Will Health Care’s Immediate Future Look a Lot Like the Recent Past?

MORE PUBLIC-SECTOR FUNDING, BUT MORE PRIVATE-SECTOR DELIVERY AND ADMINISTRATION, TOO

Mark V. Pauly
JUNE 2019
Executive Summary

Government spending on health care and health insurance will likely continue to grow despite recent Republican efforts to slow it. Public funding for care and insurance does face longer-term fiscal limits, but initial fiscal pressures have been largely met not by budget cuts, but by changes in how this spending is administered. Recent legislation and administrative changes have made total spending (whether financed by taxpayers or consumers) more “market-like,” often taking the form of de facto vouchers. The trend lines for the sources of funds (increasingly public) for health care and insurance and how they are delivered (through private insurers and other intermediaries in less-intensively regulated markets) move in the same direction: Both increase over time. Shifting the share of any increased total public subsidies (explicit and implicit) to become more market-like can potentially provide some operational efficiencies and make balancing political demand and private supply more feasible, at least until the sources of funding approach much tighter limits.
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More Public-Sector Funding, But More Private-Sector Delivery and Administration, Too

By Mark V. Pauly

After two years of Republican control of the presidency and both houses of Congress, it seems appropriate to consider the paths health policy and health care markets will likely follow for the remainder of President Donald Trump’s term and beyond. Future political events will influence some of this path’s direction, but much of it will follow a trail already in place.

A complete repeal and replace strategy for the Affordable Care Act (ACA) failed to garner sufficient Republican support in the Senate, but other administrative and legislative changes (e.g., the individual mandate, Cadillac tax, cost-sharing-reduction subsidies, risk corridor budget neutrality, Medicaid expansion, and insurance coverage requirements) have chipped away at pieces of Obamacare, and more efforts (e.g., association health plans, short-term insurance, and more permissive Medicaid waivers) are underway.

Each Trump administration effort to alter various ACA provisions was cited by ACA defenders and critics alike as a potential crippling blow to Obamacare, but the law’s basic structure limps on. However, Obamacare supporters have recently expressed pleasure that the Republican attacks and changes appear to have actually led to a stabilized, if not increased, government role in health care. Similar sentiments were expressed by the former Democratic insurance commissioner of Pennsylvania: “Republicans have inadvertently strengthened the hand of Democrats like me who prefer richer subsidies to a mandate and welcome the expanded federal role that will come with those subsidies.”

More recently, the November 2018 congressional elections demonstrated a clear shift in public sentiment, with greater popular support for retaining the ACA than for repealing or revising it extensively. Many campaigns by vulnerable Republican incumbents who had once supported ACA repeal and replace measures displayed notably greater defensiveness in retreating from their past positions to limit the law’s protections for coverage of individuals with preexisting health conditions.

The accuracy of further near-term forecasting may depend on how each wing of the health care process (finances versus operations) is actually configured. Even as the dollar amount of taxpayer-funded subsidies for health care continues to increase, the rules for how they are spent may continue a less-noticed trend of becoming more determined through private, market-like mechanisms, to such an extent that the final destination may be altered or at least more unpredictable.
What Is and Is Not “Market-Like” Versus “Government-Directed”?

The classic contrast between government and market mechanisms fundamentally turns on the number and variety of choices and the incentives that govern them. In full government financing and production, choosing what quantity and quality of services will be furnished to which members of the population is a collective choice and almost always one that allows for only limited variety in product and producer type. In contrast, in the classic model of competitive markets, individual demanders of products can choose what they want (or nothing at all) from what sellers offer at a given price, and those different sellers can decide what they want to offer and how to produce it.

A pedantic but important point in the theory of public finance is to distinguish among the ways financing, production, and choice of some good or service are determined—whether through collective and government-controlled mechanisms or private and individual means. While the three components often go together, there is no necessary reason that they do so, and sometimes they do not. Financing and choice can be separated from the bulk of government control. The classic example from 20th-century history is college spending under the GI Bill. Billions were spent helping veterans go to college, but they were largely free to use their “education vouchers” however they wanted and to use them at private or public institutions—as long as their spending on education, broadly defined by regulations and rules, was at least as much as the voucher. In this case, most of the financing was public, but the choice and production were private.

Vouchers allow public financing to be largely disconnected from both public production and collective choice—as long as voucher recipients meet the minimum purchase of the social good embodied in the voucher. Homestead subsidies in the 19th century and food stamps in the current day follow the same model: Recipients are generally as free to choose what they like as if they were buying in a market, and private and public sellers are free to compete for their business.

ACA opponents would argue that its provisions were designed initially with political goals in mind, primarily to extend the federal government’s control over health insurance financing and production arrangements. A friendlier view of the law would counter that it was designed to give consumers more power of choice among insurers meeting a minimum standard. However, the ACA’s final framework left a number of future conflicts and problems unresolved. Subsequent adjustments in regulation and enforcement and a handful of lesser statutory changes (with probably more to come) have diminished the federal government’s role substantially from what backers of the law originally envisioned. Roughly speaking, the coverage expansion (to the uninsured) remains, but many other features have been discarded or modified by the Obama and Trump administrations.

In this specific setting, I use market-like to mean the use of intermediary institutions and processes that deviate from the more government-directed procurement model that characterized traditional Medicare and Medicaid for many decades. As part of getting Obamacare past substantial political opposition and into law as an unfinished product, the ACA had to rely on multiple potential private sellers in its exchange marketplaces providing greater consumer choices and ensuring lower, competition-driven premiums. The law’s backers also had to rely on even greater involvement by managed care insurers to make its Medicaid expansion fiscally and operationally viable and therefore more politically attractive to states considering whether to adopt it.

This has meant something quite different from adopting an expanded version of traditional fee-for-service (FFS) Medicare (favored by Medicare for All backers) that would have a single government insurer set administrative prices for narrowly defined services. However, the extent of regulation of insurance options in exchange insurance is still a work in progress, as we shall see, with some intrinsic market-like elements (such as the structure of subsidies). But it also has the amount and type of regulation that, like a dial, can be (and has been) set at different levels by different states and administrations.

Market-like in this context should not be confused with anything close to theoretical models of vigorously competitive free markets, in which fully
informed decision makers can always make meaningful choices about coverage, payment, delivery networks, and premiums and whose outcome is as efficient as it can be. That full flowering of competitive equilibrium has never existed in health care or insurance, either before or after the ACA. However, there are some developments in the current environment that matter and have moved toward this structure.

Drew Altman, president of the Kaiser Family Foundation, recently observed that one linchpin of market-based insurance—having individual buyers pay more out of pocket for care—has been advanced by the design of Obamacare exchange plan options. They permit the choice of income-related, competitively bid, tax-subsidized plans with actuarial values below the average for group insurance and with substantial deductibles and cost sharing for individual insurance market buyers (at least before other ACA income-related, cost-sharing-reduction subsidies kick in). As far as any potential purchaser is concerned, the amount of his or her premium subsidy is fixed in dollars once that person’s income is determined, and it does not usually vary with which plan is chosen.

