



SINE QUA NON: A HEALTHY NATION REQUIRES REAL BUDGET CONSTRAINTS IN ALL GOVERNMENT HEALTH PROGRAMS

C. Eugene Steuerle

November 2020

Other birds, said Solomon, omitted to line their nests with mud, and as a result they did not hold water.

—in **The Little White Bird**, by James Matthew Barrie

Every government health program should operate under the same budget constraint that applies to other government programs. Failure to do so represents bad budgeting and economic, social, and health policy; redistributes income in perverse ways; and makes health care allocation extremely inefficient. No excuses for this failure to act—largely centered on fear of creating losers, distrust of all decisionmakers, and the search for permanent controls over an ever-evolving sector—hold water against this flood of adverse consequences.

INTRODUCTION

Much confusion over health insurance reform in the US comes from failure to distinguish between principles or rules that should apply to almost any decision-making process and the choices made within the boundaries set by those rules. To balance competing interests, for instance, a constitution requires legislatures to operate under majority rule. By analogy, our elected officials are like builders whose job requires choosing from a wide array of architectural designs for a building, but any choice should still adhere to fundamental laws of engineering so the building doesn't collapse. Here I want to focus on one simple, universal principle of public finance—a natural or logical consequence of limited societal resources that must be allocated:

All government programs must operate within limited budgets.

This budget principle should apply to government health spending programs and tax subsidies, even absent adequate cost constraints in the private sector. It may sound strange to reassert this principle or rule at a time when many people implicitly or explicitly say deficits don't matter or while dealing with the aftermath of two major fiscal crises within about a decade. The size of the federal budget deficit or of government spending offers no excuse for failure to allocate funds fairly and efficiently. Pick any level of total government spending, be it \$4 trillion or \$8 trillion or all of national income, with or without sizeable deficits. To maximize the benefits to society, voters and elected officials still should decide the best use of those resources within that spending level. The principle also applies regardless of what is happening in the private sector; new budget authority and appropriations should adapt to, not be subservient to, those private sector changes.

Laws that set programs to last forever with automatic spending growth particularly violate that rule. It's not that programs can't or shouldn't survive and grow according to the needs and wants of the time, but indefinite predetermined growth will be inefficient and unfair because we lack too much knowledge of the future to know precisely how much and what type of growth to set in advance, especially the further into the future we try to project. In health care alone, we don't know on which margins to operate—which program features, such as acute care, drug therapy, or preventative care, to favor or what payment rates to health care providers will yield the best use of resources to respond to future public health needs and advances in medical technology. In today's world, Medicare, Medicaid, exchange subsidies, and tax subsidies for employer-sponsored insurance all have built-in growth that operates somewhat independently from formal assessment of which needs within and outside of the health care system have become most important.

Further scheduling growth in these programs at a rate permanently above the current economy's growth rate is illogical. What can't continue won't, but scheduling unsustainable growth and adding to public expectations creates political and economic, not only logical, problems. To address new needs, elected officials must somehow gather a supermajority—that is, support of both houses of Congress and the President, or a two-thirds majority in both houses—to renege on past unsustainable promises (on both the spending and tax sides of the budget).

Within health care itself, Congress finds it hard to backtrack when it grants any consumer or provider group or set of services permanent superior status in future budgets, regardless of relative needs, whether old versus young, acute versus chronic conditions, treatment versus prevention and health promotion, or drugs for chronic care versus cure.

Think of almost any government program other than one oriented toward health insurance. Appropriated programs, including much health research, operate within fixed budgets; to grow, they compete for new appropriations over time. Although some entitlements like Social Security are permanent or even indexed to grow forever along with higher wages, only in Medicare, Medicaid, tax-subsidized employer-sponsored insurance, and—to some extent—Affordable Care Act (ACA) exchange subsidies have providers been given so much power to build an infrastructure to deliver more services and products, convince consumers that they need them, have a large say in the prices they charge, and effectively pass bills onto taxpayers. In many ways, this process effectively usurps Congress's constitutional power and obligation to appropriate.¹

Today, health insurance—whether purchased by government or private parties—follows almost accidentally from a model set by the earliest fee-for-service health insurance plans provided in 1929.² Because health costs were low, few worried much about what I label as the original sin of that health insurance design:

¹ The criticism applies only in part to ACA exchange rate subsidies. They do at times require consumers to pay most of the costs for moving to a very high cost plan, which helps limit costs. Still, subsidies automatically rise with health care costs in the community, rather than what additional monies Congress decides to appropriate, with those additional costs largely set by what consumers demand and providers charge.

² The earliest pay-for-service health insurance plans were provided by the Blue Cross Blue Shield Association.

The Original Sin of Health Insurance: for many individual or marginal health care decisions, traditional health insurance creates a division between those who consume health care and those who pay for it, encouraging limited price and sometimes limited quantity constraints by doctors, pharmaceutical companies, and other health care providers in negotiating additional health care with their patients.³

Though some attribute the problem to fee-for-service medicine, which allows providers and consumers to bargain over what services are provided, the open-ended nature of traditional insurance has also given providers much control over prices and the government health budget itself. Thus, when government has made an effort to limit inefficient cost growth in one place, it has often left new opportunities to raise prices or add services in another.

