

Health Policy Issues and the 2016 Presidential Election

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Health policy has become a highly charged partisan issue in American politics and there is no question it will be debated in the 2016 campaign. The question is: will the campaign debates allow candidates to articulate realistic positions, help voters understand the options, and provide a basis for legislation when the new president and congress take office in 2017? Or will electioneering degenerate into trading slogans (“Repeal Obamacare!” “Save Medicare!”) and mutual accusations of nefarious intentions that deepen the partisan divide and make it more difficult to agree on constructive action, no matter who wins at the polls?

The next president and congress will have to deal with at least three big health policy issues:

- Resolving the future of the Affordable Care Act (ACA).
- Slowing projected growth of national health spending, including private, state, and local, as well as federal health spending.
- Reforming the Medicare program in a way that extends the life of the Medicare trust fund and ensures the viability of Medicare for the rapidly increasing population of beneficiaries.

These issues are necessarily complex, because the American system of delivering and paying for health care is extraordinarily complex. Hence, proposed policy changes are inevitably complicated and hard to make clear to most voters. The three issues are also highly interrelated. For example, the ACA increased federal spending for health by creating subsidies for the purchase of health insurance and expanding Medicaid. At the same time the ACA reduced spending for Medicare and introduced reforms likely to make health care delivery more efficient. Hence, repealing the ACA in its entirety would make the other two issues harder to resolve.

Partisan Ideology and Political Reality

While there are diverse views on health policy within both parties, candidates in the 2016 election are likely to continue emphasizing traditional Republican and Democratic themes. Republicans will talk a lot about market solutions, empowering consumers to make choices, reducing waste and regulation, and giving states more flexibility to design and execute health programs. They will tout tort reform as a way of reducing malpractice premiums, health savings accounts as a way of giving consumers more control over health spending, and selling health insurance across state lines as a way of enhancing competition. They will demonize Obamacare as a federal power grab that is forcing people to buy health insurance even if they don't want it, punishing small business, and raising premiums for everyone. They will paint a grim picture of the future of Medicare if Democrats resist changes in the program.

Democrats for their part will talk about families getting life-saving care under the ACA and point to dire consequences of repeal, such as going back to denial of health coverage to people with pre-existing conditions or high health costs. They will talk about the millions of elderly and vulnerable people benefiting from Medicare and Medicaid and accuse Republicans of wanting to gut Medicaid by making it a block grant to the states and destroying Medicare by turning it into a voucher program. They will push for expansions in coverage and benefits on the grounds that current programs are still inadequate to meet the goal of affordable health care for all.

When a new president and congress begin to tackle these challenges, however, they will find their options quite limited no matter who has won. The American public is generally nervous about change in anything as vital and personal as health care. Medicare, for example, is such a popular program that any changes to it must be carefully designed to assuage the fear of current beneficiaries and their families that they might end up worse off. Moreover, the current health care establishment—providers, insurers, suppliers—is a large, politically sophisticated part of the economy whose jobs and income derive from the current health system and which resists changes they fear will hurt them. So any new team proposing major health policy changes will face a daunting negotiation with powerful stakeholders determined to defend and enhance their varied interests. Candidates: be careful what you wish for!

The Affordable Care Act in 2017 and Beyond

Viewed from early in the primary season, the clearest policy divide between the Republican and Democratic presidential candidates is over the future of the Affordable Care Act. The Republican candidates all promise to “repeal and replace” the ACA fulfilling the unsuccessful four year effort of Congressional Republicans and meeting what will undoubtedly be a major plank in the party’s platform. The Democratic candidates extoll the accomplishments of the Act, promise to protect it or move to a more generous program. Neither of these polar positions represents an adequate response to the situation that will face the next president. It would be highly desirable for both parties to modify and clarify their stances on the ACA by the time of the general election.

If Republicans recapture the White House, they will almost certainly retain control of both chambers of the Congress and be in a good position to repeal Obamacare early in 2017. A Democratic party smarting from losing the presidency would be unlikely to stop them. But then, what?

