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PERCSPECTIVES ON POLICY

CADILLACS FOR ALL

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The most expensive Cadillac, the CTS-V, lists for about $87,000. The CTS-V boasts 640 horsepower and a top speed of 200 miles per hour. Financing the CTS-V over 6-years, even at a 0% interest rate, will cost $1,208 per month or $14,500 per year. This annual payment puts you into the top-of-the line Cadillac, and interestingly, it is about the same as Medicare's average cost per beneficiary this year of $14,162.

So why make such a comparison between the cost of a new Cadillac and the cost of Medicare in the first place? First, "Medicare for All" has become a catchphrase in the political sphere. The promise of Medicare for All is that it will lower health care spending by reimbursing providers at Medicare's rates per procedure. The idea is to take advantage of Medicare's low reimbursement rates and extend those to the entire population. This would arguably reduce the uninsured rate and lower per-patient costs at the same time.

Comparing Cadillacs to Medicare has a secondary significance straight from the parlance of the current health care policy debates. Included in the Affordable Care Act (ACA) was a provision to begin taxing employer-sponsored health insurance plans whose premiums exceed particular thresholds. The intent of this so-called "Cadillac Tax" is to limit the size of the tax exclusion given to health care benefits offered as fringe benefits to employees. The tax of 40% on premiums above the thresholds was scheduled to begin in 2018 but has been delayed by Congressional action. In July, the House voted overwhelmingly (419 to 6) to repeal the tax altogether.

Medicare for All and the movement to repeal the Cadillac Tax both point to the importance of the continuing health care debate in the U.S. Let's look at how each fit in the current policy debate and how health care policy changes must be considered in the broader context of federal spending, revenues, deficits, and the growing debt.

Medicare for All

Compared to private health insurance, Medicare pays lower reimbursement rates to health care providers such as doctors and hospitals. In recent years, the aggregate hospital payment-to-cost ratio has been above 140% for private payers, whereas it has been below 90% for Medicare.[1] The program's reimbursements for specific physician's services are also lower than the prices paid by private insurers.[2]

Medicare's ability to pay health care providers at below-cost rates coincides with private payers paying the health care providers at above-cost rates, suggesting some of the costs Medicare incurs might have been shifted to private payers.[3] If Medicare is able to impose lower reimbursement rates by cost-shifting to private payers and if private payers would disappear under Medicare for All, then what would happen next? Do some health care providers refuse to work at Medicare rates and exit the profession? Do lower reimbursement rates lead to lower quality of care? Or are health care providers currently enjoying rents that Medicare for All will reduce?

It seems that reducing the reimbursement rates across the board would substantially affect the margins at hospitals, at outpatient facilities, and at provider offices. This might cause a reduction in the quality of care. In the long run, the quality of the health care workforce may decline relative to other occupations, facilities may become unprofitable, and the pace of medical innovation could slow.

We would therefore caution that a Medicare for All plan, based on the premise that it would lower expenditures across the board, has serious long-run implications. The imposition of Medicare's lower reimbursement rates across the board would likely adversely affect the supply of hospitals, clinics, physicians, and medical innovation.

Medicare's Trustees have long argued that the

cost growth constraints built into current law will cause harm in the long-run. In reality, Congress has routinely overturned or repeatedly delayed implementing a variety of cost constraints over the years. This occurred prior to the ACA, and it is likely to continue with the cost constraints built into the ACA. As shown in Figure 1, the Medicare Trustees project future Medicare spending both under current law (assuming the cost constraints will be imposed) and under an alternative scenario where the cost constraints are not imposed. It has been important to provide the alternative projection because of Congress's penchant for passing new legislation to overrule growth rate constraints. Thus, the illustrative alternative may be the better forecast of Medicare's spending path.