For example, government attempts to limit costs through an effort like a merit-based incentive payment system that rewards doctors for limiting excess utilization,⁴ but then it exercises limited control over prices, particularly for new equipment, drugs, and procedures. It encourages accountable care organizations or offers Medicare Advantage—systems of bundled services with overall cost limits—but then often ends up paying providers within those systems the same prices or fees as paid through fee-for-service Medicare (Chen, Hicks, and Chernew 2018). It promotes generic use of drugs only to find the drug manufacturers charging even higher prices for drugs still under patent, making modest, newly patentable, or evergreening adjustments to existing patents or suddenly multiplying prices several-fold for a generic drug in the years before other firms can organize to compete. It selectively limits some hospital costs, only to find that hospital administrators buy and increase use of the most expensive new equipment that might produce only marginally better outcomes, or find new ways to use more billing codes. Comparisons with other countries that consume greater resources than the US (Anderson et al. 2019) indicate that the higher costs in the US derive largely from higher prices.

The literature clarifies the inefficiency of marginal or individual decisions that shift so much cost to someone else. In the extreme, at zero marginal price to the consumer, demand approaches infinity. More importantly, if providers can set prices and be guaranteed government will buy their services, then prices also approach infinity. New technology seems to play a particularly large role in raising supply and demand (Chernew and Newhouse 2011), especially within this framework.

Health care doesn't absorb the entire government budget or all individual income in the economy only because some modest public and private budget controls do exist, and because not all or even most medical providers seek to maximize their own income. Once prices are set for certain services under Medicare, for instance, they are often allowed only modest inflation increases over time, though not required to decline at rates common to goods and services provided by other growth sectors. Penalties for excessive readmissions seem to have some success at reducing cost growth, though it is a crude way to measure successful outcomes. States also tend to limit payments under Medicaid, though a recent study still found that about 50 percent of the total increase in real state spending on all programs from 2000 to 2015 (from federal and state sources combined) was for Medicaid (Gordon et al. 2019).

³ To a lesser extent, we as employees bargain with our employers on policies where about one-quarter of additional costs are passed onto other taxpayers, thus encouraging excess health insurance coverage. This also adds to health care price pressures. Private business contributions to employer-sponsored private health insurance plans were \$561 billion in 2018 ("NHE Fact Sheet," Centers for Medicare and Medicaid Services, updated March 24, 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>. Proceed to NHE18 Tables, Table 23.), while tax expenditures for the exclusion from tax of employer contributions for health care, health insurance premiums, and long-term care insurance premiums in calendar 2018 (based on three-quarters of fiscal year 2018 (October 2017–September 2018) and one-quarter of fiscal year 2019 (October 2018–September 2019 estimates) equaled \$148 billion (Joint Committee on Taxation 2018 and 2019).

⁴ "MIPs Overview," Quality Payment Program, Centers for Medicare and Medicaid Services, accessed August 28, 2020, <https://qpp.cms.gov/mips/overview>.

Various cost-constraining efforts, therefore, do fight against the perverse incentives of the system. Still, the lack of effective budget constraints in government programs operates like an open-door policy where everyone comes in to get the care they can and government attempts to deal with the ever-increasing demand through selective and only partially successful attempts to force some people out the back door.

THE HUGE BUT OFTEN INDIRECT CONSEQUENCE OF FAILURE

All government program budgets, whether for health or any other activity, create political pressures on elected officials. Providers want higher payments. People want more benefits. That is not sufficient justification for the failure to enact effective budget constraints. Programs must operate within budgets because there are alternative, often better, uses for funds. The government budget process, however crude, must decide those allocation issues, ideally on a somewhat level playing field where all choices compete on the basis of need, current knowledge, and even democratic support.⁵

Consider whether the public approves of the following long-term consequences of government's somewhat open-ended budgets for its health programs:

- Before the COVID-19 crisis, major health programs, along with Social Security and interest on the debt, were scheduled to absorb essentially all future noninterest spending *growth* of the federal government.⁶
- Almost none of the scheduled growth in government spending goes for nonhealth programs that support children (Hahn et al. 2020) or promote mobility and opportunity;⁷ education, infrastructure, and most basic functions of government have been increasingly squeezed out.
- Since 1980, the US has raised the share of its economic resources devoted to health care more than other nations, while having moved to the bottom of the pack in life expectancy.⁸
- Spending ever more on treatment deters spending more on preventative care, which often has a much higher payoff;⁹ public health has also been neglected, as revealed tragically in the COVID-19 crisis.
- Some nonhealth spending that has been crowded out would improve health more than the health care provided, a primary motivation for renewed interest in the "social determinants of health."¹⁰
- Many consider \$5,000 or \$10,000 in health costs to be catastrophic, and Obamacare exchange subsidies were organized around the notion that households shouldn't have to spend more than 10 percent of their income on health insurance; yet an individual's share of total US health costs exceeds \$12,000 (a pre-COVID-19 estimate for 2020) (Mikulic 2020), and the average cost of a health insurance plan for a four-person family exceeds \$28,000 (Girod et al. 2020)—numbers far in excess of what is usually defined as catastrophic or affordable.

