employer-sponsored health insurance has operated since 1943 as an open-ended, uncapped defined-benefit entitlement of the tax code. It selectively favors certain purchasers of health insurance (higher-income workers in larger firms offering comprehensive insurance) over others. It only appears to make health care seem less expensive, while raising its real overall costs. How do we change the distorted price signals it produces throughout the health system?

**“Cadillac” Tax: Too Weak, with New Distortions.** The ACA introduced a very limited and flawed first step toward solving the price signal problem. It adopted a so-called Cadillac tax on more costly employer-provided health benefits plans, but it will not take effect until 2018. The premium thresholds at which it would first apply are set at relatively high levels compared to today’s average premium costs, and they include various special adjustments and exceptions (for age, gender, early retirees, and certain high-risk professions).

The future levy also is structured as a 40 percent excise tax on insurers and self-insured employer plan sponsors and administrators on the amount by which their plan’s premiums exceed the future thresholds. This tax was designed to raise revenue only in later years but still make the ACA look more budget-deficit neutral on paper than it would be in practice.

The Cadillac tax also tried to maintain the illusion that someone else—private insurers or employer plan sponsors—would pay it, rather than insured employees. But this politically driven camouflage found a new way to distort incentives, by disconnecting the levy’s uniform “wholesale” rate from insured workers’ different marginal income tax rates at the “retail” level. The latter rate actually determines the amount of tax subsidy that any individual with an employer-paid plan premium receives through the tax exclusion. Moreover, the Cadillac tax applies only to employer-provided group insurance. (The ACA provides different types of tax treatment for other kinds of health insurance purchased by individuals outside their workplace.)

**Clarifying and Prioritizing Multiple Objectives.** The case for changing insurance tax subsidies so that they operate much more as defined contributions than as open-ended defined benefit subsidies first requires clarifying our policy priorities. Multiple goals for reforming the tax treatment of private health insurance often are in partial, if not complete, conflict. They might include some mixture of making tax subsidies more progressive, providing more financial assistance directly to low-income insurance purchasers, maintaining the pre-ACA level of health insurance tax subsidies for everyone else, eliminating distortions and inefficiencies in health spending versus improving health risk pooling, or even favoring particular types of insurance coverage. In the real world, we simply cannot craft tax policy that runs in so many different directions without stumbling and short-circuiting. We also encounter practical barriers to carrying out at full strength most of these objectives, even in isolation. For example, equalizing the tax subsidy discount rate for all health
insurance purchasers would increase taxes on upper-income taxpayers (unless rough offsets to marginal income tax rates are made). It also would likely forgo any capping of maximum tax expenditures for individuals and families.

Providing more generous financial assistance directly to lower-income households is difficult to do with appropriated funds outside the delivery and income information infrastructure of the Internal Revenue Service. Tying more narrow policy reform goals to tax subsidies for health insurance would require complicated political and administrative distinctions or even an optional, parallel-track tax system.¹⁰

The Case for Full Repeal (of Insurance Tax Subsidies). Let’s pause and take a deep breath. There is a pure, market-based case for eliminating all tax subsidies for health insurance (and health care), except in cases of great need (based on relatively low income or predictably persistent high health risk). The current excessive levels of tax expenditures, as well as public program health subsidies in Medicare and Medicaid, try to foster the illusion that we can pay most, or at least a substantial share, of everyone’s health insurance premiums with other people’s money. But there simply is not a sustainable line of credit or enough projected tax revenue to keep financing these efforts at the same current-law levels far into the future.

The federal tax system should not, and actually does not, need to bribe upper-middle-class and wealthier Americans to purchase and maintain insurance coverage. Policymakers could instead lower their other taxes to offset the net effects of reducing or even eliminating their access to current tax subsidies for health care spending (particularly, the tax exclusion for the cost of health insurance paid by their employers). This policy reform would help make the full unsubsidized costs, and the real value, of their current coverage and care more transparent to them. It would encourage more efficient health care choices without raising overall federal taxes on workers covered by employer health plans.¹¹

However, that does not mean that additional subsidies (offset by other spending reductions in health care in the federal budget) will not be needed to help other populations targeted on the basis of their unusual income and health-risk needs. Those dollars can pay for some, and sometimes all, of the insurance costs of their basic care. But almost everyone needs to start seeing more of the real price tags in more competitive and accountable health care markets again, instead of the fake ones at the government discount store.

Starting Point: Need-Adjusted Tax Credits. So much for health reform daydreaming. Such a cold-turkey approach to substantial withdrawal from the dulling narcotic of taxpayer subsidies for health coverage would be too much of a short-term shock to embedded expectations, long-standing arrangements, and the demonstrated inability of Congress to make serious decisions on such fundamental policy changes before the last minute. Other configurations for changes in the tax treatment of health insurance could achieve at least some of the aforementioned policy goals to various degrees, but they become too complicated to withstand 30-second analyses and attract sufficient political support.¹²

Barring the onset of the oft-promised but rarely seen debate over fundamental tax reform, the defined-contribution approach should focus primarily on restoring a more level playing field for all purchasers. This is difficult to accomplish simply through changes in the deductibility of health insurance premium costs under the federal income tax.¹³ Hence, the general starting point for more balanced, defined-contribution tax subsidies involves a switch to flatter, refundable tax credits whose average value is fixed (but subject to some degree of risk adjustment). This type of tax subsidy better maintains neutral incentives on the margin...
for health spending at higher levels than the capped amount of tax credits for health insurance premiums will subsidize.

Converting today’s tax preference for employer-paid premiums into a refundable, universal credit for the under-65 population would mean that every American household could use the credit when they purchase health insurance. The likely average value of the credit might approximate the current average tax subsidy for job-based coverage—in the range of about $5,000 to $6,000 per family. Any household that chose to forgo purchasing at least some basic level of insurance would lose the entire value of the credit, which is much greater than the dollar amount of the penalties imposed under the ACA’s individual mandate, beginning in 2014. Insurers also would be highly motivated to offer new lower-cost insurance options to meet the needs of millions of cost-conscious consumers.

