

Next Steps for Health Care Reform

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Chairman, Council of Economic Advisers

The Hamilton Project
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This is an expanded version of these remarks as prepared for delivery.

I want to thank the Hamilton Project for hosting this event. One of my proudest moments running the Hamilton Project was commissioning a set of policy papers focused both on expanding health coverage and reducing health care costs. Bob Rubin and I synthesized those papers in a short piece entitled “Universal, Effective and Affordable Health Insurance: An Economic Imperative.” One of the reasons I left the Hamilton Project was to do what I could to help make that happen in practice.

Today’s event takes place against the backdrop of a health care system that has changed dramatically for the better. Since 2010, the uninsured rate has fallen by more than 40 percent, and, as of the first quarter of this year, fewer than one in ten Americans lacked health insurance, the first time that has been the case in our history. While the economic recovery has made a modest contribution to the improvement in the uninsured rate over this period, the large majority is a direct consequence of the Affordable Care Act.

At the same time, we are in the midst of a continuing period of unusually slow growth in health care costs. Health care prices have risen at the slowest rate in five decades. New data out last month show that 2015 was another year of very slow growth in premiums for employer-based coverage, and slow growth in per-enrollee costs appears to be continuing in Medicare as well. Meanwhile, other data have shown encouraging improvements in the quality of health care system-wide. Although these trends in costs and quality have a number of causes, the Affordable Care Act has made a meaningful contribution through reforms in Medicare payment policy and other initiatives.

But there is still much to do to build a health care system that provides broad access to efficient, high-quality care. Although the uninsured rate is the lowest it has ever been, too many Americans still lack reliable access to care and financial protection against the costs of serious illness. Similarly, while the combination of slow growth in health care costs and improving health care quality in recent years is encouraging, our health care system continues to suffer from serious inefficiencies that raise the cost and reduce the quality of patient care, inefficiencies that weigh on families’ budgets, our fiscal future, and Americans’ health and well-being.

Looking ahead, making continued progress will require two complementary types of effort. We do not have all of the answers, so the first category of work is identifying novel solutions to health policy problems and building the intellectual case for putting those new tools into practice, the subject of your work at this Hamilton Project forum today. The second category,

¹ Matt Fiedler led the preparation of these remarks with assistance from Rahul Rekhi, Gabe Scheffler and Samuel Young.

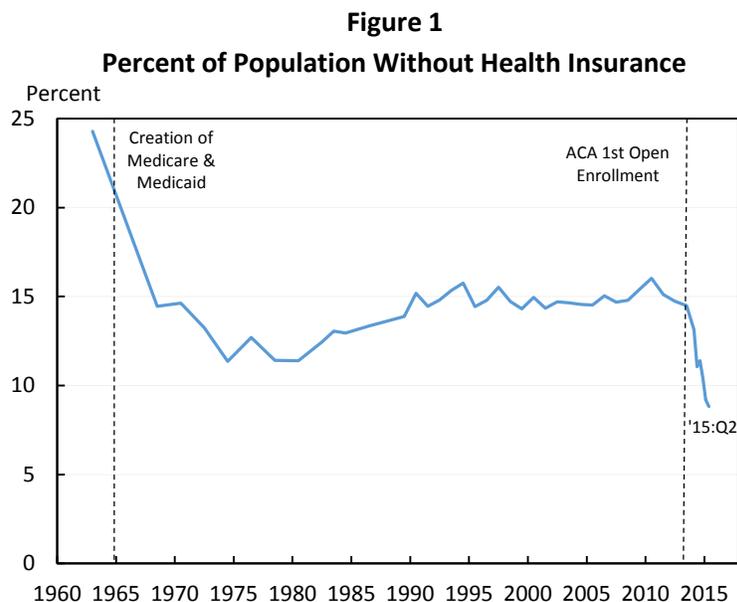
which is what I focus on together with my colleagues in government, is making the best possible use of the policy tools we already have.

After providing a brief summary of recent trends on coverage, costs, and quality, I will spend most of my time discussing three specific areas where making full use of the tools provided by the Affordable Care Act can enable substantial further progress: expanding Medicaid in additional States; widely deploying payment models that reward efficient, high-quality care; and implementing the law's excise tax on high-cost employer health care plans. We still do not have all of the answers on reducing costs while improving quality but these policies will help give doctors, hospitals, insurance companies, and others the incentive to develop innovative solutions that ensure access, reduce costs, improve quality.