The alternative forecast was initially developed to illustrate how Medicare's future spending would evolve if the Sustainable Growth Rate (SGR) Assumptions that applied primarily to Part B spending were not realized. The passage of the ACA added another cost-growth constraint known as the productivity assumption. This stipulated that payment updates for non-physician providers are to be reduced by the increase in the economy's productivity. The current law forecasts of Medicare's spending assume that the productivity adjustments are realized and that the future expenditure constraints on physician payments under the Medicare Access and CHIP Reauthorization Act (MACRA) are also realized. (MACRA replaced the SGR, and it too, assumes lower growth rates than those expected among private payers within the next decade.)

The Trustees Report notes that under current law:

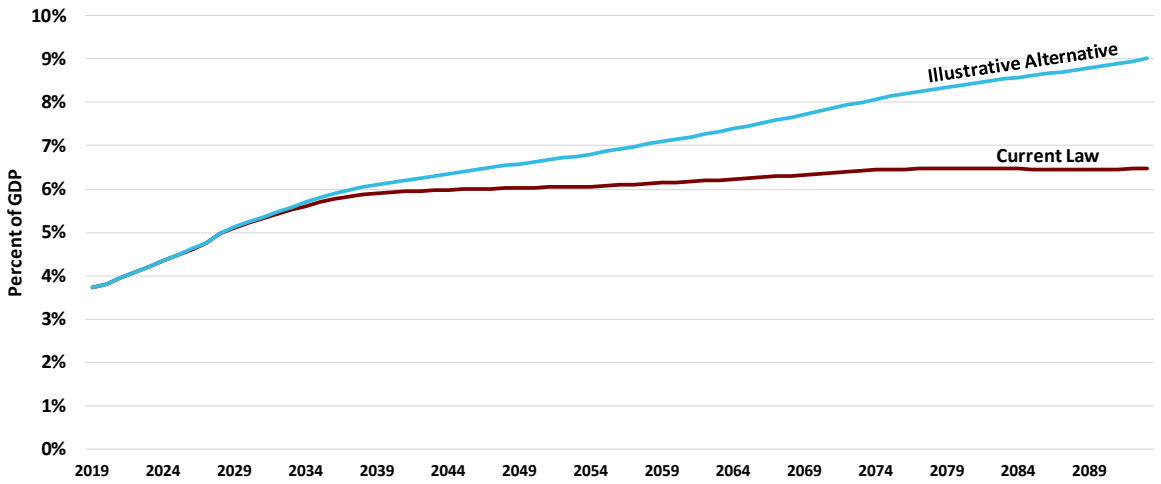
> "Over time, unless providers could alter their use of inputs to reduce their costs per service correspondingly, Medicare's payments for health services would fall increasingly below providers' costs. Providers could not sustain continuing negative margins and would have to withdraw from serving Medicare beneficiaries or (if total facility margins remained positive) shift substantial portions of Medicare cost to their non-Medicare, non-Medicaid payers."[4]

Inevitably, policies applied to a Medicare for All program would follow cost growth constraints similar to those stipulated in the ACA and other legislation aimed at constraining the government's spending on health care. Past history suggests that the cost-reductions expected from such policies are unlikely to materialize.

The Cadillac Tax

The inclusion of the Cadillac Tax in the ACA was another feature, like the cost growth constraints specified for Medicare, that was necessary to ensure the bill did not add to the forecasted budget deficits. The ACA's Cadillac Tax has yet to take effect due to Congressional action to postpone its implementation, and the momentum following the House's recent passage of HR 748 may suggest that the Senate will follow suit. If the Senate also repeals the tax, this policy that could constrain health care spending would be taken off the table.

FIGURE 1. MEDICARE'S PROJECTED SPENDING UNDER CURRENT LAW AND ILLUSTRATIVE ALTERNATIVE ASSUMPTIONS



Source: *The 2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* 2019, Figure I.1 p. 4.

Interestingly, both parties have, in the past, seen such a tax as a way to limit the tax expenditures on employer provided health insurance (EPHI). As originally stipulated in the ACA, the 40% excise tax paid by coverage providers, would apply to premiums amount above $10,200 and $27,500 in 2018 for individuals and families, respectively.[5] Legislation has postponed the implementation of the tax until 2022 and, as noted, the move is on to repeal the tax altogether.