In their initial fixed-dollar form, refundable tax credits necessarily fail to adjust for a beneficiary’s risk status or income level. An imperfect policy tradeoff here involves the feasibility of making such fine-tuned adjustments and the administrative ability to do so given the limits of current risk-adjustment and income-reporting mechanisms. Another tradeoff involves balancing the desire to unleash the potential of millions of new cost-conscious individual consumers within a more competitive insurance marketplace against concerns that policy change that is too rapid and drastic might lead to undue disruption of current coverage and insufficient capacity to provide viable choices and options. In any case, this key component of fundamental health reform needs to be addressed as soon as possible, although its pace and scope remain subject to prudential considerations and practical limits.

**Defined Contributions for Medicare Subsidies**

Applying a defined-contribution approach to taxpayer subsidies for Medicare benefits aims primarily at encouraging private plans and traditional FFS Medicare to compete for market share and determine the most economical price for a given set of health care benefits for the elderly. The taxpayer contribution to beneficiaries to help purchase Medicare coverage can be either determined by market means (competitive bidding) or fixed at a politically determined amount. The latter approach is difficult to sustain and requires periodic arbitrary, delayed, and backward-looking adjustments. It is time for a more market-based method to determine the real cost of more efficient and effective ways to deliver a package of basic Medicare benefits to beneficiaries.

**The primary role of competitive-bidding mechanisms for Medicare premium support is to discover what it actually costs to deliver core Medicare benefits in a better manner.**

**Premium Support.** Competitive bidding among all Medicare-based health plans could tell the federal government whether its defined-contribution levels are too high, too low, or getting close to being about right. It would provide the foundation for a premium support model for Medicare financing that was first developed in greater detail by the 1999 National Bipartisan Commission on the Future of Medicare. Premium support operates through a defined-contribution subsidy structure to stimulate greater price competition among private Medicare plans and the traditional FFS program and to make beneficiaries more value-conscious when they choose plans.

A well-designed premium-support approach to Medicare financing must move beyond broad rhetorical brushstrokes and fill in the structural details needed to ensure effective choice and competition for seniors. This includes

- Defining in broad terms the statutory health benefits package on which private plans and the traditional FFS Medicare program...
would bid. Using a less rigorous standard of actuarial equivalence in comparing variations in different plans’ health benefits packages would help maintain incentives for innovation, dynamic competition, and preference-sensitive variation in plan benefits.

• Defining the relevant market areas for competitive bidding. They should reflect actual health care market patterns (local and sub-regional) rather than politically constructed ones (national and regional) designed to maximize cross-subsidies and hide the real costs of care.

• Allowing the results of the annual plan bids alone to determine the benchmarks for taxpayer subsidies, rather than relying on average costs for traditional FFS Medicare in a given market area as the default setting. This would increase competitive pressure on bidders to offer their best prices.

• Determining first the competitive price for core Medicare benefits in a relevant market for the average Medicare beneficiary. Subsidies then could be adjusted at the health-plan level to deal with the peaks and valleys in income levels and health-risk profiles of particular collections of beneficiaries. Additional premium assistance for lower-income beneficiaries, and risk adjustment for plans that attract unusually large collections of high-risk or low-risk beneficiaries, may be appropriate, but it should not hide information about the basic competitive price of care and coverage.

• Deciding on how great a share of those actual costs of more efficiently delivered Medicare benefits should be subsidized by taxpayers. (Hint: the correct answer is not 100 percent!) For example, the Bipartisan Commission plan in 1999 started with a very generous initial level: roughly 88 percent of the enrollment-weighted average price of all competing bids for standard-option Medicare plans.17

• Providing full rebates to beneficiaries choosing plans whose bids set premiums at levels below the level of the resulting (taxpayer-subsidized) benchmarks. But they should still be required to pay the full marginal amount out of pocket in supplemental premiums if they choose plans more expensive than the benchmarks.

Clarifying the Primary Goal? Most of these decisions require first determining the primary policy goal of premium support and defined-contribution financing of Medicare. Is it to achieve more efficient and higher-value health care? Or is it simply to lower the future rate of growth of Medicare spending? Or, even more cravenly, just to keep currently happy beneficiaries reassured of little if any disruption to their existing health care arrangements? If we pretend that none of those goals conflict with one another, the resulting prescription for solving these several simultaneous equations remains likely to be contradictory, unaffordable, and unsustainable.

Clearer resolution of the tradeoffs between those major policy goals and their relative order of priority will go a long way in determining settings for the various elements of premium support. For example, too many promises to beneficiaries of generous benefits, limited cost sharing, protective regulation, and standardized coverage will negate other policy objectives. They will conflict with efforts to slow Medicare spending growth, reduce tax burdens on younger workers, shrink massive budget deficits, and increase choice and competition through better private plan alternatives. The political balance struck between limiting taxpayer costs, reducing Medicare spending growth, insulating beneficiaries from market-based price tags, and maintaining relative stability on the supply side of health care also will shape how policies are designed. Moreover, the actual level at which
future taxpayer subsidies under premium support might increase, phase out, or be rebated to beneficiaries will remain subject to future reconsideration and political negotiation.

Special protection must be maintained for the most vulnerable low-income or high-risk Medicare beneficiaries using separate policy tools: supplemental income-based subsidies and risk adjustment of aggregate premium-support payments made to competing plans. But just how “low-income” will low-income Medicare beneficiaries needing greater premium support turn out to be? Subsidies that creep up the income ladder above the current special-assistance ceilings for dual-eligible (Medicaid plus Medicare) seniors will hit younger taxpayers harder and reduce beneficiary incentives to make more cost-conscious care and coverage choices on the margin.

**Structural Reform First, Savings Later.** Because future supplies of Medicare subsidies are not unlimited, they should be allocated more efficiently and equitably, in a manner that no longer obscures the true cost of promised benefits. At the same time, their level and structure should provide beneficiaries with incentives to obtain the most value and opportunities to augment subsidies with their own private resources. Getting this basic reform structure right and in place soon is more important than the magnitude of the initial budget savings it produces.