A Brief Overview of Recent Trends in the U.S. Health Care System

Historic Gains in Health Insurance Coverage

Perhaps the most-discussed recent change in our health care system is the dramatic decline in the share of the U.S. population without health insurance. After making essentially no progress for four decades, the uninsured rate has fallen precipitously since the Affordable Care Act's main coverage provisions took effect at the end of 2013, generating the largest decline since the decade following the creation of Medicare and Medicaid. Fewer than one in ten Americans now lack health insurance coverage, the smallest fraction in our history.



The gains since 2013 are attributable almost entirely to the major coverage provisions of the Affordable Care Act, and a portion of the smaller decline from 2010 to 2013 reflects other parts of the law, notably the provision allowing young adults to remain on a parent's plan until age 26. A recent analysis by the Department of Health and Human Services (HHS), which looked at both sets of provisions and controlled for a variety of other factors that could affect the uninsured rate,

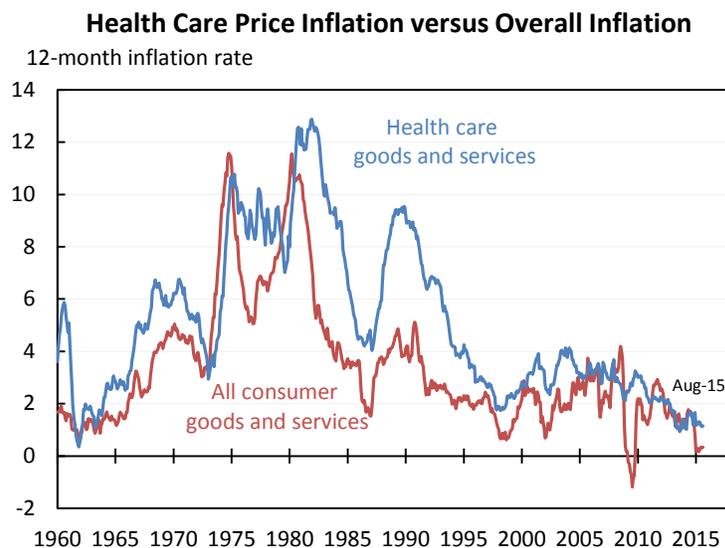
estimated that 17.6 million people have gained coverage as these provisions have taken effect.² While all estimates of this kind are subject to uncertainty, the HHS estimate provides the best available guide to the causal effect of the Affordable Care Act on insurance coverage through the third quarter of 2015.

Exceptionally Slow Growth in Health Care Costs

Recent years have also seen a period of exceptionally slow growth in health care costs. Health care cost growth began to slow in the middle of the last decade and has slowed further over the last several years, with recent evidence indicating that slow growth has continued into 2015.

Focusing first on recent trends in the prices of health care goods and services, health care prices have grown at annual rate of 1.6 percent since the Affordable Care Act was enacted in March 2010, the slowest rate for such a period in five decades, and those prices have grown at an even slower 1.1 percent rate over the 12 months ending in August 2015. Strikingly, health care price inflation has been roughly in line with overall inflation since March 2010, whereas it exceeded overall inflation by an average of 1.7 percentage points per year over the preceding 50 years.