The pattern of individually fixed subsidies and varying metal-tier premiums (tied to the actuarial value of a plan’s coverage) combined to drive the great majority of exchange buyers toward high-deductible plans, rather than pay the extra cost in full for more generous gold or platinum coverage. The relative premiums between metal tiers have since been distorted somewhat by most insurers’ strategy of “silver loading”—increasing premiums only for silver-tier exchange plans as a response to their higher costs after cost-sharing subsidy payments were removed in late 2017. Nevertheless, the other pillar of market-like settings—choice among insurance plans with buyer responsibility for premium differences—largely remains in place in the ACA’s health insurance exchanges.

Even if more federal funds were to flow into the health care sector (perhaps to make up for reduced demand without an individual mandate, as former Commissioner Joel Ario anticipates), the higher government spending need not represent “an expanded federal role” if government policy continues to convert those subsidies—whether to the lower-income buyers of individual insurance, Medicare beneficiaries, states and citizens dealing with Medicaid, and even the bulk of the population under age 65 covered by private group insurance—into de facto vouchers in reasonably competitive private markets. How market-like are various insurance and care markets at present? Here I give an initial overview; details come later.

Medicare Advantage. Perhaps surprisingly, the insurance that is most market-like in terms of incentives for consumer choice and competitive supply is the one with the largest total federal subsidy: Medicare. This relatively new characteristic of the program stems from the increased availability of a large variety of comprehensive private plans in Medicare Advantage (MA), caused by reforms under the Medicare Modernization Act of 2003. About 35 percent of beneficiaries choose MA plans. Those plans are required to provide benefits equivalent to those in traditional FFS Medicare, and they charge the Medicare-required Part B premium. But they can and do offer additional benefits or lower net premiums. In effect, the current program offers all beneficiaries a voucher roughly equal in value to an estimate of the risk-adjusted, per-person cost of the traditional plan. Then beneficiaries are free to choose between the government-administered FFS plan and a variety of private plans.

For those who choose FFS Medicare or a private plan without drug coverage and then purchase drug coverage separately through a stand-alone Part D plan, their net cost of Medicare drug coverage is also reduced by a voucher whose amount is based on bids from private Part D plans. As far as each beneficiary is concerned, the voucher amount is predetermined for a benefit package that meets some rather complex and odd cost-sharing requirements.

Individual Insurance Markets. The situation for people under age 65 who do not obtain benefits through a job and might use individual insurance markets depends on their income. Those with incomes
greater than 400 percent of the federal poverty level (FPL) and who purchase individual coverage in either ACA exchange or “outside,” off-exchange markets do not receive a government subsidy, although other government regulations control plan design and provide plan information. For individuals with incomes between 100 percent and 400 percent of the FPL, federal premium subsidies are determined by the person’s family income relative to the premium for a benchmark plan (the second-lowest-cost silver plan, or SLCSP). However, this equivalent to a fixed-dollar voucher is available only for exchange plan purchasers.

Those in the lower range of incomes eligible for premium subsidies (between 100 percent and 250 percent of FPL) can receive additional cost-sharing-reduction subsidies that enhance the benefits of any silver plan in which they enroll, beyond its normal 70 percent actuarial value. Because the latter subsidies depend more on a specific plan choice, they are less market-like than are the broader income-related premium subsidies available for all exchange plans. Although there also is an opportunity to choose an exchange plan or an off-exchange plan at all income levels, the latter type of plan remains unsubsidized regardless of income.

On the supply side, the structure of relative premiums is regulated, but their absolute amounts are not. Premiums are set by sellers and can only vary with age, location, and smoking status, not with other observable characteristics of the buyer that might predict expected expenses. Similar requirements of modified community rating caused serious problems for the stability of individual markets in many states before the ACA was enacted, but the reason for the failure of a desirable and stable competitive outcome to emerge was largely due to government regulation, not failure of markets per se.

For the individual insurance market for nonpoor people under age 65, the ACA added the opportunity to buy subsidized coverage at exchanges instead of just in the unsubsidized traditional off-exchange market, and it regulated the extent to which premiums in both markets could vary with individual risk. The most market-like features of this design were intended to be (1) the opportunity to choose among competing insurance companies and plans and, (2) for individuals with incomes below 400 percent FPL, a predetermined subsidy based on their incomes relative to the premium for a benchmark plan. The income-related subsidy does not change with the generosity of the plan chosen. This voucher arrangement has become somewhat complicated by the requirements to offer lower levels of cost sharing to certain lower-income enrollees in exchange-based silver plans. Nevertheless, for those with incomes above 250 percent of FPL in the exchange market and for anyone purchasing insurance in the non-exchange “outside” market (the majority of buyers in the overall individual market as of 2015), the scenario remains one in which they received predetermined vouchers or no subsidy at all.

The most prominent departure from prior market-like arrangements for individual insurance is the prohibition on underwriting and the consequent requirement for each insurer to charge uniform premiums for people of a given age, location, and smoking status, regardless of other indicators of varying health risk. Another departure involves transfers across plans based on the risk mix of their eventual customers. Advocates of this policy alleged that it would improve market functioning by forbidding insurers to compete on the basis of targeting lower risks. Critics have pointed out that the combination of risk-rating restrictions and risk-adjusted transfers provides a subsidy to premiums for higher-income high risks. Perhaps more importantly, it imposes a potentially high tax on premiums for low risks that will likely drive such individuals to low levels of coverage or no coverage at all. These rating rules and the mandates that support them have also been cited as the cause of uncertainty, low profits, firm exits from exchange plans, and consequently limited numbers of sellers.

One can conclude that this part of the market at present is more market-like than some alternatives, such as universal, free public coverage. Its structure has led more people to choose plans with high cost sharing, because it contains consumer incentives to consider the higher premium of more generous coverage.
Medicaid. For Medicaid coverage for the poor, the first question is who decides which benefits to buy at what premiums. That decision maker is not the poor Medicaid beneficiary who pays little or no premium. Instead, state policymakers choose whom to cover, for what, and at what provider reimbursement rate. Federal rules further constrain these choices, and federal matching funds affect the marginal cost to the state of different policies.

Two recently discussed Medicaid changes, one actual and one potential, are worthy of note. The actual change is that the majority of states and beneficiaries now obtain their Medicaid insurance coverage from a private, contracted managed care firm, sometimes with several private options to choose from and other times with only a single contractor as an alternative to state-administered FFS arrangements. While states set the specifics of contracts and monitor contractor performance, many of the key decisions on which services to cover for whom may no longer be made by government employees but instead are contracted out to private firms that either compete directly for insureds or engage in competitive bidding for a state’s business. Sometimes private contractors set prices, and their bids for state business are always affected by the prices they end up paying.

The potential change in federal policy several Republicans are now discussing would involve moving from fairly heavy federal regulation of state agencies, which have open-ended federal matching of whatever amount a state chooses to spend, toward a more flexible block grant model. In this case, states would be given a predetermined amount of federal contribution (effectively, a per-person voucher to be managed by the state), which is usually adjusted for the potential number of eligibles and has less federal regulation.