Hence, the primary role of competitive-bidding mechanisms for Medicare premium support is to discover what it actually costs to deliver core Medicare benefits in a better manner. Resetting the level at which taxpayers’ funds subsidize most, but not all, of those costs is an important, but secondary, policy decision that cannot be made persuasively until we know what all the costs really are or could be (not just those assigned through FFS Medicare’s labyrinth of administered prices and treatment codes).

Competitive-bidding mechanisms should determine relative levels of premium support by taxpayers in different health care market areas. But they need clear operating rules, guided by key policy goals. If the foremost goal is lower costs, setting the winning bid price at the least costly one submitted might drive down premiums over time, at the risk of failing to ensure sufficient capacity to serve all beneficiaries. At the opposite end, using competitive bidding to arrive at an enrollment-weighted average price of subsidized coverage based on all bids would keep more competitors in business, more beneficiaries happy, and the traditional Medicare program more insulated from competition. However, that would come at the expense of reduced pressure for greater efficiency gains and resulting higher Medicare costs falling mostly on taxpayers, but also on Medicare premium payers.

The 2011 premium-support proposal by Sen. Ron Wyden (D-OR) and Rep. Paul Ryan (R-WI) suggests that they might favor setting the premium support amount at the lower of either the second-least-expensive private plan bid in a market area, or the cost of traditional Medicare FFS. The 1999 bipartisan Medicare commission’s model relied more on an enrollment-weighted average of all competitive bids (based on the previous year’s enrollment figures for Medicare beneficiaries among all plans offering competing bids). The bottom line: enrollment-sensitive bidding rules that reward lower, but not just the lowest, premiums will provide the best long-term balance.

Competitive bids need to be “real,” with participating plans held to their bid price for core-benefits package premiums until the next year’s round of open-season bidding, enrollment, and plan switching. Private plans may not thrive in all markets when competing with the traditional FFS Medicare program. A switch to defined-contribution financing and level-playing-field competition cannot ensure that private plans will be abundant everywhere, while simultaneously rewarding efficiency with larger market share. Competition will show signs of working when FFS Medicare’s premiums have to rise or its program benefits packages and care management practices must be revised in markets where private plans can offer better benefits at the same, or lower, premiums.

**Fleshing Out Premium Support.** Several other secondary issues involving Medicare premium support rules should be resolved.
Could a supplemental tier of separately priced benefits also be offered by private insurers that first must follow bidding rules in selling an initial common core of standard Medicare benefits? Yes.

How could the power of competitive pressure unleashed through a premium-support reform overcome the ingrained inertia of most Medicare beneficiaries to choose one plan and stick with it as long as possible? Initial random assignment of newly eligible Medicare enrollees into both private plans and Medicare FFS—as a default setting subject to informed consent and opt-out guarantees—might reduce the passive bias of the current program toward enrollment in the dominant traditional FFS public program. On the other hand, premium spikes in Medicare FFS in some markets where it is less cost-competitive, or the absence of private plan options in other areas where limited provider options make network contracting by private insurers less viable, could test the limits of political tolerance.

Another unaddressed issue in many premium-support-style proposals involves how the administrative managers of Medicare FFS might be empowered (turned loose) to adjust their program configurations to respond to new competitive pressure from private plan alternatives. Political resistance to untying the hands of government bureaucrats to allow them to act like managers seeking to retain or expand market share (if not “profits”) is strongest among the many micro-managers of Medicare on Capitol Hill. But it also strikes a chord among risk-averse FFS beneficiaries.

Past constraints on FFS Medicare’s flexibility to respond to new market signals by adjusting premiums, cost sharing, and benefits and selectively contracting with providers should be relaxed from congressional shackles to level the playing field with its private competitors. The necessary safeguards include ensuring sufficient disclosure of new policies and practices and breaking up administration of the FFS program into regional, or smaller, units.

The Costs of Delay. Even the best version of premium support with competitive bidding, running at full speed, would be hard-pressed to close the entire fiscal gap between Medicare’s political promises and the resources realistically available to fund them in the immediate years and decades ahead. Projected delays in implementation would obviously make this process even slower. Hence, the issue can be addressed more effectively on a separate and faster track, which could reduce the risks of undermining the basic case for greater efficiency, affordability, and value in Medicare health care benefits through premium-support reform based on greater choice and competition.

The recently proposed Seniors’ Choice Act by Senators Tom Coburn (R-OK) and Richard Burr (R-NC) offers a number of worthy policy reforms to deliver larger Medicare budget savings sooner and more equitably. They suggest:

- Unified cost sharing across traditional Medicare’s alphabet soup (parts A, B, and D) of program and provider silos;
- Income-related maximum stop-loss protection against catastrophic risks;
- Means-tested cost-sharing levels;
- Restrictions on secondary Medigap coverage of FFS Medicare’s cost-sharing requirements;
- An early phased-in increase in the share of Medicare Part B costs paid by beneficiary premiums; and
- Gradual increases in the initial age of eligibility for Medicare.
At least some of these provisions will need to be enacted in the near term, despite the political obstacles they face.

In one way or another, American voters and officeholders will need to reconsider the degree to which means testing for access to large taxpayer subsidies for Medicare is both economically necessary and politically tolerable. Another layer of response to imminent fiscal pressures will involve gradually lowering in later years whatever initial levels of premium support are determined purely through competitive-bidding mechanisms. More drastic fiscal pressures will lead to more formulaic budgetary targets for larger cost reductions.22

The biggest challenge to defined-contribution-style reform of Medicare may involve the need to deliver Medicare cost savings soon enough and large enough. That would mean applying premium support to earlier cohorts of newly eligible enrollees, and perhaps even current enrollees so that the benefits of competitive cost pressures make a difference before fiscal pressures overwhelm the program another 10 years from now. The Ryan-Wyden plan, like most other reform proposals, dodges this issue by calling a timeout on implementation for another decade, even though this contradicts the purported message that choice and competition should be good for everyone, not just new beneficiaries much further over the next election year’s horizon. The ACA roadmap for Medicare cost reductions offers little more than the unsustainable illusion of perpetual annual reimbursement cuts for health care providers,23 and it then redirects them to help pay for the other new entitlement subsidies it dispenses to younger Americans. All of those “savings,” and more (but implemented in a more choice-sensitive and competition-driven manner) will be needed in the decades ahead merely to keep Medicare solvent for its older beneficiaries.