Figure 2

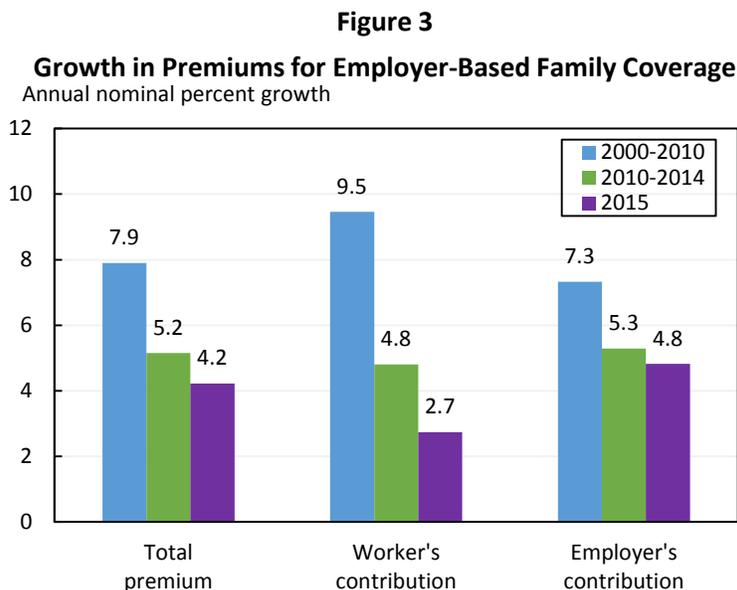


Driven by slow growth in health care prices as well as slow growth in per-enrollee health care utilization, per-enrollee health care spending has seen unusually slow growth in both the public and private sectors. Last month, the Kaiser Family Foundation reported that the nominal premium for employer-based family coverage rose 4.2 percent in 2015, continuing the recent period of slow growth. The cumulative impact of the slow growth in premiums in recent years is quite large. Had premium growth since 2010 matched the average rate over the preceding decade, the average family premium would have been nearly \$2,600 higher in 2015.

Slower growth in employer premiums is generating important benefits for workers. Much of the savings described above has accrued directly to workers in the form of lower premium

² Office of the Assistant Secretary for Planning and Evaluation, United States Department of Health and Human Services. September 2015. “Health Insurance Coverage and the Affordable Care Act” (<http://aspe.hhs.gov/health-insurance-coverage-and-affordable-care-act-aspe-issue-brief-september-2015>).

contributions, and economic theory and evidence imply that employers' savings on their portion of premium costs will also be passed on to workers as higher wages in the long run.³ To the degree that not all of the savings have been passed through to workers in the short run, then slower growth in premiums has likely boosted employment by reducing employers' compensation costs.⁴



The slow growth in premiums has not been offset by an increased growth rate of deductibles. Although rising deductibles in employer coverage have attracted significant attention in recent years, recent changes are in line with long-standing trends, and there is no evidence that those trends have accelerated since 2010. Moreover, among those with employer coverage, the share of total health care spending accounted for by out-of-pocket spending has actually drifted lower in recent years, as measured using data from the household component of the Medical Expenditure Panel Survey.⁵ Here too, changes since 2010 are largely in line with pre-2010 trends.

³ See, for example, Katherine Baicker and Amitabh Chandra. 2006. "The Labor Market Effects of Rising Health Insurance Premiums." *Journal of Labor Economics* vol. 24, no. 3, pp. 609-634.

⁴ Jason Furman. April 2015. "The Economic Benefits of the Affordable Care Act" (https://www.whitehouse.gov/sites/default/files/docs/20150402_aca_economic_impacts_fifth_anniversary_cap_0.pdf).

⁵ Data from the National Health Expenditure Accounts show a broadly similar decline in out-of-pocket spending as a share of total spending system-wide in recent years. A recent brief from the Health Care Cost Institute (HCCI), which uses data from several large commercial insurers, shows broadly similar trends for the period for which data are available. Specifically, the HCCI show an uptick in the share of total spending in employer coverage that is accounted for by out-of-pocket spending from 2009 to 2010, followed by little net change since 2010. Health Care Cost Institute. October 2014. "Out-of-Pocket Spending Trends (2013)" (<http://www.healthcostinstitute.org/issue-brief-out-pocket-spending-trends-2013>).