Employment-Based Group Insurance. The last major segment of the insurance market is employment-based group insurance for workers under age 65 and their dependents. As already suggested, there is a major distortion in this market. The tax exclusion for group insurance premiums has been shown to lead to choices of more generous plans that then cause increased rates of utilization and higher health care prices, compared to lower levels for both when out-of-pocket payments are involved. This flaw is countered to some extent by the possibility of a tax-shielded health savings account coupled with a high-deductible health plan, an option chosen by 29 percent of people in this market. However, even those plans do not directly extend market discipline to choices among expensive treatments above the deductible, and the subsidy to the spending account attenuates incentives to choose tightly managed care plans.

Instead of cost-sharing choices among plans, the other primary option in the group market involves choosing among different plans with similar levels of cost sharing but different managed care rules or different networks, especially plans that are more or less permissive in terms of covering expensive new technologies and drugs that largely drive the growth in health spending. Some (larger) employers offer a wider range of plan options to their workers, but all firms can choose among these plan types in selecting at least one for their workers. While these options can offer a kind of “market in cost containment,” in which one can choose how and to what extent one wants premium growth to be slowed, the tax subsidy for group insurance premiums reduces the net saving to workers from choosing a more restrictive plan. The overall effects, compared to a capped or eliminated tax subsidy, are higher levels of spending and possibly higher levels of spending growth for those with the most generous subsidies, as well as further spillover effects to those with lower incomes and lesser subsidies who still have to buy in this distorted market.

Measures of Federal Spending and Federal Control: Levels and Trends

The overall qualitative picture then is one with at least some elements of markets present for many buyers of insurance and care, but with some variations. What are the levels and trends over time for taxpayer subsidies and government-affected choices (an upper-bound measure of collective influence) versus
the proportion of people subject to market-like influences because of voucher-type arrangements? I first present data on the levels and trends of tax-financed health care spending from 2008 to 2024; the later years include the government's own projection for the future. (This period is emphasized in my main analysis because it is the only one that provides estimates of all the key categories.)

The best picture is provided by the fractions of health consumption expenditures (HCE) associated with government. HCE is a measure of total spending on medical care and health insurance. It differs from the measure of national health expenditures commonly used by excluding costs for investment, such as research, structures, equipment, and some other items. It does include payments for care and insurance administration, both of which might be affected by government. Periods before 2008 show similar patterns of modest growth in the government share, following the earlier implementation of Medicare in 1965 and 1966. The shares of each of the components of total spending, including public and private insurers' administrative costs, have remained fairly stable over time. Projections for future years are based on the Centers for Medicare and Medicaid Services' (CMS) 10-year projections made in 2018. (Details of methods, including assumptions and extrapolations, are available in the appendix.)

A lower-bound measure of the extent of government spending (and influence) would be the total amount of explicit federal spending as outlays for medical care and health insurance in different government programs. In Table 1, I first used 2016 data from the CMS website (as the latest year available that matched the final year of presidential administrations) to describe current levels. The measure includes federal spending for Medicare, Medicaid, Children's Health Insurance Program (CHIP), exchange subsidies, and other federal programs. When similar data for 2017 became available in late 2018, I cross-checked for any significant changes in short-term spending trends and found none.

Columns 1 and 2 of Table 1 show the main categories of explicit federal government-controlled direct spending in health programs in 2016 and 2017, respectively: total government spending on Medicare, the federal share of Medicaid and CHIP, subsidies to exchange plans (i.e., premium tax credits, cost-sharing-reduction payments, and reinsurance), and other federal spending (i.e., Tricare, Veterans Affairs, etc.). As indicated, explicit federal spending amounts to nearly 40 percent of HCE. The data I use here are based on CMS tabulations of sources of funds for different kinds of plans. (There is another measure for Medicare showing a lower share that is based on data for sponsors of different plans and that excludes Medicare premium payments by beneficiaries, payroll taxes for the self-employed, and some other categories. Because Medicare payment rules apply to the total reimbursement through Medicare and do not distinguish between sponsors, I think the total amount from Medicare as a source is the best measure of federally controlled direct spending.)

Columns 3 and 4 of Table 1 add to this fraction with the implicit spending entailed in the loss of federal tax revenue for employment-based group health insurance (employer contributions and cafeteria-plan employee contributions) and tax losses from flexible spending accounts, health savings accounts, and itemized medical deductions in the federal income tax. They also add state payments for Medicaid and CHIP. (These columns do not include lost state and local income taxes from the exclusion of group insurance premiums.) Adding in these numbers pushes the total public share of explicit and implicit public spending on medical care to 55 percent of the total.

I then show trends in Table 2 by comparing those levels with those from four and eight years previously (2012 and 2008) and four and eight years after (2020 and 2024), along with an updated insert for the most recent 2017 data. The two earlier years antedate almost all spending associated with the ACA, while 2020 is the last year of President Trump's term. My projections are largely based on estimates generated by Medicare actuaries in 2018.

Table 2 shows the patterns over time of these two measures of government funding. The government share of medical spending has indeed been growing up to 2016. More growth is likely to continue at a
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moderate rate through the current Trump term, but at a somewhat diminished pace over the next four years. However, governments shape a much larger share of spending than the fraction they finance directly. Government affects and regulates the out-of-pocket payments for Medicare-covered services, any Medigap benefits, beneficiaries’ payments for their share of Part B and Part D premiums, and out-of-pocket payments for services covered by subsidized exchange plans. The generosity and prevalence of employer-sponsored insurance is shaped by the sizable tax-exclusion subsidy, especially for high-income workers. Relatively little additional regulation is associated with the tax exclusion per se, but state and federal rules determine which benefits must be included in employer group coverage and set restrictions on employee premium variation. Column 1 of Table 3 tabulates the shares of government-affected

Table 1. Direct Federal and Total Public Subsidies as Share of Health Consumption Expenditures, 2016 and 2017

<table>
<thead>
<tr>
<th></th>
<th>Direct Federal Subsidy Share (Percentage)</th>
<th>Total Public Subsidy Share (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016</td>
<td>2017</td>
</tr>
<tr>
<td>Medicare</td>
<td>21.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Federal Share of Medicaid</td>
<td>11.3</td>
<td>10.9</td>
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<tr>
<td>Federal Share of Children’s Health Insurance Program</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Marketplace Credits and Subsidies</td>
<td>1.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Other Federal Health Insurance and Programs Spending</td>
<td>3.4</td>
<td>3.5</td>
</tr>
<tr>
<td>Federal Direct Contributions to Employee Insurance</td>
<td>1.1</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Total Federal Direct Subsidies</strong></td>
<td><strong>38.5</strong></td>
<td><strong>38.4</strong></td>
</tr>
<tr>
<td>Federal Revenue Losses from Group Insurance Tax Exclusion</td>
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<tr>
<td>Income Tax Deductions for Self-Employed Insurance</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Income Tax Health Care Expense Deductions</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Exclusion of Workers’ Compensation Benefits</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Health Savings Accounts</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Other Federal Deductions and Exclusions</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>State Share of Medicaid and Children’s Health Insurance Program</td>
<td>6.6</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total Public Subsidies</strong></td>
<td><strong>54.6</strong></td>
<td><strong>54.7</strong></td>
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</table>

Note: Due to rounding, the numbers presented for each category of health spending may not add up precisely to the totals listed. Source: See appendix.
spending in 2016 and shows that it is close to 80 percent of all spending—not leaving much in the unfeathered, market-based category.