⁵ Some budget decisions, of course, should be made for time periods longer than an annual basis, for instance, when people legitimately become dependent on programs. One wouldn't, for instance, suddenly yank away Social Security and Medicare benefits from an older population for whom it is too late to modify earlier work, saving, and other preretirement behavior. And some decisions do require reference to payment rates made by private insurance—though, for all the reasons stated above, they should also refer to other needs of society.

⁶ Eugene Steuerle, "Congress is Supposed to Decide How the U.S. Spends Money. Soon It Won't Be Able To," *Washington Post*, September 12, 2019, https://www.washingtonpost.com/outlook/congress-is-supposed-to-decide-how-the-us-spends-money-soon-it-wont-be-able-to/2019/09/12/3a7f77f8-d411-11e9-9343-40db57cf6abd_story.html.

⁷ Eugene Steuerle, "Congress is Supposed to Decide How the U.S. Spends Money. Soon It Won't Be Able To."

⁸ Austin Frakt, "Medical Mystery: Something Happened to U.S. Health Spending After 1980," *New York Times*, May 14, 2018, <https://www.nytimes.com/2018/05/14/upshot/medical-mystery-health-spending-1980.html>

⁹ Georges Benjamin, "Prevention Funding: One Step Forward, Two Steps Back," *Health Affairs Blog*, March 1, 2012, <https://www.healthaffairs.org/doi/10.1377/hblog20120301.017420/full/>.

¹⁰ "Collaborative Approach to Public Good Investments," Urban Institute, accessed August 28, 2020, <https://capgi.urban.org/>.

- By one estimate, the price of \$1 of health goods and services rose from 1980 to 2018 to about \$4,¹¹ independent of any increase in quality or quantity. Meanwhile, general inflation for all goods and services rose for each \$1 to a little more than \$2.50 over the same period;¹² if health care prices had simply risen at the same rate as general inflation over this period, then health care costs would be closer to 11 or 12 percent of GDP rather than 18 percent; that such inflation is excessive is proven partly by comparison with almost all other growth sectors of the economy, such as information technology and entertainment, that tend to have below-average, not above-average, price growth.
- For health care spending to rise to 18 percent of GDP, it has typically absorbed more than 30 percent of the growth in per capita income (Steuerle 2016).
- Growth in health care costs is a significant cause of limited growth in cash wages,¹³ particularly among workers with low and middle incomes.

Budgets force better recognition and legislative attention to these issues. Far from doom and gloom, good budget policy enhances growth by enhancing efficiency. It's likely with better budget constraints that sellers of opioid drugs would have been forced to track and prove better outcomes for users; that employers and employees would be more cost conscious of the health insurance costs they incur, allowing a higher rate of cash wage growth; that insurance companies would have greater incentives to compete on costs; and that incentives would align to replace low-value with high-value care¹⁴ and reduce outright administrative waste (Cutler 2020).

THE EXCUSES FOR FAILURE TO ACT

In the following sections, I focus on the seven excuses of health care advocates and analysts for operating government health programs without true budget constraints. Admittedly, I simplify and stereotype a bit, but I hear these excuses repeatedly, including in conferences among experts. These excuses largely revolve around a fear of creating losers, distrust of all decisionmakers, and the search for permanent controls over an ever-evolving sector.

¹¹ "NHE Fact Sheet," Centers for Medicare and Medicaid Services, updated March 24, 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>. Proceed to NHE18 Tables, Table 23.

¹² "Gross Domestic Product: Implicit Price Deflator," Federal Reserve Bank of St. Louis, accessed August 28, 2020, <https://fred.stlouisfed.org/series/GDPDEF>.

¹³ Robert J. Samuelson, "Yes, Americans Are Feeling the Squeeze. It's Coming from Health Care," *Washington Post*, November 21, 2019, https://www.washingtonpost.com/opinions/yes-americans-are-feeling-the-squeeze-its-coming-from-health-care/2019/12/01/b66b42f0-12c5-11ea-9cd7-a1becbc82f5e_story.html.

¹⁴ "Focusing on Better Health Care Value," Research Consortium for Health Care Value Assessment, accessed August 28, 2020, <https://www.hcvalueassessment.org/>.

THE SEVEN EXCUSES FOR FAILURE TO ADDRESS HEALTH COST ISSUES

The Fear of Creating Losers

1. We can't create losers or prevent anyone from holding onto their own insurance policies.
2. If government succeeds in limiting cost growth, providers will abandon health care.
3. We can remove excessive health costs by attacking wasteful health spending.

Distrust of All Decisionmakers

4. Government cannot be trusted to determine prices or what services should be covered.
5. Individuals don't know enough and don't have enough resources to cover average, much less large, health expenses.
6. Insurance companies and health maintenance organizations cannot be trusted to restrict spending within a limited budget.

The Search for Permanent Controls Over an Ever-Evolving Sector

7. We don't know exactly what to do, so we must wait to act until we agree on some new permanent solution.

THE FEAR OF CREATING LOSERS

Budgetary reform of health care fails in no small part because the political process hates creating losers—in this case, dealing with the potential outcry among health care providers and consumers. After all, when they compare any sustainable reformed system, even if growing, with a baseline of automatic growth at an unsustainable rate, the simple calculation appears to create only losers: consumers who spend less and providers who earn less within the aggregate health care system. Politicians' demand to avoid the appearance of losers in turn affects what experts suggest for reforms, such as excessive attention to ending wasteful but not inefficient health care.