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimate that the tax will generate $96 billion in revenues for the period 2022 to 2029. But they also note that the tax would result in lower premiums and a shift to higher wages and salaries for the affected workers. This would produce an ancillary tax revenue effect as workers pay payroll and income taxes on their higher earnings. The CBO and the JCT estimate $97 billion in new taxes for the years 2022-2029 for a total revenue effect of $193 billion.[6]

As it now stands, the real continuing bite of the Cadillac Tax is through the fact that the thresholds at which the tax would take effect are increased annually by general price level increases. Because health care premiums are expected to grow faster than general prices, an increasing share of policies will face the excise tax in coming years. Besides the tax revenue effects, the resulting policies would include more cost sharing through higher deductibles and copayment amounts and would, at the margin, cause consumers to become more cost conscious.

The Cadillac Tax would only partially recover the revenue loss to the federal government due to the tax exclusion on EPHI. According to longstanding tax law, both employer and employee contributions to the purchase of EPHI are excluded from an individual's taxable income. The CBO estimates that in 2019, the tax exclusion resulted in tax expenditures of $287 billion dollars and for the years 2019 to 2029, the tab in terms of foregone tax revenues will be $4.5 trillion.[7] Basically, the Cadillac Tax would be a modest limit on the scale of the tax exclusion on EPHI so that the preferential tax treatment is not extended to the costs of a health insurance plan that are above and beyond a threshold deemed luxurious.

The fiscally responsible approach is not just to pass the Cadillac Tax, which is only a small step in the right direction. It would be better to take the giant step and repeal the tax exclusion on EPHI. Indeed, in addition to resulting in the tremendous revenue losses to the federal government, the tax exclusion has been criticized on grounds of both efficiency and equity. By allowing the purchase of health insurance with pre-tax dollars, the tax exclusion lowers the relative price of health care and thereby increases its consumption inefficiently. Moreover, because the health insurance subsidy is tied to marginal tax rates, high-income workers disproportionately benefit. To give workers and their families incentives to continually participate in employer provided health insurance, lump-sum tax credits financed with a considerably lower level of tax expenditures can be introduced, along with repealing the tax exclusion on EPHI.[8]

We spend a lot of money on health care in the United States compared to the rest of the world's developed economies. Government spending on health care – either directly through programs like Medicare and Medicaid, or indirectly through tax expenditures – is a major contributor to the federal budget deficits and the rapidly growing federal debt. The current interest in Medicare for All and the possible repeal of the Cadillac Tax indicates that policy makers, while voicing concerns about the health care spending in general and the government spending on health care in particular, have little appetite to take the actions necessary to affect either. Washington continues to kick multiple cans down the road and citizens must decide when and if to stop the kicking.

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[1]*Trend Watch Chartbook 2018: Trends Affecting Hospitals and Health Systems*, American Hospital Association (Chart 4.6 on page 40).

[2]Jeffrey Clemens and Joshua D. Gottlieb find that surgical payments in the private market are 60% higher than in Medicare and that non-surgical services are about 30% higher, in "In the Shadow of a Giant: Medicare's influence on Private Physician Payments," *Journal of Political Economy*, February 2017.

[3]The differences between private payers' reimbursement rates and the considerably lower rates enjoyed by Medicare raise the question as to why Medicare reimbursements are lower and how private sector reimbursements are affected by changes in Medicare's reimbursement structure. In addition to the explanation based on cost shifting from public to private payers, it has also been suggested that Medicare may be exerting its market power.

[4]T*he 2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2019*, p. 180.

[5]Scott Eastman, "The 'Cadillac' Tax and the Income Tax Exclusion for Employer-Sponsored Insurance, The Tax Foundation, Fiscal Fact No. 661, June 2019.

[6]"Federal Subsidies for Health Insurance Coverage for People under Age 65: 2019-2029," Congressional Budget Offices, May 2019. p. 17.

[7]Ibid. p. 16.

[8]See "Getting Out of Our Health Insurance Quagmire," PERC Policy Study 1903, September 2019.

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