Nevertheless, this total money flow and its trend may overstate the degree of government control over the health care sector. Instead of describing the sources of public funding and the categories of spending subsidies, I next look at the institutional structures under which that money is spent and try to characterize the extent to which the setting for such government-influenced transactions operates more like a market. The second column of Table 3 tabulates the fraction of spending in the government-influenced category that might be classified as more market-like, and the last column converts that to shares of HCE. The point here is to distinguish between the trends in payment flows by the sector just described and the trends in degree of collective regulation or control over total spending.

To make some illustrative calculations, I assumed that the share of Medicare spending attributable to private MA spending is market-like, compared to the

### Table 2. Time Trends in Public Subsidy Shares of Health Consumption Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2012</th>
<th>2016</th>
<th>2017</th>
<th>2020</th>
<th>2024</th>
</tr>
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<tbody>
<tr>
<td>Direct Federal Subsidies</td>
<td>34.4</td>
<td>35.6</td>
<td>38.5</td>
<td>38.4</td>
<td>40.1</td>
<td>42.1</td>
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<tr>
<td>Indirect Federal and Total State</td>
<td>14.2</td>
<td>16.8</td>
<td>16.1</td>
<td>16.3</td>
<td>15.7</td>
<td>15.8</td>
</tr>
<tr>
<td>Total Subsidies</td>
<td>48.6</td>
<td>52.5</td>
<td>54.6</td>
<td>54.7</td>
<td>55.8</td>
<td>57.8</td>
</tr>
</tbody>
</table>

Note: Due to rounding, the numbers presented for each category of health spending may not add up precisely to the totals listed. Source: See appendix.

### Table 3. Estimated Shares of Government-Affected Health Consumption Expenditures: Total and Proportion Market-Like, 2016 (Percentage)

<table>
<thead>
<tr>
<th>Category of Specialty</th>
<th>Proportion Government-Affected</th>
<th>Adjustment Variable</th>
<th>Adjustment Factor</th>
<th>Proportion Market-Like</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medicare Spending (Including Medigap and Out of Pocket)</td>
<td>23</td>
<td>Enrollee Proportion in Medicare Advantage Plans</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>Total Medicaid and CHIP Spending (Including Out of Pocket)</td>
<td>18</td>
<td>Medicaid Managed Care Proportion</td>
<td>81</td>
<td>15</td>
</tr>
<tr>
<td>Total Exchange Spending on Insurable Services (Including Out of Pocket)</td>
<td>2</td>
<td>Federally Managed Exchanges</td>
<td>54</td>
<td>1</td>
</tr>
<tr>
<td>Total Employment-Based Spending in Insurance Services (Including Out of Pocket)</td>
<td>34</td>
<td>Proportion Self-Insured</td>
<td>61</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>77</strong></td>
<td></td>
<td></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>

Source: See appendix.
traditional FFS side of the program, which remains more heavily government controlled. For Medicaid I assume that the fraction of total spending in states made through private Medicaid managed care (MMC) plans is far more market-like than is the portion that remains administered by state-government employees. That difference takes two forms. Some states offer Medicaid beneficiaries the choice of different private plans. In others, the state administration, which makes the payments for the insurance, buys from competing private plans thorough bidding or negotiated arrangements. I regard either form—even if there is only a single winning private MMC plan chosen—as market-like. In exchange plans, I assume that the federally administered exchanges are more market-like than are the state-controlled ones.

Finally, I attribute total group insurance spending by self-insured employer plans—which are free from most state regulations—as much more market-like compared to the spending for fully insured employer-sponsored coverage, which is subject to state control and even somewhat more federal regulation under the ACA. However, the fraction of remaining privately insured persons covered by high-deductible health plans is not taken into account here, so this calculation may underestimate somewhat the extent of market arrangements in the private sector. The estimate of the market-like share of HCE in 2016 thus generated is 44 percent.

This illustrative calculation is just that—an oversimplified illustration. It sketches out the recent relative growth of spending that may be publicly financed but is less influenced by strict government control and instead operates in more market-like settings than in the past. Other attributions of portions of spending to the market are possible, but our emphasis here on trends is well illustrated by what we have chosen.

This general trend echoes the one Altman identified: a growing share of spending made in settings with more choices for consumers and state decision makers and more incentives for them to consider the cost of insurance and health care as they choose a type of coverage. The calculations also document the greater variety in choices actually made. Some Medicare beneficiaries choose MA plans, some exchange participants buy bronze (60 percent actuarial value) plans even when silver plans get extra income-related cost-sharing-reduction payments, some states contract out the administration of their Medicaid benefits, and many employers and workers eschew traditional insurance for alternative administrative and benefit arrangements. This great variety of choices presented a challenge to the acceptability and implementation of Obamacare, even with generous subsidies, and it is likely to present an even greater challenge in the future when government subsidies become more constrained. This also provides strong evidence that different Americans, even at the same income level, want different things with health insurance coverage and management and that diversity of preferences presents a challenge to collective choice.

Similar calculations for other years (depicted in Table 4) illustrate the trends in government-affected and market-like spending shares, past and future. They appear to move in similar, rather than opposite, directions. More government funding means “more market,” rather than less. As the share of government-influenced spending has risen, it has become more market-like, but that second trend dominates. The growth in the government share over 2008–24 is only 4 percent, while the growth in the market-like proportion is 36 percent. (The growth in public subsidy percentage share in Table 2 of 19 percent was offset by a smaller share for the tax subsidy.)

The main point is that the Obamacare chassis, in Republican hands, has been well structured for expansion of private market arrangements even if the fraction financed by federal funds is stable or rising. Such expansion is likely to occur for the near future.

This is obviously not the only way to forecast trends suggesting greater use of market-like features. If Medicaid funding is converted to state per capita block grants (still a Republican policy goal), taxpayers in the states affected will be looking at an even more market-like arrangement in which they directly bear the full marginal cost of any coverage expansion and, over a considerable range, could capture the savings from lower-cost arrangements, with (presumably) fewer limits on their choices about the activities (such as work requirements) attached to Medicaid.
coverage. They could also choose to convert Medicaid to a de facto voucher usable on the ACA exchanges or for other private managed care plans.

The tax subsidy’s effect on private group insurance also will be diminished somewhat as marginal income tax rates fall and reduced further (and made voucher-like) if the amount of spending subject to the full subsidy is capped eventually by either the Cadillac tax or through some more carefully designed tax-subsidy reform. Growing shares of high-deductible private insurance may offset some effects of more comprehensive insurance through Medicaid expansions. Finally, the budgetary projections for the impact of the Tax Cut and Jobs Act of 2017 may indicate reduced tax revenue, which, according to some congressional Democratic leaders, may constrain (eventually) federal subsidies to Medicare, Medicaid, exchanges, and other categories of federal spending most subject to the influence of politics and fiscal limits.

**A Look Just over the Cloudy Political Horizon**

How these trends might work out in the future with specific programs is the next crucial question to address. The empirical evidence is fairly convincing that there are somewhat offsetting trends in the respective roles of government and markets in the American medical care and insurance system. There is not only moderately increasing public financing but also rapid transition in many settings to more market-like arrangements.