Excuse 1. We can't create losers or prevent anyone from holding onto their own insurance policies.

I've worked on budget, spending, and tax policy for more than four decades, and if there is any one constant, it's the continual demand by elected officials for their staff members and campaign advisers to develop proposals that create or pretend to create only winners.

In health care, this plays out in statements that everyone should be allowed to hold onto their own current health insurance policy or keep their own doctors—a promise President Obama made in advocating for the Affordable Care Act, a critique made against health reform proposals advocated by 2019–20 Democratic primary candidates, and a promise in the 2016 presidential campaign by then-candidate Trump that he wouldn't touch Medicare. In fact, no one ever keeps the exact same insurance policy from year to year. As providers offer new goods and services, insurance intermediaries change the prices they pay, and consumers and providers both respond to those changes.

Suppose Congress would reduce the scheduled *growth* in Medicare, Medicaid, and other major health spending under the current law from more than \$665 billion¹⁵ to, say, more than \$500 billion by 2029 compared with 2018. That would mean government would pay providers \$165 billion less than scheduled, and some companies, doctors, and other providers would "lose." In responding, they might provide fewer or different services, just as there might be less spending on owner-occupied housing if Congress reduces subsidies for homeownership.

Here's the secret of how opponents of cost-restraining reform play the lobbying game. Note that in the example above I did not say people would get less health care *than today*. In aggregate, they would get \$500 billion more. In politics,

¹⁵ Eugene Steuerle, "Congress is Supposed to Decide How the U.S. Spends Money. Soon It Won't Be Able To."

advocates and associations representing members try to establish the highest baseline of expectations for what government will provide. The inaccurate language that they—and much of the press, with its attraction to controversy, use—is that health care spending is being “cut,” when the accurate phrasing would be that the rate of growth in health care spending is being slowed.

Moreover, the net savings would free up resources for other purposes, so in an accounting sense, the net losses would equal the net gains. Whether the economic or social gains exceed the losses depends on how well the money is used pre- and post-reform.

Excuse 2. If government succeeds in limiting cost growth, providers will abandon health care.

But won't cost-containing efforts lead some providers to abandon health care? Don't some doctors already retire early when burnt out or abandon Medicaid patients altogether?

Health care has long been among the fastest growing employment sectors in good economic years and bad. Perhaps the growth in number of higher-priced providers would slow when prices rise more solely under stronger budget constraints, but the demand for other more modestly priced providers, such as nurse practitioners and physician assistants, likely would increase. Payments for primary care might rise with lower payments for specialty care, and Medicare could further encourage that shift through how it pays for graduate school education. Surgeons making \$600,000 annually today might not find earnings growing to \$800,000 in another decade and might turn over activities like MRI scan review to well-trained technicians, especially if the (relative) prices for those reviews fell. Health care providers might even increase work years to meet long-term retirement goals. And, remember, no evidence exists that US health outcomes have been made better than those abroad with our much higher cost of care.

Although government already tends to pay significantly lower rates for hospital services through Medicare and Medicaid than does private insurance, the extent to which the gap would increase and the extent to which doctors would migrate is uncertain.

First, employers and their insurance companies would likely look for an opportunity to lower prices when Medicare or even Medicaid lower theirs. White (2013) argues that lower Medicare rates lead to lower private payment rates, and logic tells us that insurance companies, employers, and Medicare officials all examine comparison data in determining their payment rates.

Of course, budget limits in every government health program would extend to the tax break for employer-sponsored insurance. Though a recently enacted cap was soon repealed for the political reasons noted above, almost all researchers agree that capping the tax break or limiting subsidies for high-cost plans would provide further incentives for employers and employees to bargain for lower-cost private plans that would push for lower prices. By itself, that would encourage some doctors not to abandon but instead provide more services through Medicare and Medicaid.

These sets of government limits on their own programs might make it easier to consider further restrictions such as market-based price caps (Chernew, et al. 2020);¹⁶ for instance, the tax exclusion for employer-sponsored health plans might be allowed only for plans that capped their prices at some multiple of the Medicare prices paid to the same providers.

Second, the notion that tighter government budget constraints would lead a large share of doctors and hospitals to walk away from government's share of the money supporting health care is preposterous. When one adds tax subsidies such as the nontaxability of employer-sponsored insurance, public employee benefits, and other government health

¹⁶ See also Michael E. Chernew, Maximillian J. Pany, and Richard G. Frank. 2019. “The Case for Market-Based Price Caps.” Health Affairs Blog, September 3, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20190826.369708/full/>.

programs to Medicare and Medicaid, government covers about 65 percent of total health expenditures (Himmelstein and Woolhandler 2016), and that may be an understatement.¹⁷ Medicare acts as the mothership; Medicaid and the large private insurance companies fueled with tax subsidies serve as the battleships, while other government programs form a large part of the fleet.

Excuse 3. We can remove excessive health costs by attacking wasteful health spending.