This policy menu for Medicare is particularly complex and politically uncharted. It certainly merits much more discussion, initial experimentation, and careful monitoring, but those uncertainties should not dissuade policymakers from allowing it to unfold sooner rather than later.

**Defined Contributions and State-Level Accountability for Medicaid**

**Medicaid before the ACA Expansion.** The ACA plans to add about 16 million more low-income Americans to the Medicaid program without making any important structural changes in how Medicaid operates. Even before this massive expansion (the fiscal equivalent of a steroid injection of federal funding) begins in 2014, Medicaid is already in a near-crisis state, both fiscally and operationally. States are buckling under the weight of its costs. Networks of physicians and hospitals willing to see large numbers of Medicaid patients continue to shrink. The resulting quality of care delivered to many Medicaid beneficiaries remains disappointing.24

Moreover, the distortions in today’s Medicaid program of matching federal financial support for defined-benefits spending, both of which encourage high costs, will be made even worse as the ACA initially increases the federal match for all states to 100 percent for the “Medicaid expansion” population that begins to receive new benefits beginning in 2014. The states will respond to this incentive quite predictably, by dropping any remaining efforts to control Medicaid’s costs for newly eligible enrollees and looking for ways to push even more costs off of their books and onto the federal budget for as long as they can.25

The existing Medicaid program’s many rules at the federal level, and the thousands of pages of regulations defining them, already repeatedly hamstring state-level flexibility, innovation, and cost containment. The process for states to seek a waiver from the federal government is often lengthy and time consuming. As a
result, too many important elements of the current system remain trapped in a one-size-fits-all approach with little meaningful competition for services.26

States seeking to implement broader and more coordinated managed-care approaches to particular Medicaid populations first must obtain federal waivers from “unrestricted choice of provider” rules—a process that exhausts precious time and resources and delays unnecessary reforms. ACA advocates say that the new law will support innovative efforts to establish more integrated and customized care for various types of Medicaid beneficiaries and will solve these problems. But wary state officials recall similar previous promises that failed to materialize in practice, as the imperative to maintain federal command and control, or simply bureaucratic caution and inertia, delayed and frustrated many state-based initiatives.

Too many important elements of the current system remain trapped in a one-size-fits-all approach with little meaningful competition for services.

The most recent urgent concern for states already struggling to maneuver through difficult budgetary environments involves the maintenance of effort provision imposed on them in the ACA. This provision keeps states from reducing or restricting eligibility to their Medicaid programs below the level that was in place when the law was enacted on March 23, 2010. The ACA will increase states’ Medicaid costs in other ways, particularly when it encourages higher numbers of previously eligible people to enroll in the program (because of both its individual coverage mandate and more unified processes to determine eligibility for federal subsidies through state-based health benefits exchanges). One congressional report, Medicaid Expansion in the New Health Law: Costs to the States, issued jointly last year by the Senate Finance Committee (Minority) and the House Energy and Commerce Committee (Majority) estimated that the ACA will cost state taxpayers at least $118.04 billion related to Medicaid through 2023—nearly double the previous Congressional Budget Office estimates of $60 billion through 2021.27

Mainstreaming Medicaid Beneficiaries into Private Insurance? Because Medicaid was originally established in 1965 primarily to provide health coverage for nonelderly welfare recipients,28 it was never integrated into the insurance system for working-age Americans. Lack of coordination between Medicaid coverage and private health insurance for lower-income Americans continues to cause serious problems. When nonelderly Medicaid beneficiaries earn more income, they often lose eligibility for Medicaid even if they face uncertain prospects for insurance in the employer-based market. This creates strong disincentives to gain employment and move up the wage scale. It can also disrupt ongoing relationships with physicians and other regular sources of health care as someone moves back and forth between Medicaid and private employer insurance plans.

Ideally, replacing both traditional Medicaid assistance and the tax preference for ESI with defined-contribution payments for both kinds of coverage would open up new possibilities for explicit and beneficial coordination between them. In most past formulations for restructuring taxpayer financial contributions for health insurance coverage, all working-age Americans and their families would receive a baseline amount of assistance through a fixed, refundable tax credit. But Medicaid beneficiaries with especially low incomes will need greater financial assistance. Medicaid funds could supplement the tax credits to pay for more of their remaining premiums and cost sharing. Phasing out the full amount of those additional Medicaid payments in gradual steps related to household income would avoid large disincentives for the beneficiaries to increase their wage earnings and other income.

One approach might give states an incentive to develop specific insurance-selection structures that allow Medicaid beneficiaries to enroll in the same kinds of plans as workers with higher wages and to
have full choice among competing plans with different models for delivering and accessing health services. Medicaid participants could have a greater share of their premiums subsidized by a combination of a refundable tax credit and a still-substantial portion of the Medicaid payments for which they previously were eligible. The premium assistance would flow directly to the Medicaid beneficiaries, but they still would face some additional costs if they chose to enroll in more expensive coverage options.

However, several lesser versions of this approach have been proposed before, with very limited success at best. For example, most states were already granted authority well before the ACA to use Medicaid funds to provide premium assistance to subsidize the purchase of private health insurance for eligible beneficiaries, such as employer-sponsored coverage. Enrollment in such premium-assistance options has been less than 1 percent of total Medicaid or Children’s Health Insurance Program enrollment. The leading impediments to premium assistance include federal and state price controls that shift costs to private payers, complex and costly administrative procedures, lack of affordable (or any) employer-sponsored coverage for many low-income workers, and employers’ concern about increasing their own health plan costs.