Figure 4

Average Deductible in Employer-Based Single Coverage

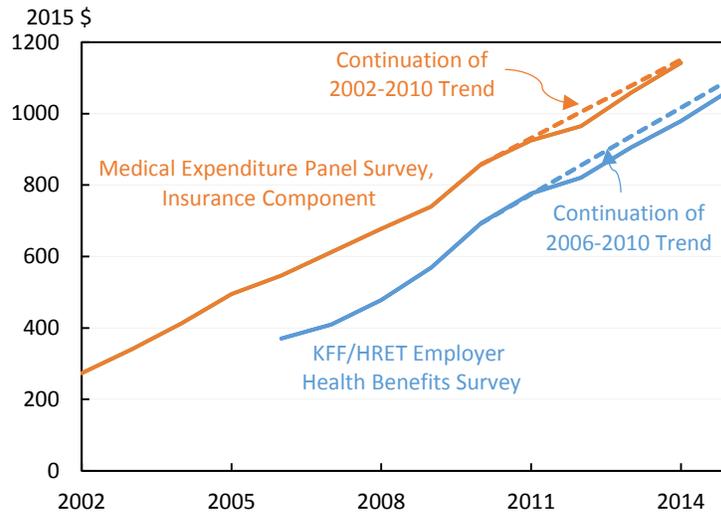
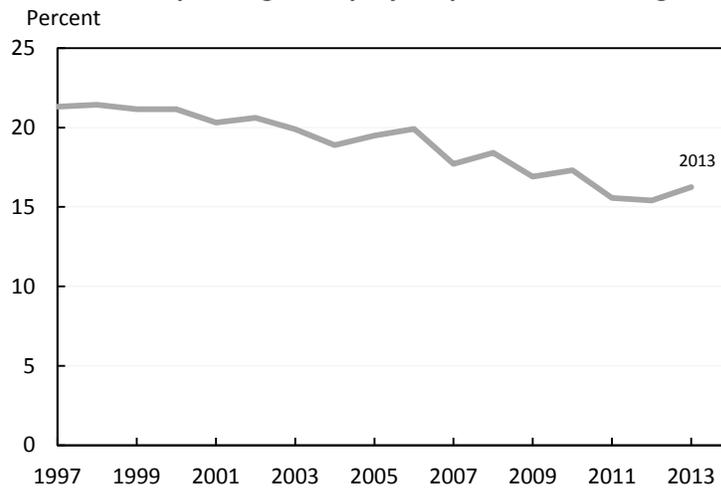


Figure 5

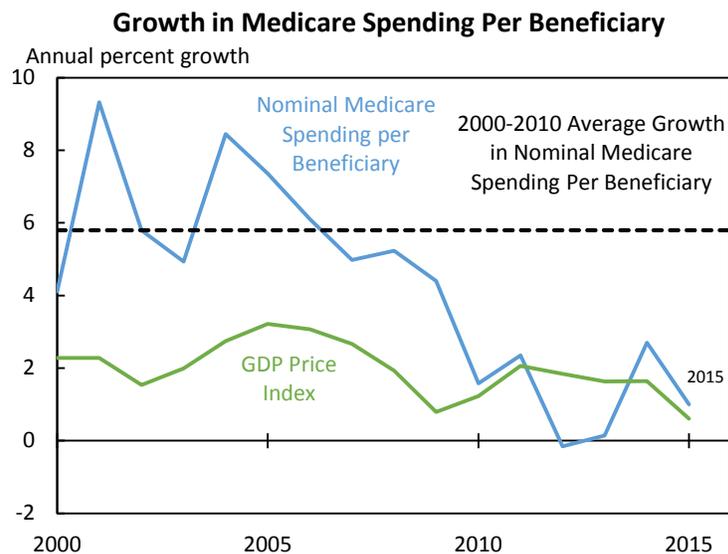
Out-of-Pocket Spending as a Share of Total Spending in Employer-Sponsored Coverage



Public programs have also seen exceptionally slow growth. Based on the most recent projections from the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS), it appears that 2015 will be yet another year in which growth in per-enrollee Medicare spending is roughly in line with inflation economy-wide. By contrast, Medicare spending per beneficiary rose 3.6 percentage points faster than overall inflation over the preceding decade, even after adjusting for the introduction of Medicare Part D. Medicaid has seen similarly slow growth in per-enrollee spending.

The recent slow growth in health costs has generated major fiscal benefits. Since August 2010, due largely to the recent slow growth in health care spending, the Congressional Budget Office (CBO) has cut its projections of Medicare and Medicaid spending in 2020 down by \$175 billion or around 13 percent. The slower growth in health care costs is thus contributing to deficit reduction now and in the future—leading to some combination of higher national savings, less distortionary taxation, or more growth-enhancing investments—all of which can raise future national income.