Health care provision in the US entails significant waste; a recent review of 54 peer-reviewed studies concluded that waste accounted for approximately 25 percent of total health spending (Shrank, Rogstad, and Parekh 2019). A popular example involves health services, often near death, that do more harm than good for the patient, though one needs to be careful with this example because doctors and hospitals often don't know how long people might survive. Although I don't dispute the worthiness of efforts to reduce this waste, such as in the Choosing Wisely promotion by the American Board of Internal Medicine Foundation, exact measurement at the point of care remains difficult even under the best value-based insurance designs. Much health care still involves trial and error, forcing caution in using measures from actual results, rather than forecasts, to determine waste. Even the Shrank and colleagues (2019) study that found one-quarter of health spending wasteful also concluded that projected potential savings from interventions might eliminate only one-sixteenth of total health spending, and that calculation says little about making the underlying long-term growth rate sustainable.

Advocates who offer "waste" as evidence that budgetary health reform can be cost free—the political imperative often sought by elected officials—often end up stalling, misdirecting, and killing true budgetary reform.

The complication comes partly when health reform is considered only as a health issue. Simply put, many gains from potential health reform reside outside the formal health care system. James House (2015), for instance, demonstrates that the problems of our broken health care and insurance system will not be solved simply by reforms like Obamacare, because they are interconnected with growing social disparities in education, income, and other conditions of life and work—issues that also require budgetary resources.

We must distinguish, moreover, between waste, defined often as pure loss, and inefficiency. Health care can be of positive benefit but still inefficient. Suppose that for every additional \$100 we spend in health care we get \$50 in benefits in return—a number at least hinted at by the multidecade, above-average rate of price increases in health care goods and services. If we would spend that \$100 outside of health care, it might be worth \$100 or more, as when early childhood education improves health and other life prospects (Heckman, Humphries, and Veramendi 2016). Households with modest incomes might prefer an extra \$5,000 in quality teachers, or simply more cash on which to live, instead of \$5,000 extra in health insurance that offers improved access to higher-cost surgeons and other providers. This could also be the case for spending more on improving lifestyles to limit chronic care needs versus servicing those chronic care needs. Those trade-offs are seldom broached when the health community looks only to its own internal needs and interests or when reformers suggest health reform must provide the same level of health benefits that would be provided under today's unsustainable cost-growth system.

¹⁷ The formal tax expenditure budget does not include the value of the nontaxability of many government benefits. For simplicity, assume a household is in a 25-percent tax bracket and receives \$20,000 worth of insurance under Medicare, Part A, tax-free. The tax expenditure budget does not count the \$5,000 in tax benefits that would be calculated under typical tax expenditure methods. That's not all. A household who had to pay for similar insurance out-of-pocket and without a tax subsidy directly would have to earn \$26,667 to be able to pay for a \$20,000 policy, so the value of the tax break equals \$6,667, not the \$5,000 that would be calculated under existing tax expenditure procedures. This add-on to the traditional tax expenditure method would also apply to the value of the employee exclusion for employer provided insurance, which is in the tax expenditure budget. This in-the-weeds methodology issue was formerly raised in a Treasury effort to calculate the value of tax expenditures under an "outlay equivalent" method.

DISTRUST OF ALL DECISIONMAKERS

Even when voters and their representatives can be convinced to accept some losers in the health reform process, they almost always fail to reach agreement on which payers can be trusted to constrain costs—government, individuals, or private intermediaries such as employers and insurance companies. The discussion below acknowledges the advantages and disadvantages of placing responsibility for saying “no” on any of these decisionmakers. Failure to face up to this dilemma, however, has resulted in a stalemate in which adequate responsibility rests nowhere.

Excuse 4. Government cannot be trusted to determine prices or what services should be covered.

If government took control over all health care today, it might improve efficiency in the short run. The complication: nobody has the capability to predict what future health reforms might bring. By way of analogy, nationalizing steel may have been efficient in some countries when reducing duplication of administrative costs across firms or when one firm could take full advantage of economies of scale. But, historically, countries that did nationalize, like Great Britain or East Germany, ended up with no easy way of deciding what consumers value at what price, what new methods or processes might otherwise arise from competition, and how politically to take resources away from state-monopoly interests and deploy them elsewhere. The long-run gains for future citizens, particularly in any rapidly changing industry like health care, come from improvements and discoveries yet to be made and often provided by new competitors whose interests differ from older providers.

This legitimate concern, however, often evolves into an excuse that government shouldn't set prices or other limits on what it does provide. Yet all health insurance plans, including Medicare, Medicaid, and employer plans exercise some price and quantity controls. Otherwise, health care costs would quickly absorb 100 percent of our income. For instance, Medicare inpatient reimbursement rules exercise moderately firm control except for covering new therapies, while Medicaid pays the lowest drug prices, with reimbursements skimpy, at least relative to private insurance.

Of course, as explained above, most controls to date remain weak and still leave providers with substantial options for offsetting those cost constraints elsewhere, such as charging more for less constrained items or monopolizing services through private consolidation in various communities (Anderson et al. 2019).

Drugs provide one of the best examples of this insufficiency. Manufacturers of new drugs get patent protection for a temporary monopoly and the power to set prices for a government that almost automatically purchases a substantial share of those drugs. This, at its core, is an impossible combination.