While Republican presidential primary candidates are unanimous in calling for “repeal,” they have not coalesced around a concept of “replace.” Some have proposed tax credits for the purchase of health insurance and either retaining the ACA insurance market reforms or replacing them with federally supported state-based high-risk pools or other devices. Others have been silent. If the Republican nominee sticks to a vague “repeal and replace” formula, health insurance markets could be badly disrupted. Indeed, many ACA beneficiaries, insurers and employers are likely to face great uncertainty that will make them reluctant to adhere to the ACA’s requirements starting as early as mid-2016. If a Republican electoral victory looks plausible in the spring and summer of 2016 and there is no clarity on what “replace” implies, insurers may be reluctant to submit premium bids for 2017 to the exchanges or they may propose significantly increased rates to compensate for heightened uncertainty; some healthy individuals may drop their coverage reasoning that the penalties will not be enforced by a new administration; many providers may drive harder bargains with insurers and plans in anticipation of reduced pressure to control costs; and states may constrain their Medicaid rolls fearing that a less generous block grant will replace the ACA’s Medicaid expansion in 2018. Alternatively, some states might expand their Medicaid program in anticipation of a block grant that will be based on each state’s current level of spending.

To avoid this kind of chaos, the public, providers, insurers and the media should insist that the Republican candidate reduce this uncertainty during the campaign by providing the details of the “replace” component of the Republican plan and the time table for the changes.

These details might include plan specifications or even draft legislative language which non-partisan analytical organizations like CBO and independent think tanks could evaluate and provide estimates of the proposal's likely costs, coverage and distributional impacts. Clearly, it would be unusual to specify such policy detail during a political campaign, but the potential disruptive consequences of the repeal and replace policy to society and the economy are also likely to be highly unusual and consequential.

The Democratic nominee would also be wise to do more than praise and promise to defend Obamacare. If the Democrats retain control of the White House they are likely to continue to encounter major difficulties engaging Republicans on legislation to fix the difficulties that have emerged in implementing the ACA. They should make clear that they would like to find some common ground with Congressional Republicans who will likely control at least one congressional chamber. This should be more than a long-overdue technical corrections bill. The Democrats should be willing to consider some alternative to the Independent Payment Advisory Board (IPAB), which is unlikely to be constituted as long as Republicans control the Senate, the elimination of the employer mandate which [some independent analysts](#) have concluded has only a marginal impact on coverage (but not on costs), a restructuring of the Cadillac tax on employers that is scheduled to take effect in 2018, and other modifications that three years of experience suggest are warranted.

[A recent paper by analysts at the Urban Institute](#) suggests that the accomplishments of the ACA could begin to erode as the premium and cost-sharing requirements of exchange policies become increasingly unaffordable for middle income and elderly families and as the consequences of inadequate funding for administration become more apparent. The Democratic campaign should lay out those areas that its health policy experts feel need fixing. The list should include a more generous tax credit and cost-sharing schedule for exchange participants; a fix for the employer-based insurance "glitch;"ⁱ and augmented federal grants for IT development and operations, education, outreach, enrollment and oversight and enforcement of insurance regulations. While congressional Republicans may find such enhancements unacceptable, they may be more receptive to the Urban Institute's researchers suggested compromise relating to the ACA's Medicaid expansion. Under this proposal, states that have not expanded Medicaid eligibility to 138 percent of the Federal Poverty Level (FPL) as the ACA required—and the Supreme Court decision made optional—would be given the option of allowing their residents with incomes between 100 percent and 138 percent of the FPL to enroll in fully federally subsidized exchange plans if they agreed to increase the state's threshold for Medicaid eligibility to 100 percent of the FPL.ⁱⁱ

Moderating the Growth of National and Federal Health Care Spending

The United States devotes an extraordinary 18 percent of its GDP to health care—a substantially larger fraction than other advanced countries with modern health care systems. For several decades, health spending per capita grew faster than other spending. Continuation of past trends seemed likely to push the fraction of economic resources devoted to health care ever higher—to 20 percent and beyond—squeezing out spending for competing needs in public and private budgets, including investment needed to give young people the skills and tools to ensure future prosperity. However, in the last few years health spending slowed markedly. Over the past 5 years (2009-14) National Health Expenditures (NHE) have risen at an average rate of 3.5 percent a year on a per capita basis, compared with 6.5 percent in the previous decade

(1999-2009). [Medicare spending has risen](#) at a rate of 1.3 percent per beneficiary and the comparable figure for Medicaid is 0.5 percent. The causes of the recent spending slowdown are the subject of a lively debate. The great recession and the slow recovery, the ACA's cost reduction measures and other federal initiatives, efforts by employers to constrain spending by shifting costs onto workers through high deductible and narrow network plans and other mechanisms, the shift to generic drugs, a slowdown in the introduction of expensive new interventions and blockbuster branded drugs, and provider efforts to improve efficiency have all played some role in slowing the growth in per capita costs.