Figure 6

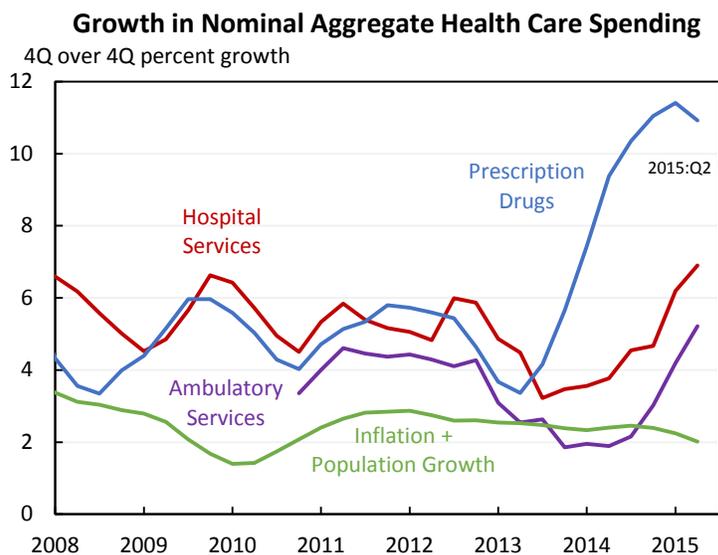


Driven by slow growth in per-enrollee costs in both the public and private sectors, the years leading up to 2013 saw the slowest growth in aggregate health care spending since records began in 1960. Despite the continued slow growth in per-enrollee spending since the end of 2013, recent data have shown faster growth in aggregate spending on health care goods and services. This uptick in growth is largely attributable to increased utilization by the millions of people who have gained insurance coverage over that period and begun to access care, and the effects of expanding coverage on aggregate spending growth will subside as coverage stabilizes at its new, higher level. Faster growth in aggregate spending due to expanding coverage is also not a cause for concern: what matters to individual households is how much the amounts they pay for health care are rising, and, as we have seen, the pace of those increases remains unusually low.

The exception to this general story is prescription drug spending, where the uptick in spending growth is much larger than can be accounted for by recent coverage expansions. Available data indicate that the main factor driving faster drug spending has been the arrival of costly, though

often effective, new therapies.⁶ While the implications of the recent acceleration in drug spending for the overall health care spending outlook should not be overstated since drug spending currently accounts for only about one-tenth of total health care spending and growth may not persist at its recent rapid pace, trends in this area have raised concerns about access and affordability in both the public and private sectors.

Figure 7



The recent slow growth in health care costs has a variety of causes, unlike the sharp decline in the uninsured rate which is almost entirely a direct result of the Affordable Care Act.⁷ The Great Recession and its aftermath undoubtedly put some downward pressure on health care spending growth. However, slower health cost growth has persisted even with the economy in its sixth year of recovery, and the Great Recession could never persuasively explain the slowdown in Medicare, so “structural” factors (i.e., factors not linked to the business cycle) must also have played an important role.

The full list of structural factors that have contributed to recent trends will probably never be fully understood. Private-sector efforts appear to have had some success in slowing cost growth in private coverage even before the recession hit and the Affordable Care Act was enacted, and these efforts have continued to exert downward pressure in recent years. Transitory factors have also played some role, particularly the now-ended period of slow growth in prescription drug spending, which resulted from a surfeit of patent expirations and a dearth of new drug introductions.

But collectively these factors do not explain the full magnitude of the slowdown, and the Affordable Care Act has played a role as well. Affordable Care Act reforms that reduced

⁶ The Express Scripts Lab. 2015. “The 2014 Drug Trend Report”; IMS Institute for Healthcare Informatics. 2015. “Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014.”

⁷ CEA has written extensively on this question, and I refer those of you who are interested to our earlier work for a more detailed discussion: Jason Furman and Matt Fiedler. December 2014. “Historically Slow Growth in Health Spending Continued in 2013, and Data Show Underlying Slow Cost Growth Is Continuing” (<https://www.whitehouse.gov/blog/2014/12/03/historically-slow-growth-health-spending-continued-2013-and-datashow-underlying-slo>); Council of Economic Advisers. March 2014. The Economic Report of the President.

excessive payment rates to medical providers in Medicare—as well as “spillover” effects on payment rates in the private sector—are a major reason that growth in health care prices has been historically low in recent years and are, in turn, a contributor to slow growth in total spending. While more difficult to quantify, the law’s efforts to move Medicare’s payment systems toward “alternative payment models” that reward efficient, high-quality care have also likely helped to drive greater efficiency in medical practice, both by reinforcing similar payment changes already underway in the private sector and by catalyzing further private-sector changes.