This tension between what government must do versus what it can't do well also plays out in the debate over Medicare for All. In many ways, the multiple and seldom detailed Medicare for All proposals often entail advocacy for broad-based government price and quantity controls throughout the health care sector as much as for expansion and equalization of health insurance coverage. Indeed, some Medicare for All advocates join in opposing budget controls within existing policies unless and until government somehow controls more of the market. Yet most foreign, more universal government health care systems—a base of comparison often used—do not cover all health expenses, and neither does Medicare (Cubanski, Neuman, and Freed 2019). Thus, the Medicare for All label could imply anything from a British health system to a Swiss approach with substantial use of vouchers for private insurance to expansions of Obamacare exchange subsidies to everyone. Indeed, Medicare itself already involves government insurance, private insurance to fill gaps, a voucher-like payment system in Medicare Advantage, and various cost-sharing among individuals.

The simple point here is that whether or not government eventually subsidizes a larger or smaller share of the health market, it bears responsibility for managing the resources it already has. Opposition to additional budget controls will rise under any policy regime, as evidenced by the partial budget constraints Congress enacted in Obamacare, then

rescinded, through a strengthened Independent Payment Advisory Board, a Cadillac tax on expensive employer-sponsored health plans, and the tax (individual mandate) on those who don't purchase insurance.

Excuse 5. Individuals don't know enough and don't have enough resources to cover average, much less large, health expenses.

Cost containment efforts at times focus on individuals, who do respond to incentives. People will buy less, for example, by not paying for an expensive test if they have a high deductible plan. Some advocates push for making individuals bear costs more directly, such as through higher copayments or Health Saving Accounts, where, by bearing the full cost of using the money in those accounts, they have incentives to spend their money in the accounts more wisely.

Even if government were to follow some private efforts to offer very high deductible plans, however, it would do little to deal with complex and chronic care conditions that absorb most of health care expenses (Delbanco et al. 2016). Most health care spending occurs at levels way above these deductibles and way beyond the cash available to most households.

Recall that total health costs in the US per individual equals about \$12,000. Or, for a family of four, an average private insurance plan by itself costs more than \$28,000. Many households would have great trouble paying those average costs out of pocket—though households on average do cover those costs indirectly through lower wages, taxes, and government debt left to their children. Many more households cannot cover the cost of more catastrophic, not only “average,” expenses that often accompany chronic care. Also, today millions of eligible households do not insure themselves on an exchange even though the government offers to keep their cost of an insurance policy to 10 percent or less of their income.

Even if they had the money in some sort of health account, a person with modest means might be more reluctant than a wealthy person to pay even small amounts for health care if they had other food or shelter needs for which money in the account could eventually be spent. This raises issues of equity surrounding access to health care, perhaps the most fundamental objection to trying to solve health cost issues by asking individuals to bear that responsibility at time of illness and injury. No one suggests that we deny care to those who have inadequate funds when they are about to go on the operating table.

This tension over improving individual incentives versus equity in the provision of health care has led to a standoff. Continual cost increases have pushed employers, insurance companies, and government to add onto individual payment requirements, but in the end, out-of-pocket spending still makes up only 10 percent of health costs¹⁸ and has been rising more slowly than total national health expenditures.

But that still doesn't answer why there hasn't been greater movement toward vouchers or premium support systems, where individuals would face the real cost of buying insurance beyond some minimum subsidized amount at time of insurance purchase, not while on the operating table. We now turn to that issue.

Excuse 6. Insurance companies and health maintenance organizations cannot be trusted to restrict spending within a limited budget.

The government, as well as employers, can limit health costs by providing capped amounts of premium support to individuals through their insurance companies, thereby shifting to intermediaries the administrative burden of enforcing limits on prices and availability of services. If given options to benefit immediately by choosing lower-cost plans in such a voucher system, individuals themselves would help put pressures on costs. Government employees have proven that

¹⁸ “NHE Fact Sheet,” Centers for Medicare and Medicaid Services.

people will choose lower-cost plans when, as under the Federal Employees Health Benefits (FEHB) program, there is a maximum government subsidy for whatever government-offered plan they purchase,¹⁹ and they pay the excess.²⁰

Such requirements to stay within budgets could be applied more broadly. Government already provides fixed payments under Medicare Advantage to health maintenance organizations (HMOs), such as Kaiser Permanente, and similar institutions. Though payment rates under Medicare Advantage rise along with payment rates to traditional fee-for-service Medicare, some evidence exists that the former saves on hospital costs relative to the latter (Baker et al. 2015). Medicare itself could offer greater and more explicit cash incentives to people to purchase even lower-cost insurance.

Why doesn't Congress move more in this direction? The first answer is politics. In previous work on vouchers or voucher-like efforts such as premium support, I found this particular tool tended to be favored by Democrats and opposed by Republicans when it expanded government (e.g., food stamps), while the reverse held true when it might effectively limit public spending (e.g., school vouchers) (Steuerle 1999). The same division has played out in health policy, in efforts to cap subsidies for employer-sponsored health care or put some burden ("individual mandate") on people with middle incomes who don't buy insurance but then rely on free care in the emergency room. At one point, health care vouchers tended to be favored by Republicans and opposed by Democrats when the debate centered on how to reduce costs, but the parties switched sides when the ACA created partial vouchers in exchanges as a way to expand net government spending. The two parties reverse again when they debate Medicare Advantage, with Republicans often more supportive. Thus, the politics surrounding the government-size debate, rather than the economics of best practices from a health policy perspective, reign when it comes to using vouchers or premium support as a tool of public policy.