**ACA Exchanges and the Individual Insurance Market.** ACA exchanges were originally envisioned to attract and support many private individual insurers, including for-profit, nonprofit, and consumer cooperative types. They would enter what was for many a new market with new rules to create a system that allowed them to cover their costs and offer reasonably stable premiums year after year. Those premiums would attract a large fraction of nonpoor individuals without access to group insurance or with limited access through their small-business employers. That initial vision has not materialized yet, and the current in-between states of many exchange markets have raised some serious problems. The exchanges were supposed to be like a “Travelocity” service for health insurance. People could search for and compare a wide set of competitive plans offered at different premiums, fortified if needed by a subsidy tied to income and benchmarked against whatever happened to be the SLCSP premium. This would be similar to how MA subsidies are benchmarked primarily against the per-person adjusted cost of traditional FFS Medicare.

This worked in some settings with a sufficient number of competing insurers, but in many markets there were only a few suppliers (and sometimes just one), which frustrated the subsidy strategy. This meant that the supplier of insurance could increase the size of the subsidy by setting a higher-than-competitive price for its silver plan. If there was a monopoly, then the sole seller (within limits) controlled the subsidy. If there were just a few sellers, one of them could raise its price. In that case, one would imagine that the expected subsidy would increase by

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**Table 4. Total Share of Government-Affected or Market-Like Health Care Spending (Percentage)**

<table>
<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2012</th>
<th>2016</th>
<th>2020</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government-Affected Health Care Spending</td>
<td>75.2</td>
<td>75.5</td>
<td>76.9</td>
<td>77.4</td>
<td>78.2</td>
</tr>
<tr>
<td>Proportion of Health Consumption Expenditures That Is Market-Like</td>
<td>36</td>
<td>40</td>
<td>44</td>
<td>47</td>
<td>49</td>
</tr>
</tbody>
</table>

Source: See appendix.
\( p \) times the increase in its premium, where \( p \) is the probability of ending up the SLCSP seller.

Results in recent years have deviated from the intended subsidy environment. Competition among insurers was supposed to anchor the premiums and subsidies, but that anchor in many places has been lost. The evidence on this point suggests that lower numbers of sellers are associated with higher exchange premiums, though the impact on quantities bought and off-exchange premiums has not been documented as thoroughly.\(^{26}\) That finding is consistent with strategic behavior to raise the SLCSP premium level.

The other trend is greater variability across states in how exchanges behave and are regulated. Some states (such as California and Connecticut) use exchanges as an extension of state regulatory and political power, favoring certain kinds of coverage and insurers and as-yet unproven delivery models. Early on, many states favored consumer cooperatives (newly organized in response to the law), which set low premiums, lost millions, and exited exchange markets. The opposite model is a “hands-off” approach in which exchanges have small budgets, do the minimum required by law to keep subsidies flowing, and have little volume. In between are exchanges that integrate to a considerable degree with state Medicaid policies and administration, using the same management bureaucracy and the same type of enrollment and contacting mechanisms. Depending on state politics, they may also emphasize things such as work requirements, health savings accounts, emphasis on preventive care, and actions to affect the social determinants of health.

Because exchange behavior is strongly related to and controlled by state political behavior, future forecasts depend both on whether states will generally lean further right or left and whether federal oversight will be permissive for such leanings.

ACA exchanges primarily serve highly subsidized buyers—those with lower incomes receiving premium tax credits and those with very costly health conditions gaining access to comprehensive benefits and protection by ACA regulations from individualized risk rating (and often a combination of both). This trend will increase as higher-income and healthier individuals exit those same markets when they face even greater hikes in unsubsidized premiums. Removing the individual mandate’s tax penalty and curtailing subsidies for insurers required to reduce cost sharing for lower-income enrollees, or insurers that attract a larger share of high-risk individuals, may lead to higher benchmarks for subsidies pegged to increased gross premiums for SLCSPs. Continued reductions in the number of insurers offering exchange-based coverage in many local markets have limited the fraction of those markets that can claim to face competitive pricing pressures.\(^{27}\) Even more exchange plans will operate like “Medicaid Plus” plans, serving a disadvantaged small minority of the population that enrolls in plans with more limited but less costly provider networks.

Users of the exchange plans will be low-income, low-risk individuals who receive a near 100 percent subsidy; other generously subsidized, low-income, moderate-risk enrollees; and a small number of heavily subsidized, high-risk purchasers at all income levels.\(^{28}\) The composition of off-exchange business in the individual market is more difficult to predict. With regulations recently changed to permit 12-month “short-term” plans with underwriting and guaranteed renewability, there may be an increase in business. If not, this market will be limited to unsubsidized, higher-income, older-but-still-moderate-risk individuals who find the benefit packages more attractive than those available on exchanges.

**Medicaid.** Medicaid remains in a politically unstable situation, inviting further change. Fourteen Republican states continue to reject federal taxpayers’ largesse to tempt them to add nondisabled poor adults to their programs.\(^{29}\) If getting at least 90 cents on the Medicaid expansion dollar from Washington still cannot close the deal, what else might?

Various efforts to offer states waivers to permit more operating discretion have produced some changes thus far in specifications of plan design and conditions for eligibility, but none that are known to have appreciably affected costs for the federal government or the states. The trend to contract out Medicaid administration in an
approximation of competitive bidding seems likely to continue, and states are responding to bids for administering different program features by choosing some and dropping others. At least at the state taxpayers level, there is a market in alternative plans they could offer to their lower-income citizens, distorted only by federal matching rates that require them to share any savings with the federal government and, apparently, leading high-income states to maintain generous programs with easy entry.

A more comprehensive version of the Trump administration’s Medicaid reform ambitions would need to revive block grant funding, ideally linked to some concept of the numbers of medically needy in the state (with or without private insurance but with the greatest gap between likely medical expenses and available income). Some states favor the greater flexibility such grants provide, and federal budget officials definitely like the predictable and predetermined spending they entail. These block grants, potentially divided for different Medicaid subpopulations, would in effect function as state-government-level vouchers, with the states incentivized to economize on any spending in excess of the voucher or grant because it must be funded with 100 percent of their own money.

Any move in this direction would only extend and intensify the underlying trend already well underway in most states’ Medicaid programs—the greater delegation of plan management and design to private managed care firms. In some states these firms are chosen in a quasi-bidding process. In others the state announces what effectively is a per capita payment rate (voucher) and permits any qualified firm to accept it and compete for a share of the state’s Medicaid business. The point is that for almost all Republican and many Democratic states the Medicaid program has been effectively privatized at the operational level in much the same way and even to a larger extent than Medicare under MA. While there are a few states where state bureaucracies administer Medicaid, the trend is toward private management. The specificity of the rules under which private firms operate also varies across states, but the trend is toward greater permissiveness as long as spending growth and complaints (from providers and beneficiaries) remain low.