**Beyond Medicaid Block Grants.** Another approach to Medicaid reform frequently proposed by Republican members of Congress involves transferring the federal government’s financial share of Medicaid financing to state governments as block grants. The main political hurdles facing such proposals involve disagreements over how those funds would be reallocated among the states, how generously they might be adjusted in the future relative to projected health care costs, and what level of current federal guarantees and minimum standards for Medicaid should be maintained. Giving state governments a different aggregate allotment of Medicaid funding and more discretion does not by itself solve the problems of lack of informed choice, insufficiently vigorous competition in benefits design, and poor incentives for improved health care delivery.

Future efforts to develop a defined-contribution alternative for Medicaid coverage should start by holding taxpayer costs and program eligibility rules relatively more constant, while allowing the nature, level, and quality of Medicaid’s health benefits to become more variable. New defined-contribution arrangements must have the freedom to include a different mix of benefit, cost sharing, and medical-care management than traditional Medicaid. This approach would reward insurers, health care providers, and state policymakers for raising the quality of health care, the value of health benefits, and the satisfaction of Medicaid patients instead of just struggling to keep the apparent costs of the program lower (or hidden). States pursuing more market-based, consumer-choice reforms also should acknowledge that they may have to decide to cover fewer people, leave more details of health spending decisions to beneficiaries ready and eager to make them, pay participating health care providers for the full costs of care, and measure quality of delivered care more accurately.

Such a defined-contribution version of Medicaid needs a clear integration plan with the employer market so that choices made by eligible Medicaid beneficiaries can be retained even as they move out of pure Medicaid financing into other private coverage financed in part with tax credits. For that reason, this reform should target initially the portion of the Medicaid population below age 65, nondisabled, and looking for a qualitative upgrade from traditional Medicaid coverage that only promises seemingly generous benefits but actually pays providers too little to deliver them. Applying a defined contribution to the costliest and most medically complex Medicaid beneficiaries—the aged, blind, and disabled, many of whom are dually eligible for Medicare coverage—is more problematic and less practical in the near term.

Delinking levels of state and federal spending on this portion of Medicaid is equally important. The open-ended federal reimbursement of at least half, and often more (the average is 57 percent across all states), of state Medicaid program expenditures creates strong incentives for states to spend less carefully. Each state’s
Medicaid program ends up larger than it would be if its own taxpayers had to pay the entire cost.

The primary policy options include the politically treacherous overhaul of the Federal Matching Assistance Percentages (FMAP) rules that, in practice as opposed to in original theory, have rewarded richer states at the expense of poorer ones and encouraged additional state Medicaid spending on the margin to maximize matching federal dollars. Rearranging the federal share of Medicaid funding into block grants to the states, with future annual updates indexed somewhat below current Medicaid spending growth rate projections, has traditionally provided a formulaic shortcut. A more aggressive approach might limit federal assistance to funding fully just the upper layers of catastrophic acute care for the below-65, nondisabled portion of Medicaid participants, while states become responsible for financing as much of the coverage and cost sharing below those levels as they decide to handle.

In one form or another, putting Medicaid on a more fixed budget would provide greater budgetary certainty at both levels of government. By knowing the likely amount of federal assistance to expect in future years, state Medicaid programs could be managed more carefully for the long haul. The best working example thus far for doing this involves a capped allotment of federal funds through the current FMAP formula to provide states with upfront funding over a predetermined period of time. Such initially fixed federal funding should come with incentives: if the state spends below the grant, it can use the savings for other areas of need, just like in the Temporary Assistance to Needy Families program. Congress can also provide bonus payments for each state if it achieves appropriate benchmarks.

The federal government should allow states adopting this option to

- Determine their own eligibility categories and income threshold levels for Medicaid;
- Establish rates and service delivery options;
- Design benefit packages that best meet the demographic, public health, and cultural needs of each state or region (whether that involves adding, deleting, or modifying benefits); and
- Use cost sharing as a way to promote individual responsibility for personal health and wellness.

Rhode Island pioneered this Medicaid reform approach after receiving a Medicaid global waiver in 2009 (approved by the outgoing Bush administration) to establish a new state-federal compact. Under the waiver, Rhode Island promised to operate its Medicaid program under an aggregate budget cap (combined federal and state spending) over a five-year period. If the state program spends more than the average historical spending trend rate the state and federal governments agreed on and its total Medicaid spending exceeds the cap, Rhode Island is responsible for 100 percent of those additional costs. This waiver is not a pure block grant because it preserves the FMAP formula for determining the relative federal share of the total level of the state Medicaid program’s spending through 2013, but only up to the aggregate spending cap. Within these federal funding limits, the state has much greater freedom to design and redesign its Medicaid program. Rhode Island also gained much more flexibility in administering its program, and federal reporting requirements were streamlined.

Early results in Rhode Island are promising. The state was able to make a number of important changes in the way it administers its Medicaid program,
including rebalancing long-term care, keeping more seniors in community settings rather than expensive nursing homes, incentivizing higher-quality care, designing wellness programs to prevent the need for more expensive care, purchasing reforms to increase competition, and giving beneficiaries more direct control over health care spending. A December 2011 independent evaluation of the waiver by the Lewin Group focused just on the early effects of the state’s reforms to rebalance long-term care (LTC) services. It estimated budget savings of $56–61 million for state fiscal year 2008 to state fiscal year 2010 for three of the state’s Medicaid waiver and budget initiatives. Lewin noted significant increases in the number of physician visits for LTC Medicaid beneficiaries transitioning from fee-for-service care to a care management program, as well as reductions in their number of emergency room visits and inpatient admissions. The report concluded that the global waiver was highly effective in controlling Medicaid costs and improving beneficiaries’ access to more appropriate services (particularly primary care, home, and community-based services).33