The second answer relates to our topic in this section: public distrust. The managed care revolution in the 1990s emphasized HMOs among private employers and succeeded in restricting health cost growth for a few years but then faded in its impact. Alain Enthoven (1999) examined this trend at the end of that decade, and without going into all the factors involved, a major factor was both consumers' and doctors' lack of engagement in what often was a forced arrangement, as when employers switched to HMOs by offering employees no other options. Some consumers viewed any savings generated as accruing only to employer or insurer, not to themselves, and some doctors clearly felt they would lose out if they had to join managed care plans. Remember also that more senior employees and those with higher wages—those most interested in sustaining generous health plans—dominate in bargaining with employers.

Hollywood joined the attack on HMOs in the 1997 film *As Good as It Gets*, when Helen Hunt cursed HMOs for not providing needed care for her son, as well as in the 2002 film *John Q*, where an HMO denies necessary care. Insurance companies operating at a profit, HMO or otherwise, came to be viewed as untrustworthy when it came to saying "no" to some procedure or its cost.

THE SEARCH FOR PERMANENT CONTROLS OVER AN EVER-EVOLVING SECTOR.

This leads to the last and perhaps most misleading set of excuses: the ephemeral effort to provide a permanent *institution* for providing health care, when those opposing anybody else's plan can quickly appeal to potential losers and public distrust of whomever might be empowered to say "no."

¹⁹ See the listing of "biweekly Maximum Government Contribution" in OPM's healthcare plan information, <https://www.opm.gov/healthcare-insurance/healthcare/plan-information/premiums/>.

²⁰ For many years, FEHB benefits were not only capped so that individuals paid for the full cost of insurance above some capped amount, but they received no tax exclusion for those excess payments. Thus, FEHB provides an example of how to offer people strong incentives at the margin to limit health costs through upfront insurance contributions; let them, rather than the employer, reap the benefits from such cost constraints; and provide ways for employers to administer caps on the exclusion for employer-sponsored insurance.

Excuse 7. We don't know exactly what to do, so we must wait to act until we agree on some new permanent solution.

Amid so many competing claims, at many conferences one hears the excuse that we can't enact budget constraints because we don't know exactly what to do.

This is like two parents arguing over what their child should do—play the piano or do her homework—when the child is playing in traffic. We seldom know exactly what to do. We still know what constraints or boundaries should surround our choices. We take the child out of traffic.

A variation on this theme centers on not knowing the future well enough to design health reform around it. Of course, the further into the future we try to see, the less we know. Health care in the US is approximately the size of the French economy. Whether it is the French economy or the US health care budget, resources must still be allocated on a limited knowledge basis. The purpose of a principled budget process is to try to facilitate rational decision-making. Health insurance cannot be excluded from competing with alternative uses of resources without causing severe problems in the wider economy, as well as within the health sector itself.

A reliable budget process requires whatever programs exist to operate within budget limits, even while elected officials debate program reforms. Alternatives then can more easily be tested over time, and automatic growth can no longer preclude reallocations both outside and within the health sector.

CONCLUSION

We do know how to budget for government health programs and pursue better outcomes for the nation. Health care programs, like all government programs, must operate within budget constraints. As long as they exist as separate programs, Medicare, Medicaid, exchange subsidies, the exclusion from taxation of employer-sponsored health benefits, and other health programs should be designed to stay within budget limits that can and should be amended over time, but not through legislation that prescribes permanent and automatic adjustments that empower private decisionmakers to determine Congressional appropriations. The same holds true for any future reformed system that makes greater use of vouchers or premium support, combines Medicaid and exchange subsidies, increases or decreases controls over private health insurance, or moves toward Medicare for All or some other more unified system.

When operating government programs within budget constraints, we still will need a process to deal with the biggest and most important health issue we understand least: what health care will look like tomorrow. That generally requires some private market competition over what new goods and services to provide. Within government's share, we need a system where, for instance, we can switch substantial shares of the health care budget to preventative and public health from chronic and acute care, or to primary care doctors and nurses from surgeons, or to young from old, if evidence supports such shifts. That won't happen until providers face limits on their power over the prices and services for which they charge government. With resources accordingly freed up, it becomes possible in a growth economy to allocate new revenues to new priorities set by the voters and representatives of the day, not those of dead legislators (Steuerle 2014).

As for mechanisms for controlling costs within program budgets, let Democrats enact their price controls and Republicans their vouchers and private cost shares but still within a budget. No permanent political nirvana exists in which people as a whole can get more health care without paying for it and in which they will not always want more if someone else will pay. Any sustainable future system almost inevitably will contain evolving attempts at different means of direct government control, indirect controls through vouchers, bundling or capping health care goods and services, and some continued cost-sharing among individuals. Medicare already has all three elements, though mainly in an inadequate, uncoordinated, and open-ended way. Permanent political agreement on some optimal mix of these various

mechanisms may never be achievable, but budget constraints in each program will help decisionmakers make and remake those other choices more rationally over time.

In sum, no one knows the precise mixture of health care goods, services, and prices that should apply in the future, and, quite bluntly, neither do you nor I. We need a process that by adhering to normal budget principles provides a more rational way to adjust to new findings and opportunities as they develop. Let's stop saying we don't know what to do while tolerating massive inefficiency and poor outcomes for the health dollars we spend.