**Medicare.** The Medicare program is already a voucher program. Any beneficiary can choose between the FFS Medicare and a number of private MA plans. The cost is financed primarily with an effective voucher approximately equal to the estimated risk-adjusted taxpayer cost of that person in FFS Medicare. This feature guarantees that the government-run FFS Medicare program will have premiums equal to its legally required levels (25 percent of average spending levels for FFS Medicare’s Part B and Part D programs), and FFS enrollees will not be subject to additional out-of-pocket premiums above that level even if FFS Medicare’s cost increases more than those for MA plans.

Several years ago, Paul Ryan, then House budget committee chairman, was concerned about cost growth in FFS Medicare, which is not directly subject to market forces or discipline. He proposed a Medicare reform based on premium support. In its purer form, premium support disconnects the predetermined payment amount from whatever FFS Medicare’s cost turns out to be. Instead, it uses some other method (variations of enrollment-weighted competitive bidding from MA plans and the estimated average, pre-risk-adjusted cost of FFS Medicare in a given geographic market) to determine the voucher amount. Opponents fear that this could lead to traditional Medicare premiums rising more than is politically acceptable, at least in some parts of the country.

However, recent budget constraints on FFS Medicare spending growth in Parts A and B, primarily from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the ACA’s annual hospital “productivity” cuts in provider payments, may turn it into something closer to a publicly predetermined per-beneficiary payment linked to FFS Medicare’s administered price costs anyway (unless volume gets out of control). One way or another, the voucher amount will be decided politically. However, the functioning of markets does not really depend on the voucher amount per se (though what beneficiaries will get from markets does).
The issue yet to be confronted is how attractive FFS Medicare will continue to be when even more serious limits on its cost and reimbursement growth kick in during the mid-2020s. For the immediate future, one may expect continued growth in private MA plans and perhaps a transfer of the mantle of innovation to private plans from FFS Medicare and its intrusive but thus far ineffective Accountable Care Organization and bundling models.\textsuperscript{33}

The wild card for Medicare is the drug benefit. It has no government-managed option; all plans are offered by competing private firms. Despite some fairly persuasive evidence that the private drug plans currently offered in Part D have succeeded in bargaining down drug prices as much as can be achieved, there remains a bipartisan desire (and faith-based impulse) to see if the federal government could wield its supposed greater bargaining power to do better. Never mind that effective bargaining (especially for a high-benefit new product with few close substitutes) would imply the willingness of an insurer to walk away and leave its beneficiaries without financing for the purportedly latest and greatest. Political hopes persist for rolling out an updated government procurement model for drugs, along with bully pulpit attempts to jawbone prices down. The political appetite for price controls poses the most likely threat to a more uniform evolution toward a market model.

**Public and Private Spending.** On the public spending side of health care, FFS Medicare’s growth has been constrained by legislation. Medicaid growth may be limited by political bounds even if current open-ended characteristics are retained. Changing to block grants or other devices to give states more flexibility are the most likely ways to do so. However, it seems reasonable to predict that growing real income will lead to a willingness by the population under age 65 (especially those better off) that have private insurance coverage to spend more on new health-improving products and to do so at a faster rate than their incomes grow.\textsuperscript{34} Although financing this higher spending will cause grumbles in the private sector, past increases in demand have usually been accommodated by private insurance.

In contrast, any similar accommodation by public program health coverage directly financed by taxpayers who had to pay providers at rates somewhat equivalent to those of private insurance plans would also have to raise taxes for public programs relative to income. But the primary tax bases used for federal spending historically have at best increased at rates roughly proportional to income (income tax) or somewhat slower-growing wages (payroll tax), and no greater expansion of the tax base is in sight. Either financing an ever-growing share of gross domestic product will require higher tax rates, subject to political and economic objections, or the level of reimbursement in taxpayer-financed insurance programs would need to fall even further behind the private level. As taxpayers become better-off, they conceivably could choose to favor higher taxes for public in-kind transfers to the poor and the elderly (through Medicaid and Medicare), but it is an understatement to say that such a shift is by no means automatic. In other words, the public sector faces far greater political and economic challenges in financing spending growth linked to rising medical costs.

If public spending growth on health entitlements hits what are thought, by the Medicare actuaries and other fiscal forecasters, to be unsustainable levels, more market-like arrangements will not emerge automatically from the wreckage.\textsuperscript{35} Nevertheless, the political desire to unload the responsibility for additional public payments through less-visible, off-budget means suggests that they might. Government officeholders essentially may tell non-low-income Medicare beneficiaries and their providers: “Here is how much money you can expect from us. If you want more, spend your own money or do the best you can.” Federal officials may convey the same message to states for their Medicaid programs.

Will both federal and state policymakers decide to shift such unpleasant political balancing acts to more market-like arrangements with spending constrained by fixed-dollar vouchers and block grants? The main alternative (depending on the direction of the political winds) may be a far more sweeping government takeover of health care spending decisions through administered prices and limits on
costly technology, as has occurred in other developed countries.

**Future Politics**

Health care market forecasts are subject to politically driven changes in current law or regulations, and the predictability of politics, to say the least, has become even lower in the current environment. However, the near-term projections up to the end of President Trump’s term in 2020 still seem fairly plausible. Even after Republicans lost control of the House of Representatives in the 2018 elections, the status quo in legislation and the continuation of executive branch efforts to reduce regulation remain likely to continue (somewhat similar to the last two years of the George W. Bush administration).

What would come after that? If control of the federal government is reshuffled but still remains divided after 2020 (e.g., Democrats elect a president, but Republicans hold at least one branch of Congress), a continued pattern of gridlock would make projection of only modest changes to the mostly stable trends of the recent past seem plausible.

But what if Democrats do capture full control (like in November 2008) and seek to pursue an agenda involving Medicare for All or Medicaid Options for All? It may remain hard to stuff the institutionalized genies behind MA and Medicaid private managed care plans back into their bottles, so some limited version of market-like arrangements there may persist. Overall, even when the current period of Republican control in the executive branch ends, the political constituency in place for market-like coverage—such as MA and Medicaid arrangements, and even for many exchange plans—will pose substantial transition barriers. Being able to keep the insurance you like may be hard to challenge politically yet again.

Of course, greater stability and better outcomes would ensue if some organized and bipartisan agreement could be reached on where market-like arrangements should continue to grow and where subsidies need to be trimmed or increased. Another useful agreement would decide which regulations of premiums and subsidy designs do the best job of targeting public subsidies to where they are most needed in ways that distort consumer and governmental choices the least. Today’s haphazard mix of markets, collective choice, and governmental administration needs to be changed. This report suggests some directional possibilities, but experience teaches us to expect them to develop later than sooner.