Another recent example of Medicaid innovation at the state level involves Florida’s section 1115 Medicaid Reform Waiver. This comprehensive demonstration program was designed to improve the state’s Medicaid delivery system by coupling the use of managed care practices with customized benefit packages, opt-out provisions, and health-related incentives or enhanced benefits for beneficiaries. After five years, the Medicaid Reform Pilot (now operating in five counties while the state awaits federal action on its proposal to extend and expand the waiver statewide) maintained health outcomes at or above the national average for the majority of measured indicators. It improved outcomes for recipients through financial incentives. The program achieved patient satisfaction levels above the national averages of other state Medicaid programs and even commercial health maintenance organizations, while still restraining costs (flattening the cost curve for per-person spending).34

The current political climate makes further discretionary approval of Medicaid waivers for such experiments less likely and a broader legislative overhaul of the program’s financing more necessary. The Obama administration remains committed to implementing the ACA’s plan for massive expansion of Medicaid and further federal control of eligibility, benefits, and even reimbursement policy.35 Moreover, several other cautionary notes remain before proceeding with overoptimistic assumptions for the primary alternative: sweeping state-driven Medicaid reform.

**Health policy should support broader economic policy incentives to work, save, and invest more effectively so as to protect the most vulnerable Americans without increasing their numbers.**

**Speed Limits for State Medicaid Reform.** First, even achieving the most optimistic vision of improvements in Medicaid’s health care delivery quality and efficiency cannot overcome the effects of slow or stagnant economic growth, rising levels of disabling health conditions, and lack of improvement in the dependency ratio between working taxpayers and beneficiaries dependent on publicly financed health entitlement programs. Hence, health policy should support broader economic policy incentives to work, save, and invest more effectively so as to protect the most vulnerable Americans without increasing their numbers.

Second, there are clear fiscal and administrative ceilings on the degree to which current Medicaid beneficiaries can be mainstreamed quickly into higher-quality private insurance coverage by offering defined-contribution subsidies that flow directly to them and their chosen insurer. Our long-term goal should be to coax more Medicaid beneficiaries into private insurance coverage by offering defined-contribution subsidies that flow directly to them and their chosen insurer. However, doing so will either cost more money or cover fewer people than both the ACA and the old Medicaid program pretend to do at
cut-rate prices. Better private coverage has to pay health care providers more to deliver better care, and the current level of Medicaid spending—even for the less medically challenged nonelderly, nondisabled portion of its covered population—is far from sufficient to handle the cost of those higher premiums on a large scale.  

Third, managed care for an increased share of Medicaid beneficiaries is no panacea. Its effects on costs and quality depend on how well it is executed in practice, as well as the setting in which it occurs. Managed care programs already cover about two-thirds of all Medicaid beneficiaries, and broader efforts to focus managed care on dual eligibles are expanding or getting underway. Yet a recent study by Duggan and Hayford found that shifting Medicaid recipients from traditional FFS benefits programs into Medicaid managed care ones did not reduce Medicaid spending in the typical state.  

Finally, greater emphasis on “federalism” in health policy must travel a two-way street. Each state Medicaid program should be accountable for measured improvement in health care quality, whether through better health outcomes or performance metrics, rather than just for close compliance with federal rules and regulations. The latter often have little if any real impact on the lives of beneficiaries and fail to promote efficiency and cost containment.

In a block-grant or capped-allocation approach to Medicaid reform, the primary role of the federal government should be to ensure true accountability and responsibility on the part of states given greater freedom in spending federal dollars. The federal government should offer every state the opportunity to enter into a simplified compact that sets outcome measures and benchmarks and then requires a participating state to report periodically (perhaps quarterly) on its performance in achieving them. Federal oversight should be triggered when there is a significant deviation in the reported versus projected performance. The number of measures should be limited to no more than 10 for each dimension of health care: cost, quality, and access. This will simplify or eliminate the state plan approval process, allowing states and their constituents to concentrate more on what matters most: better health outcomes, better value, and lower costs.

Notes


2. Supplemental coverage involves either individually purchased or employer–provided “Medigap” coverage, or additional Medicaid assistance for the low-income elderly.

3. Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare and the Health Care Delivery System (Washington, DC, June 2012): 3-29, www.medicare.gov/chapters/jun12_ch01.pdf (accessed September 24, 2012); see also Adam Atherly, “Supplemental Insurance: Medicare’s Accidental Stepchild,” Medical Care Research and Review 58, no. 2 (2001): 131–61 (finding a spending increase averaging about 25 percent among Medicare beneficiaries with supplemental coverage) and Sandra Chris-tensen and July Shinogle, “Effects of Supplemental Coverage on the Use of Services by Medicare Enrollees,” Health Care Financing Review 19, no. 1 (1997): 5–17 (estimating that use of Medicare services ranged from 17 percent higher for those with employer supplemental coverage to 28 percent higher for those with individual Medigap policies). Other researchers have suggested that at least some of this higher spending is due to risk selection effects that attract less healthy beneficiaries to supplemental coverage, but a recent
MedPAC-sponsored study confirmed that when elderly beneficiaries are insured against Medicare’s cost sharing, they use more care and have higher Medicare spending. See Christopher Hogan, “Exploring the Effects of Secondary Insurance on Medicare Spending for the Elderly,” Study 09-28 for MedPAC (2009), www.medpac.gov/documents/Jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf. The Hogan study estimated that total Medicare spending was 33 percent higher for beneficiaries with Medicare gap policies than for those with no supplemental coverage after controlling for demographics, income, education, and health status. Beneficiaries with employer-sponsored coverage had 17 percent higher Medicare spending, and those with both types of secondary coverage had 25 percent higher spending.


5. Although the ACA officially expands Medicaid to cover all households earning up to 133 percent of the federal poverty level, including childless adults, its “income disregard” rules increase the effective ceiling to 138 percent. The 100 percent federal financing eventually phases down to 90 percent by 2019.

6. The Supreme Court ruling on the ACA’s Medicaid expansion made participation in the new, expanded Medicaid program more of an option for states, rather than a federal mandate with a heavy penalty for noncompliance (potentially as much as loss of all existing federal Medicaid subsidies for a noncomplying state’s current Medicaid program). Nevertheless, the incentives to take maximum advantage of the increased subsidies from federal taxpayers remain on the table for participating states.