REFERENCES

- Anderson, Gerald F., Peter Hussey, and Varduhi Petrosyan. 2019. "It's Still the Prices, Stupid: Why the US Spends So Much on Health Care, And a Tribute to Uwe Reinhardt." *Health Affairs* 38 (1).
- Baker, Laurence C., M. Kate-Bunddorf, Aileen M. Devlen, and Daniel P. Kessler. 2015. "Medicare Advantage Plans Pay Hospitals Less than Traditional Medicare Pays." *Health Affairs* 35 (1533).
- Chen, Julius L., Andrew L. Hicks, and Michael Chernew. 2018. "Prices for Physician Services in Medicare Advantage Versus Traditional Medicare." *American Journal of Managed Care* 24 (7): 341–44.
- Chernew, Michael E., Leemore S. Dafny, and Maximillian J. Pany. 2020. "A Proposal to Cap Provider Prices and Price Growth in the Commercial Health-Care Market." The Hamilton Project. Washington, DC: Brookings Institution.
- Chernew, Michael E., and Joseph Newhouse. 2011. "Health Care Spending Growth." In *Handbook of Health Economics*, edited by Mark Pauly, Thomas McGuire, and Pedro Barros, 1–43.
- Cubanski, Juliette, Tricia Neuman, and Meredith Freed. 2019. "The Facts on Medicare Spending and Financing." San Francisco, CA: Kaiser Family Foundation.
- Cutler, David M. 2020. "Reducing Administrative Costs in U.S. Health Care." The Hamilton Project. Washington, DC: The Brookings Institution.
- Delbanco, Suzanne F., Roslyn Murray, Robert A. Berenson, and Divvy K. Upadhyay. 2016. *High Deductible Health Plans*. Washington, DC: Urban Institute and Catalyst for Payment Reform.
- Enthoven, Alain. 1999. "Managed Care: What Went Wrong? Can It Be Fixed?" Stanford, CA: Stanford Business School Insights.
- Girod, Christopher S., Paul R. Houchens, David M. Liner, Andrew L. Naugle, Doug Norris, and Scott A. Wetz. 2020. *2020 Milliman Medical Index*. Seattle, WA: Milliman.
- Gordon, Tracy, Megan Randall, C. Eugene Steuerle, and Aravind Boddupalli. 2019. *Fiscal Democracy in the States: How Much Spending is on Autopilot?* Washington, DC: Tax Policy Center.
- Hahn, Heather, Cary Lou, Julia B. Issacs, Eleanor Lauderback, Hannah Daly, and Eugene Steuerle. 2020. *Kids Share 2020: Report on Federal Expenditures on Children Through 2019 and Future Projections*. Washington, DC: The Urban Institute.
- Heckman, James J., John Eric Humphries, and Gregory Veramendi. 2016. "Returns to Education: The Causal Effects of Education on Earnings, Health, and Smoking." NBER Working Paper 22291. Cambridge, MA: National Bureau of Economic Research.
- Himmelstein, David U., and Steffie Woolhandler. 2016. "The Current and Projected Taxpayer Shares of US Health Costs." *American Journal of Public Health* 106 (3): 449–52.
- House, James S. 2015. *Beyond Obamacare: Life, Death, and Social Policy*. New York: Russell Sage Foundation.
- Joint Committee on Taxation. 2019. *Estimates of Federal Tax Expenditures for Fiscal Years 2019–2023*. Washington, DC: Joint Committee on Taxation.
- . 2018. "Estimates of Federal Tax Expenditures for Fiscal Years 2018–2022." Washington, DC: Joint Committee on Taxation.
- Mikulic, Matej. 2020. "National per Capita Health Expenditure in the United States from 1960 to 2020." Hamburg, Germany: Statista.
- Shrank, William H., Teresa L. Rogstad, and Natasha Parekh. 2019. "Waste in the U.S. Health Care System." *Journal of the American Medical Association (JAMA)* 332 (15): 1501–09.

- Steuerle, Eugene. 1999. "Common Issues for Voucher Programs." In *Vouchers and the Provision of Public Services*, edited by C. Eugene Steuerle, Van Doorn Ooms, George Peterson, and Robert D. Reischauer. Washington, DC: Brookings Institution.
- . 2014. *Dead Men Ruling: How to Restore Fiscal Freedom and Rescue Our Future*. New York: The Century Foundation.
- . 2016. "Health Cost Growth and the Federal Budget." In *Symposium Monograph on Sustainable U.S. Health Spending*, edited by Paul Hughes-Cromwick, Erica Munoz-Rumsey, and Ani Turner.
- White, Chapin. 2013. "Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates." *Health Affairs* 32 (5).

ACKNOWLEDGMENTS

This brief was funded by the Altarum Institute and the National Institute for Health Care Reform (NIHCR). We are grateful to the organization and to all our funders, who make it possible for the Urban-Brookings Tax Policy Center to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban-Brookings Tax Policy Center, the Urban Institute, the Brookings Institution, their trustees, or their funders.

The Tax Policy Center is a joint venture of the Urban Institute and Brookings Institution. For more information, visit taxpolicycenter.org or email info@taxpolicycenter.org.

Copyright © 2020. Tax Policy Center. All rights reserved. Permission is granted for reproduction of this file, with attribution to the Urban-Brookings Tax Policy Center.