**About the Author**

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**Acknowledgments**

I thank Grace Patrice for excellent research assistance.
Appendix

The historical and projected direct federal shares of total health consumption expenditures (HCE) shown in Tables 1 and 2 of the report were calculated using data from the Centers for Medicare and Medicaid Services (CMS), the Congressional Budget Office (CBO), and the Joint Committee on Taxation (JCT). All CMS projections of national health expenditures and enrollment used in the report were from the CMS Office of the Actuary. Historical annual Medicare and federal share of Medicaid expenditures were obtained from CMS Table 3 “National Health Expenditures by Source of Funds.” The corresponding projected annual expenditures were obtained from CMS Table 3 “National Health Expenditures by Source of Funds” (for Medicare) and CMS Table 16 “National Health Expenditures, Amounts and Average Annual Growth from Previous Year Shown by Type of Sponsor” (for the federal share of Medicaid).37

The historical and projected annual federal direct contributions to employee insurance were taken from CMS Table 5-6 “Private Health Insurance by Sponsor” and CMS Table 16 “National Health Expenditures by Sponsor,” respectively.44

The historical and projected implicit public subsidy shares of total HCE shown in the report tables were also calculated using the CMS, CBO, and JCT data. The historical and projected values of the federal tax losses from group insurance for 2016, 2017, 2020, and 2024 were extracted from Table 2 of the 2016 and 2017 CBO reports “Federal Subsidies for Health Insurance Coverage for People Under Age 65: Tables from CBO’s March 2016 Baseline” and “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027.” Because values were not reported for 2008 and 2012, an estimate was made by creating a weighting factor consisting of the ratio of the value of the federal tax exclusion for employment-based health insurance coverage to total employment-based group health insurance premiums. The federal tax exclusion for employment-based coverage for 2016, obtained from the 2016 CBO report, was $266 billion, and the total employer-sponsored health insurance premiums for 2016, obtained from CMS Table 21 “Expenditures, Enrollment and Per Enrollee Estimates of Health Insurance,” was $991 billion for 2016. The resulting weighting factor of 0.27 was then applied to the total employment-based group health insurance premium expenditures for 2008 and 2012, obtained from CMS
Table 21 “Expenditures, Enrollment and Per Enrollee Estimates of Health Insurance,” to create an estimate of the 2008 and 2012 federal tax exclusion for employment-based group health insurance.

The historical and projected values of the income tax deductions for the self-employed, the income tax expense deductions (including deductions for medical and long-term care expenses), and the exclusions related to health savings accounts were obtained from the JCT reports of estimates of federal tax expenditures for fiscal years 2008–12, 2012–17, 2016–20, and 2017–21.47 The projected 2024 values of these items were not reported, and, therefore, estimates were made using the available data and applying a linear best-fit function. The values of the deductions for charitable contributions to health organizations, tax credits for small businesses purchasing employer insurance, tax exclusions associated with flexible savings accounts, and exclusions for interest on state and local government-qualified private activity bonds for private nonprofit hospitals were consolidated and reported as “other federal deductions and exclusions” in Table 1 of the report.

The values of the individual components of this item were derived from the JCT reports of estimates of federal tax expenditures for fiscal years 2008–12, 2012–17, 2016–20, and 2017–21, as well as the JCT report “Exclusion for Employer-Provided Health Benefits.”48 Because the 2024 values were not reported, an estimate was made using a linear best-fit function. The historical state share of Medicaid and CHIP expenditures was obtained from CMS Table 3 “National Health Expenditures by Source of Funds” and CMS Table NHE2016.49 (Projections for 2020 and 2024 were only reported for total CHIP and were found in CMS Table 17 “Health Insurance Enrollment and Enrollment Growth Rates.”50) Therefore, the 2020 and 2024 federal share of CHIP expenditures (obtained from “Detail of Spending and Enrollment for the Children’s Health Insurance Program—CBO’s January 2017 Baseline”) were subtracted from total CHIP expenditures to obtain the state share.51

Direct federal and implicit public subsidies were expressed as a share of annual total HCE, obtained from CMS Table 3 “National Health Expenditures by Source of Funds Selected Calendar Years 1960–2016” for historic HCE and CMS Table 4 “Health Consumption Expenditures by Source of Funds Calendar Years 2010–2026” for projected HCE.52

The historical and projected estimated proportions of total HCE that were considered government-affected or made in market-like settings are presented in the report in detail in Table 3 for 2016 and in summary format by year in Table 4. They were derived from data reported by the CMS, the CBO, the Board of Medicare Trustees, the Kaiser Family Foundation (KFF), and the Medicare Payment Advisory Commission (MEDPAC) referenced below. The categories of government-influenced health expenditures shown in Table 3 included the totals of spending on Medicare, Medicaid, and CHIP; Health Exchange insurable services; and employment-based insurance services, shown as a proportion of total HCE. (Note that a residual of health expenditures remains that is not government-influenced, and it is not included in this table’s percentages of total HCE in the estimated years.)

The components of total Medicare expenditures included Medicare benefits, Medigap purchases, and out-of-pocket spending. The sources of historical and projected Medicare expenditures and enrollment have previously been described.53 Historical Medigap expenditures were available in CMS Table 21, “Expenditures, Enrollment and Per Enrollee Estimates of Health Insurance.”54 Although projected Medigap expenditures for 2020 and 2024 were not reported, projected total direct individual purchased insurance expenditures, including Medigap, Exchange, and other direct insurance purchases, were available from CMS Table 17, “Projected Health Insurance Enrollment, and Enrollment Growth Rates.”55 An estimate of the Medigap expenditures for 2020 and 2024 was calculated by multiplying the CMS projected total direct individual purchased insurance expenditures for 2020 and 2024 by a weighting factor of 0.2, derived from the ratio of the value of 2016 Medigap expenditures ($18.7 billion) to 2016 total direct individual purchased insurance expenditures ($95.5 billion).56

The total historical and projected Medicaid and CHIP expenditures also were obtained from CMS
Tables 17 and 21. Medicaid-related out-of-pocket spending was assumed to be nominal and, therefore, was not considered in the calculation of total Medicaid expenditures. Total Health Insurance Exchange spending included premium expenditures and related out-of-pocket spending. Exchange insurance premium spending was first reported for 2016 in CMS Table 21 “Expenditures, Enrollment and Per Enrollee Estimates of Health Insurance.” Projected Exchange premium spending was not reported and, therefore, was estimated by multiplying the CMS projected total direct individual purchased insurance expenditures (including Exchange premiums) for 2020 and 2024 by a weighting factor of 0.5, derived from the ratio of 2016 Exchange premium expenditures ($47.3 billion) to 2016 total direct individual purchased insurance expenditures ($95.5 billion). The total employment-based insurance spending consisted of group insurance premiums paid by employers and employees and related out-of-pocket expenditures. Historical and projected employment-based group insurance premium expenditures were obtained from CMS Tables 17 and 21.

Total historical and projected insurance-related out-of-pocket spending was calculated by adding total out-of-pocket expenditures for physicians and clinical services, hospitals, and prescription drugs obtained from “Historical” CMS Table 7, “Hospital Care Expenditures,” Table 8, “Physician and Clinical Services Expenditures,” and Table 16, “Retail Prescription Expenditures” and from “Projected” Table 6, “Hospital Care Expenditures,” Table 7, “Physician and Clinical Services Expenditures,” and Table 11, “Prescription Drug Expenditures.” Shares of total out-of-pocket expenses were subsequently allocated to Medicare, Health Insurance Exchange, and employment-based insurance programs based on the relative amount of expenditures attributable to each program.