7. The tax exclusion is passed through to workers as a pretax discount that reduces the net cost of their employer-paid health benefits. Many workers also use a premium conversion option offered by their employer (particularly larger ones) to extend this tax benefit to the share of employer-sponsored insurance premiums that they pay directly. Among employers offering health benefits, 41 percent of small firms (with 3 to 199 workers) and 91 percent of larger firms (200 or more workers) offer plans that allow employees to use pretax dollars to pay for their share of premiums. See Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2012 Annual Survey (Menlo Park, CA: Author, 2012), exhibit 14.2 at 237, http://ehbs.kff.org/pdf/2012/8345.pdf.

8. Whether the premium assistance tax credits provided under the ACA (beginning in 2014) for exchange-based coverage are more or less generous than tax exclusion subsidies for ESI depends on a worker’s household income level. In general, the income-based premium assistance tax subsidies are more progressive, in subsidizing lower-income individuals more generously than the value of a tax exclusion based on their marginal federal income tax rate. See, for example, Eugene Steuerle, “Health Care Reform: Implications of a Two Subsidy System,” presentation, AEI Conference, Are the Current Health Reform Bills Fair? December 4, 2009, www.aei.org/files/2009/12/04/Eugene%20Steuerle-%20AEI%2012-4-09.pdf. See also James C. Capretta, “A 70% Tax on Work,” National Review Online, October 5, 2009, www.nationalreview.com/critical-condition/48181/70-tax-work/james-c-capretta, regarding likely disincentives to work as income increases. But ACA rules generally prohibit workers with ESI coverage offers from taking advantage of exchange-based insurance subsidies, and the health law provides no additional tax subsidies for purchases of individual market coverage outside of the ACA-approved exchanges.


11. This budget-deficit-neutral approach assumes “static” scoring of changes in tax policy. Under a more realistic “dynamic” scoring model, the pro-growth incentives triggered by reductions in marginal income tax rates that offset a larger base of taxable income actually would increase overall federal tax revenue.

12. For example, see Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2012, 16–18.
13. The tax exclusion for ESI also shelters the value of job-based health benefits from the payroll taxes that finance Social Security and Medicare, not just from federal income taxes. Hence, individual deductibility of premium costs under the federal income tax code alone fails to provide equivalent tax treatment for purchasers of individual market health insurance.

14. Of course, if policy goals include being more generous to those more in need and extending tax subsidies for health insurance to new populations, this will mean either moving away from the same flat, fixed-dollar subsidy for everyone or raising the budgetary price tag substantially for a much more generous level of total tax expenditures than under current law. If policymakers insist on budget neutrality in line with this existing baseline, the average per-capita tax subsidy spread across a broader population would need to be lower. In any case, everyone receiving the same amount of “less-generous” tax credits is probably the least likely political scenario of all.

15. The penalties for failing to comply with the insurance-purchasing mandate under the ACA also are rather modest in proportion to the likely average premium cost of required coverage. The penalty will be the greater of a flat-dollar amount or a percentage of the violator’s income. After the penalty amounts are phased in over three years (ending in 2016), the flat-dollar version will equal $695, and the percentage-of-income version will equal 2.5 percent of income. The likely result is that a significant percentage of lower-income individuals will calculate that it is much less expensive to pay the penalty than to purchase mandatory insurance. The law’s guaranteed-issue incentives for potential purchasers allow them to enroll “just in time” when sick and “go bare” when healthy (and pay less in penalties than in total premiums), further ensuring limited and erratic mandate compliance. See Thomas P. Miller, “The Individual Mandate: Ineffective, Overreaching, Unsustainable, Unconstitutional and Unnecessary” AEI, March 23, 2012, www.aei.org/papers/health/healthcare-reform/ppaca/the-individual-mandate-ineffective-overreaching-unsustainable-unconstitutional-and-unnecessary/.


17. In 1999, a majority of the National Bipartisan Commission members supported a plan with a premium payment formula under which beneficiaries would be expected to pay, on average, 12 percent of the total cost of standard option Medicare plans. (That total cost was calculated as 100 percent of the national enrollment-weighted average of all plan premiums, including both the government/taxpayer and beneficiary shares). Taxpayers would pay the remaining 88 percent. For plans that cost less than 85 percent of the national average weighted plan price, there would be no beneficiary premium at all. For plans with prices above 100 percent of the national weighted average, the taxpayer subsidy share of premiums would be capped and additional beneficiaries’ premiums (above the baseline 12 percent share) would include all costs above that national average. For premiums between 85 and 100 percent of the national weighted average, the government’s share would increase by roughly $1 for every $3 required of the beneficiary. (For example, a plan with premiums at the 88 percent level would charge beneficiaries premiums at only 3 percent of total plan costs, whereas a plan with total costs at the 96 percent level would charge beneficiaries premiums at 9 percent of plan costs.) See Jeff Lemieux, “Subject: Cost Estimate of the Breaux-Thomas Proposal,” National Bipartisan Commission on the Future of Medicare, March 14, 1999, http://rs9.loc.gov/medicare/cost31499.html, referencing “Schedule 2: An Alternative Premium Schedule,” February 17, 1999, http://rs9.loc.gov/medicare/images/sched02.pdf.


20. The latest research by Feldman, Coulam, and Dowd estimates that competitive bidding—a key feature of the Wyden-Ryan plan—could have saved Medicare $339 billion over 10 years, starting in 2010, while maintaining basic benefits and without raising taxes. Fully implemented competitive bidding from 2010 to 2020 would save 9.5 percent of
then-projected Medicare spending. However, the Affordable Care Act is estimated to save 4.2 percent if implemented as the law requires, so competitive bidding would save 5.6 percent more of Medicare spending, as projected under the ACA-adjusted baseline.


