The Uncertain Future of Paying for Medical Care

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Cost containment: This time we really mean it!

- Medical spending (not “cost”) growth has historically outpaced almost every economic aggregate—GDP, disposable income, tax revenues, you name it.
- No one expects to reduce spending, but economic prospects for Medicare and health reform will be greatly assisted by slowing the rate of growth.
- And political prospects require it.
- But how to do it, in a way that does more good than harm, and that is likely to work?
The general problem (according to me)

• There are and always have been “promising” devices to slow spending growth.
• But most, even though “promising,” have not worked, and the few that have we haven’t liked (HMOs, cost sharing).
• So what should we try now, and who are “we” anyway?
• Nature will not willingly divulge her secrets here—if she has any.
Plan of talk

• Some overall background on health reform and Medicare’s sustainability, spotlighting the role of “cost containment” as part of financing.

• Discuss options in terms of expected (best guess) effects and risk/imprecision (worst case).

• I will argue that a “good” method is not only one that is effective if it works as well as hoped but not so bad if it does not.
The specific problem (according to me)

- We want and perhaps need things that slow growth a lot over a long period of time. But that desire to solve a problem does not mean that there exists a solution.
- Things that we know work tend at best to be small and one shot and/or to have side effects: HMOs and APNs.
- There is a large lump of “waste” (25-50%) but is it inefficient (in the sense that we know what to do about it in mutually beneficial ways)? Or is medical waste like winter in North Dakota—generally undesirable but impossible to change with reasonable effort?
- And for this we have only promising but unproven ideas—that may not work. Nothing approvable by the FDA of cost containment as proven safe and effective.
- Plus, what for an encore on future growth and waste?
Options in the ACA (and hypotheses they represent)

- More preventive care and wellness.
- Medical home/bundled payment/ACOs/pay for outcomes.
- Cadillac tax
- Insurance reform
- Others? (Single payer/public option?)
The case for being cautious on medical care cost containment

- Technology to date appears to have provided more benefits than cost (though a little less benefit might save a lot on cost).
- People with growing incomes want to spend more on increasing quantity and quality of life—up to a point still much above where we are now.
- But the lower income part of the under 65 population is now priced out of progress, as is Medicaid—and Medicare may be soon!
But the grim future awaits.

- Tax burdens to pay for old folks and poor (and not-so-poor) folks’ medical care projected to take a third or more of GDP in 20 years.
- Medicare’s potential savings already used to cover the uninsured.
- The high prospective tax rates are said to be politically if not economically infeasible.
- Not because we want to, but Medicare as we know it and ACA as passed will have to change!
Options going forward

• Do nothing much now and hit the wall at 90 miles an hour (especially for Medicare).

• Try to engineer and plan our way out. “Give me that chart!”

• Premium support for Medicare (and everything else): use the current quiet period to warn 50-somethings not to count on the same “Medical Christmases” as prevailed earlier, and to rely only on a limited promised amount of growth in public funding (Medicare without Magic).
Tax my benefits, please!

- Current tax subsidy of $200B + for generous coverage for better-off Americans.

- ACA in 2018 will tax *insurer* 40% if plan cost is above about $27,500. This raises money and offers incentives for frugality for those who need to be frugal. (“Persuade insurers to offer cost effective plans.”) Not the best but it will have to do.

- Best case: taxing all benefits could cut under 65 spending by 30% *and* slow (or at least validate) future growth.
What if people keep buying resource guzzlers?

• Worst case: upper middle class do not curtail their generous benefits or their lavish Christmas spending.
• Will still raise revenue to subsidize lower income health insurance.
• And if high income people decide they value high cost care so much, it should not be cut: but they will be paying for it themselves.
ACOs, medical homes, and bundling

• Combines “coordination” by a nice person, use of formal organizational structure, and capped payment.
• Could use brute force to control capped payment: budgetary target.
• And, this time, *typical* docs and hospitals might actually work and play well together—and patients might be more docile.
• So give it a shot!
But will it work?

- Limited numbers of MDs with the right attitude?
- IT will increase quality but not lower cost.
- Can a hospital really coordinate an outpatient care/wellness/conservative care model? If not, who is the entrepreneur?
- So it could be a big waste of money and effort (again), with no upside (other than learning).
Preventive care and wellness

• People I respect say wellness can work.
• *Medical* preventive care with current technology will not save money at the margin, only lives.
• Plus just postponing higher cost does not really save much at low interest rates.
• If only behavior could be changed, that would matter. But where are the Mac and Cheese programs?
What if it doesn’t work?

• We waste money—paying for physicals as a Medicare benefit.

• We waste time: reduced prevention in the Rand experiment would have worsened health if the experiment had run more than 5 years—but what if not?

• We waste energy: so much hope by politicians and policymakers: could be HMO-like “failure” all over again.
Insurance reform and cost containment

- Not much there in terms of profits: 4%
- Administrative costs are the price of choice, and are a small and constant fraction of total NHE.
- Murphy’s Law of Ratios: you maintain profits and increase MLR by being more permissive on claims and costs.
- Plus community rating and no exclusions cannot be taken literally. Bad side effects in terms of covering the uninsured.
Conclusion: Long term cost containment and best bets

• Medicare’s financing problem is made worse because it is financed by current taxes which generate serious distortions.

• Health care is a luxury good—which means ever-increasing marginal tax rates!

• Why not 100% tax financed single payer? Could/would limit cost by regulation—but what of benefits, choice, and functioning of the rest of the economy with an additional trillion in taxes?
Wrenching choices

• OK to pay for a luxury good privately—it’s your money and your lost benefits.
• But higher taxes generate an additional cost on the economy (the leaky bucket).
• Which implies that we will need to accept two-class medicine.
• Unless we want/can get private insurance to get as tough as Medicare must.
Conclusion: The future

• My Dad’s advice: you should have thought of that beforehand—so we should. But hard to do in politics.

• The economist’s credo: If things cannot go on as they are, they will not go on as they are. But all real solutions require painful tradeoffs.

• Need to make those of us who can pay more for our own health care while working and in retirement.

• And hope for the best.