It was assumed that out-of-pocket expenditures by purchasers of Medigap plans would be nominal. Therefore, the fraction of total Medicare enrollees who also purchased Medigap coverage was multiplied by the total Medicare benefits expenditures to get the share of total Medicare expenditures attributable to purchasers of supplemental insurance. The Medigap enrollee share of total Medicare expenditures was subtracted from total Medicare expenditures before determining the out-of-pocket spending allocation weight for Medicare. To perform these calculations, the total historical and projected Medicare enrollment was obtained from CMS Tables 17 and 21. Medigap enrollment was available for 2010 through 2015 and obtained from MEDPAC’s February 2017 report “Trends in Medigap Enrollment, 2010 to 2015” and America’s Health Insurance Plans’ April 2017 report “Trends in Medigap Enrollment and Coverage Options, 2015.” Medigap enrollment for the unreported years was estimated by applying a linear best-fit function to the available enrollment data.

The total historical and projected employment-based insurance beneficiary enrollment was obtained from CMS Tables 17 and 21. The historical Health Insurance Exchange enrollment was first reported by CMS in 2016 and was available in CMS Table 21. Projected Exchange enrollment for 2020 and 2024 was not reported. However, total historical and projected direct purchased insurance beneficiary enrollment (including Medigap, Exchange, and other direct insurance) was available in CMS Tables 17 and 21. Because, at the time of this calculation, CMS only reported Exchange enrollment data for 2016, a weighting factor consisting of the ratio of Exchange enrollees (10 million) to total direct individual insurance enrollees (24.8 million) for 2016 was calculated to be 0.4. It was assumed that this relationship was maintained through 2020 and 2024. Therefore, an estimate of the Exchange enrollment for 2020 and 2024 was calculated by multiplying the CMS projected total direct individual purchased insurance enrollment for 2020 and 2024 by 0.4.

The share of total out-of-pocket expenditures attributable to Medicare, employment-based insurance, and Exchange beneficiaries was calculated by dividing the enrollment numbers in each insurance program by the sum of enrollment in all three programs (obtained from CMS Tables 17 and 21) and using the weighting factor method described above to estimate the 2020 and 2024 Exchange enrollment) to obtain the allocation fraction of total out-of-pocket spending to be assigned to each program. The total
out-of-pocket expenses considered were for hospital care, physician and clinical services, and prescription drugs and were obtained from CMS Tables 7, 8, and 16 for historical data and from Tables 6, 7, and 11 for the projected numbers. The dollar amount of out-of-pocket spending on Medicare, employment-based insurance, and Exchange beneficiaries for each year was obtained by multiplying the annual allocation fraction of out-of-pocket expenditures for each program by the total annual out-of-pocket expenditures. The out-of-pocket expenditures for Medicare, employment-based insurance, and Exchange beneficiaries were then added to the expenditures for Medicare and Medigap premiums, employment-based premiums, and Exchange premiums to obtain the totals for each category of health insurance spending. These were divided by the historic and projected total annual HCE to obtain the proportions of HCE that were government-affected.

The market-like adjustment factors to government-influenced spending included the Medicare enrollee proportion in Medicare Advantage plans, the Medicaid managed care proportion of total Medicaid, the fraction of the total number of Health Insurance Exchanges that are wholly federally managed, and the share of workers with employment-based coverage who were in self-insured plans. The historical and projected Medicare Advantage and total Medicare enrollment were obtained from Tables IIIA.3 and VB.4 of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds Boards of Trustees’ 2009 and 2017 reports.

Information on total Medicaid managed care enrollment as a percentage of total Medicaid enrollment was available for 2007 through 2014 through the KFF and CMS’s 2014 Medicaid managed care enrollment report. The Medicaid managed care share was 0.71 for 2008, 0.75 for 2012, and 0.81 for 2016. Because additional enrollment data were not available, enrollment was forecasted through 2024 using a linear best-fit function.

The fraction of federally managed Exchanges was available for 2015 and 2018 from the KFF report “State Health Insurance Marketplace Types.” Only federally facilitated exchanges were included—that is, state-based exchanges using a federally facilitated information technology platform were excluded. I assumed one less federally facilitated exchange in 2016 than 2018, which is the same number as 2015—that is, 27 federally facilitated exchanges and 50 exchanges in total; the federal facilitated fraction was 0.54. For 2020, I assumed one newly created federally facilitated exchange from 2018 (not converted from a state-run exchange)—that is, 29 federally facilitated exchanges and 52 overall; the federally facilitated fraction was 0.56. For 2024, I assumed one more newly created federal exchange—that is, 30 federally facilitated and 53 exchanges overall; the federally facilitated fraction was 0.57.

The proportion of self-insured workers was obtained from KFF’s 2015 “Employer Health Benefits Survey.” The share of the self-insured from 2016 through 2024 was estimated using a linear best-fit function.

The proportion of HCE that was both government-affected and market-like for 2016 was obtained by taking the sum of the products of:

- Total Medicare spending proportion of HCE and the proportion of enrollees in Medicare Advantage plans (Table 3, second row);
- The total Medicaid and CHIP spending proportion of HCE and the proportion of Medicaid enrollees in Medicaid managed care plans (Table 3, third row);
- The total Exchange spending on insurable services proportion of HCE and the proportion of Exchanges that are federally managed (Table 3, fourth row); and
- The total employment-based spending in insurance services proportion of HCE and the fraction of workers in self-insured plans (Table 3, fifth row).

This process was repeated for 2008, 2012, 2020, and 2024 and presented in summary format in Table 4 of the report.
Notes


9. The initial benchmarks for MA plan payments in a particular county are adjusted further to reflect that country’s particular quartile of per capita Medicare FFS spending (higher percentage adjustments are applied to countries with the lower FFS spending). The benchmarks also are adjusted by MA plan quality. Congressional Research Service, “Medicare Advantage (MA)—Proposed Benchmark Update and Other Adjustments for CY2020: In Brief,” February 7, 2019, https://fas.org/sgp/crs/misc/R45494.pdf.


18. See the appendix.

19. Explicit spending excludes government influenced spending.


nationalhealthexpenddata/nationalhealthaccountshistorical.html. For the state share of Medicaid in Table 1, the 2016 values were obtained from CMS Table 3. For state share of CHIP in Table 1, the 2016 values were obtained from CMS Table 19.


35. Pauly, Health Reform Without Side Effects.


42. Centers for Medicare and Medicaid Services, “Historical,” Table 3.
43. Centers for Medicare and Medicaid Services, “Historical,” Table 17.
44. Centers for Medicare and Medicaid Services, “Historical,” Tables 5-6 and 16.
50. Centers for Medicare and Medicaid Services, “Historical,” Table 17.
53. Centers for Medicare and Medicaid Services, “Historical.”
55. Centers for Medicare and Medicaid Services, “Historical,” Table 17.
56. Centers for Medicare and Medicaid Services, “Historical.”
61. Centers for Medicare and Medicaid Services, “Historical,” Tables 7, 8, and 16; Centers for Medicare and Medicaid Services, “Projected,” Tables 6, 7, and 11.
67. Centers for Medicare and Medicaid Services, “Historical.”
69. Centers for Medicare and Medicaid Services, “Historical,” Tables 7, 8, and 16; and Centers for Medicare and Medicaid Services, “Projected,” Tables 6, 7, and 11.
70. Centers for Medicare and Medicaid Services, “Historical.”