22. Critics of several House Republican budget resolutions in recent years have pointed to those budgets’ use of formula-based reductions in the future rate of growth of premium support payments for Medicare spending (such as reducing it to the annual rate of gross domestic product growth, plus either 1 percent or 0.5 percent) to ensure budget savings. However, the ACA also caps future overall spending growth to a similar annual rate beginning in 2015. Its combination of annual automatic reductions in provider reimbursement rates (euphemistically called “productivity adjustments”) and other Medicare spending reductions, to be enforced by an Independent Payment Advisory Board, will limit growth in per-capita Medicare spending to a fixed rate (initially set at the midpoint between general inflation in the economy and inflation in the health sector, but starting in 2018 set permanently at per-capita GDP growth plus 1 percent). See, for example, James C. Capretta, “Paul Ryan’s Medicare Fix,” *National Review*, May 2, 2011, 30–33; Marilyn Werber Serafini, “FAQ: Obama v. Ryan on Controlling Federal Medicare Spending,” Kaiser Health News, August 29, 2012, www.kaiserhealthnews.org/stories/2012/may/04/obama-ryan-controlling-federal-medicare-spending-faq.aspx.


25. The 100 percent federal support phases down to a 90 percent federal match of state funding within five years, and many state officials doubt that such “generosity” will be sustainable under future federal budgetary pressure.

26. For example, one federal rule provides that medical assistance must be made available to those who qualify for Medicaid as categorically needy and categorically related eligible persons in the same “amount, duration, or scope,” and another federal Medicaid rule provides that similarly situated individuals must receive comparable services. See section 1902(a)(10)(B) of the Social Security Act. See also US Social Security Administration, “Medicaid Program Description and Legislative History,” *Annual Statistical Supplement*, 2010, www.ssa.gov/policy/docs/statcomps/supplement/2010/medicaid.html. However well-intentioned these uniform federal requirements once might have been, they often frustrate state efforts to created targeted benefits packages for specific populations or put reasonable limits on benefits for certain types of patients. The federal government also restricts state efforts to limit Medicaid beneficiaries’ right to choose a health care provider, including the location of the services, even when more narrow alternatives might be more cost effective and improve the quality of care delivered. Another federal rule provides that a Medicaid beneficiary is free to choose any “institution, agency, community pharmacy, or person, qualified to perform the service of services required . . . who undertakes to provide such services” (42 U.S.C. § 1396a(a)(23)).


28. However, Medicaid also provided, since its enactment nearly 50 years ago, medical assistance to other categories of low-income Americans not covered by the then-traditional Aid to Families with Dependent Children federal “welfare” program (such as those who are disabled or above age 65).

29. Cynthia Shirk, “Premium Assistance: An Update,” National Health Policy Forum Background Paper no. 80,


31. Rhode Island could organize and deliver services in a more targeted and cost-effective manner, across populations and acute and long-term care settings, to address the complex and interrelated needs of beneficiaries throughout their life-cycle. The state also could leverage its purchasing power to create new provider markets or drive change in existing ones through competition. The waiver also allows the state the freedom to implement strategies already successful in the commercial health insurance market that encourage and reward beneficiaries who take responsibility for their own health and welfare. See Tom Miller, “Taking Medicaid Off Steroids,” in The Great Experiment: The States, The Feds and Your Healthcare (Boston: Pioneer Institute, 2012), 84. Rhode Island also rebalanced its long-term care system. The state improved care management programs for children with special health care needs and adults with disabilities and promoted the availability of community-based services as an alternative to nursing home placement. See The Lewin Group, An Independent Evaluation of Rhode Island’s Global Waiver (Falls Church, VA, December 2011), 1–3.

32. In the first 18 months under the global waiver, estimated savings were $100 million, and the annual rate of growth in total Medicaid spending was reduced by more than half, from 7.94 percent to 3 percent. If the state’s Medicaid spending continues on the same path for the next three years, it will amount to a few billion dollars less than the cap agreed to for the five-year demonstration. See Miller, “Taking Medicaid Off Steroids,” 84.


34. Tarren Bragdon, Florida’s Medicaid Reform Shows the Way to Improve Health, Increase Satisfaction and Control Costs (Washington, DC: The Heritage Foundation, November 9, 2011); Florida Agency for Health Care Administration, Florida Medicaid Reform, Year 4 Annual Draft Report (Tallahassee, FL, 2012), www.fdhc.state.fl.us/medicaid/medicaid_reform/pdf/reform_draft_annual_report_yr4_070109-063010.pdf, 61, 99, 103 (table 46); Paul Duncan, “Evaluating Medicaid Reform in Florida: Lessons for Other States” (presentation, National Medicaid Congress, Washington, DC, June 8, 2010), http://mre.phhp.ufl.edu/talkpresentations/The%20National%20Medicaid%20Congress_Paul%20Duncan_Final%20PPT_06-08-2010.pdf, slide 17. The Florida waiver also saved the state’s Medicaid program up to $161 million annually. If implemented statewide, it could reduce Medicaid spending by up to $1.9 billion annually. If Florida’s Reform Pilot experience were replicated nationwide, Medicaid patient satisfaction would soar, health outcomes would improve, and state Medicaid programs could save up to $91 billion annually.

35. For example, section 2304 of the Affordable Care Act expands the definition of “medical assistance” that states participating in Medicaid are required to provide to encompass both payment for services provided and the services themselves. This would appear to require states to provide the actual services, if reimbursement levels for them fail to ensure sufficient access.

36. No single set of comparisons can control fully for other secondary factors, but let’s compare the average annual premiums for single (nonfamily) coverage of adults for private, employer-sponsored health insurance with annual costs for Medicaid coverage of adults. In 2010, private employer coverage premiums were $5,049 for single coverage and $13,770 for family coverage. The Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2010 Annual Survey, 2010, 12, http://ehbs.kff.org/pdf/2010/8085.pdf. For Medicaid, per-enrollee spending for health services was estimated to be $6,775 in 2010. But estimated per-capita spending for children ($2,717) and adults ($4,314) was much lower than that for aged ($15,495) and disabled ($16,963) beneficiaries,