Even without disruption in the health sector that could result from election-related policy turmoil, spending growth is projected to accelerate in the future. Per capita NHE are projected to rise at an annual rate of 5.1 percent over the next 10 years, Medicare spending at a rate of 4.2 percent per beneficiary, and Medicaid expenditures at a rate of 1.6 percent per enrollee. And when looking at total, rather than per capita, health care spending, demographic trends will exacerbate the situation. Over the next decade the baby boomers will expand Medicare's rolls by almost 3 percent a year. While the under 65 population will be growing at an anemic rate of 0.4 percent a year, an increasing fraction of them will be concentrated in the 50-64 age group where medical expenditures tend to be high.

The lull in new expensive medical innovations seems to be coming to an end. Pharmaceutical manufacturers are introducing new drugs for cancer and other chronic conditions with extremely high price tags—often in excess of \$50,000 per year—and costly innovations based on genomic and nano technology breakthroughs are being developed. In addition, provider consolidation (hospital, nursing home, and home health agency mergers), acquisitions of insurance companies by other insurers, and the purchase of physician groups by hospitals threaten to reduce what little effective competition exists in the health care sector.

Faced with the prospect that rapid health care spending growth will resume on their watch, the presidential candidates should use the campaign to lay out their view on the seriousness of the challenge and how their administration would address it. Republicans who advocate repealing the ACA should specify what they would do to replace the ACA's health spending reductions. The ACA contains initiatives—such as the Cadillac tax (an excise tax on high cost employer sponsored plans), medical loss ratio limits and premium rate reviews that are intended, at least in part, to dampen expenditure growth by private plans. What measures, if any, would replace these?

The ACA also reduces the growth of Medicare's spending significantly. It cut payments to most institutional providers and to MA plans, initiated multiple demonstrations and pilot programs designed to test the efficacy of various approaches to reducing costs, and established the Innovation Center within CMS to explore new payment methods for government programs and a non-profit Patient-Centered Outcomes Research Institute to sponsor clinical comparative effectiveness research of medical treatments that hopefully will reduce costs and improve the efficiency of care delivery. It also called for an IPAB, a body that can institute cost reducing measures if Medicare's spending exceeds specified target growth rates.ⁱⁱⁱ While many of these initiatives have yet to show significant impacts on the pace of cost growth, CBO has estimated that Medicare's direct spending would increase \$802 billion over the 2016-25 period if the ACA were repealed.^{iv} Advocates of repeal should make clear which, if any, of the ACA's cost saving measures they would retain and what alternative approaches they would propose.

Reforming Medicare to Extend the Life of the Trust Fund

Even if the future of the ACA were not an issue of political contention, a continuation of current policy would not be sufficient to address the challenges facing Medicare. [The Trustees project](#) that the Trust Fund out of which Medicare pays hospital claims will be depleted in 2030 even assuming realization of all of the ACA's savings. At that point revenues dedicated to Medicare will be sufficient to pay only 86 percent of Medicare's Hospital Insurance's costs. Unlike other components of the federal budget, Medicare has no legal authority to run a deficit in the trust fund and would have to cut spending. Repealing the ACA would accelerate, possibly to the middle of the next decade, the date of trust fund depletion. This would occur because trust fund spending would increase when the productivity-related reductions in payment updates for institutional providers (hospitals, Skilled Nursing Facilities, etc.) and other cost-reducing measures disappeared and when the increase in payroll taxes on those with high earnings required by the ACA was terminated, thereby reducing the Trust Fund's revenue.^v

Moderating the growth of spending of the physician and drug components of Medicare (Parts B and D) is also important. Under current law, general revenues automatically cover the any difference between spending in parts B and D and premiums collected. In other words, the extra spending increases the federal deficit. With total Part B and Part D spending projected to rise by an average of 7.6 percent and 8.9 percent a year respectively over the next decade, these two programs will impose an increasing burden on federal budget resources as well as on beneficiaries who will face rising premiums tied to increased program costs. Over the next two decades, expenditures for part B and D are projected to grow from 2.04 percent to 3.38 percent of GDP.

It would be highly desirable for the next president and congress to address the future of Medicare and not wait until trust fund depletion forces hasty action. Taking action sooner rather than later will permit consideration of a wider range of solutions, solutions that can distribute the unavoidable burden across a broader array of stakeholders and generations. Furthermore, significant policy modifications to Medicare (and Social Security) must be phased in gradually to allow affected individuals, businesses and institutions adequate time to adjust.

However, Medicare, perhaps even more than Social Security, is the third rail of American politics. The millions of older and disabled people who depend on Medicare—and their children—are extremely fearful of proposals to limit Medicare benefits, and they tend to show up at the polls. The list of policies that have been suggested for putting Medicare's finances on a more sustainable path is long but all the items are controversial. The policies include transforming Medicare into a system of premium supports in which beneficiaries receive a government subsidy that enables them to purchase insurance through an exchange; raising the age at which Medicare is available from 65 to the age at which unreduced Social Security benefits are available (or even higher); increasing Part B and D premiums; increasing deductibles and cost sharing; moving to new payment mechanisms such as reference pricing, and episode-, bundled-, or value-based payments; limiting payments for expensive pharmaceuticals; and raising Medicare Hospital Insurance payroll taxes. The efficacy and political appeal of any of these policies, of course, depends critically on the detail.

Any viable plan for moving Medicare onto a sustainable track for the future would have to include controversial elements. A candidate that put forward such a plan would risk scaring older people and being demonized by the other side. Hence, we suspect that both major party

nominees will stick to generalities about the need to preserve Medicare, but avoid saying how they would do it.

Conclusion

There are of course other health policy issues that the next president will have to address. Examples include: the poor health of Americans associated with unhealthy food, drug abuse, violence and other non-medical factors that impact health; the disparities in health between the affluent and low-income populations; and how to encourage and share the benefits of biomedical innovation. But the issues we have focused on in this paper—how to improve the Affordable Care Act, how to control rising health spending, and how to preserve Medicare for the growing elderly population—are likely to dominate election debate. If the candidates present realistic proposals and explain them well, the campaign can be a constructive step toward crafting future health policy solutions. If the candidates mainly bash each other and talk vaguely about panaceas they cannot defend, the public will be confused and it will be harder for the next administration and congress to work together to improve health policy.

ⁱ Employees of firms that offer insurance to their workers can enroll in exchange plans with tax subsidies rather than their employer's plan if the premium costs for the worker-only policy they are offered exceed 7 percent of their income. However, if the premium for a worker-only policy is below this threshold but the premium for a family policy exceeds this level the family is precluded from accessing subsidized coverage through the exchange unlike the situation facing workers whose employer offers no insurance.

ⁱⁱ Currently, 19 states have not expanded Medicaid eligibility under the ACA. Many of these states limit eligibility to certain categories (only adults with children) and those with incomes well below the FPL. Specifically, as of April 2015, 21 states offered no Medicaid coverage to childless adults, 13 states offered parents of dependent children Medicaid only if their incomes fell below 50 percent of the FPL and 4 offered such parents Medicaid coverage if their incomes fell between 50 and 100 percent of the FPL. In Alabama and Texas eligibility was restricted to parents with incomes at or below 18 percent of the FPL. Under federal law, all children in families with incomes below the FPL and assets below constricted thresholds are eligible for coverage. Kaiser Family Foundation, "Where Are States Today? Medicaid and CHIP Eligibility Levels for Adults, Children, and Pregnant Women" (Menlo Park, CA: April 2015), <http://kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>.

ⁱⁱⁱ If it objects to the IPAB proposals, Congress can either approve an alternative package with comparable savings or vote to reject the IPAB package. In the latter case, Congress would probably be faced with over riding a presidential veto.

^{iv} Congressional Budget Office, "Budgetary and Economic Effects of Repealing the Affordable Care Act," (Washington: June 2015), 10-11.

^v The ACA reduced the annual payment updates for most institutional providers by the 10 year average increase in multifactor productivity (about 1.1 percentage points) and increased the HI payroll tax by 0.9 percentage point on those with earnings in excess of \$200,000 (\$250,000 for joint returns).