The mere fact that at least a meaningful portion of the recent slow growth in health costs is attributable to structural factors is no reason for complacency. Notably, without continued commitment from policymakers, the portion of those structural changes driven by policy could at least partially dissipate. For example, while the Affordable Care Act’s changes to annual payment rate updates in Medicare will exert continued downward pressure on price and spending growth if left in place, that pressure would disappear immediately if the Affordable Care Act were repealed. Similarly, the law’s efforts to develop and deploy new ways of paying providers will only produce sustained downward pressure on growth if we make continued progress in increasing participation in these models and improving their effectiveness.

Encouraging Improvements in Health Care Quality

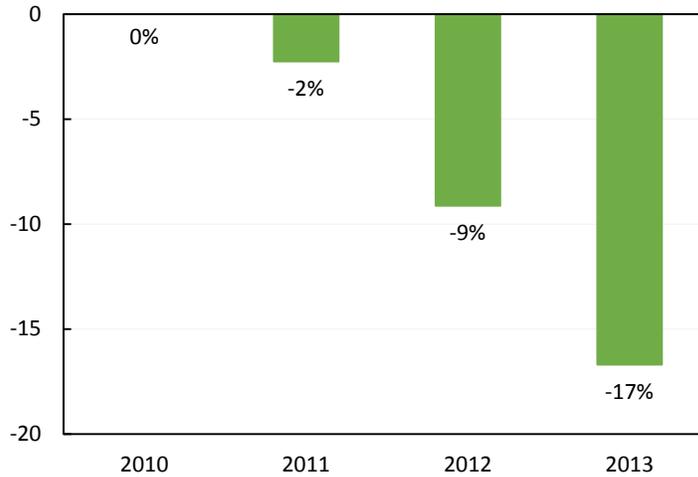
While trends in health care costs generally receive the most attention, I do want to touch briefly on recent trends in health care quality. Quality trends are equally important in determining how the overall economic contribution of the health care sector is changing over time. If cost savings were coming at the cost of lower-quality care, that would be a cause for concern, not celebration, whereas if we were saving money by reducing errors and improving the quality of care, that would be an especially welcome development.

Hard data on trends in health care quality are, unfortunately, scarcer than data on trends in health care costs. Nevertheless, the data we do have on trends in quality are encouraging. The Agency for Healthcare Research and Quality (AHRQ) has recently begun tracking the incidence of hospital-acquired conditions, like infections or complications due to medication errors, system-wide. Since the AHRQ data began in 2010, the nationwide hospital-acquired condition rate has fallen 17 percent, and AHRQ estimates that this decline in the rate of patient harm corresponds to 50,000 avoided deaths from 2010 through 2013.

Figure 8

Change in Rate of Patient Harm in U.S. Hospitals

Percent change in harm rate since 2010

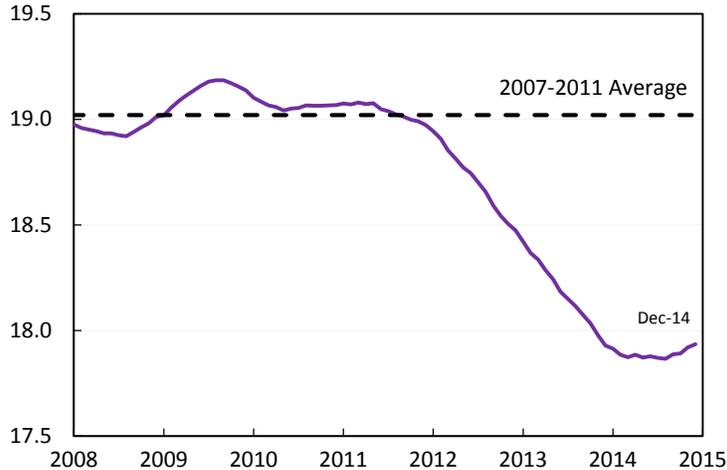


The last several years have also seen a sharp reduction in the rate of hospital readmissions, instances in which a patient returns to the hospital soon after discharge. Readmissions are often the result of low-quality care during an initial admission or poor planning for how a patient will receive care after discharge. After having remained approximately flat for several years, the 30-day readmission rate in Medicare fell sharply starting in 2012, a decline that translated into 150,000 avoided readmissions over the period from January 2012 to December 2013.

Figure 9

Medicare 30-Day, All-Condition Hospital Readmission Rate

Percent, 12-month moving average



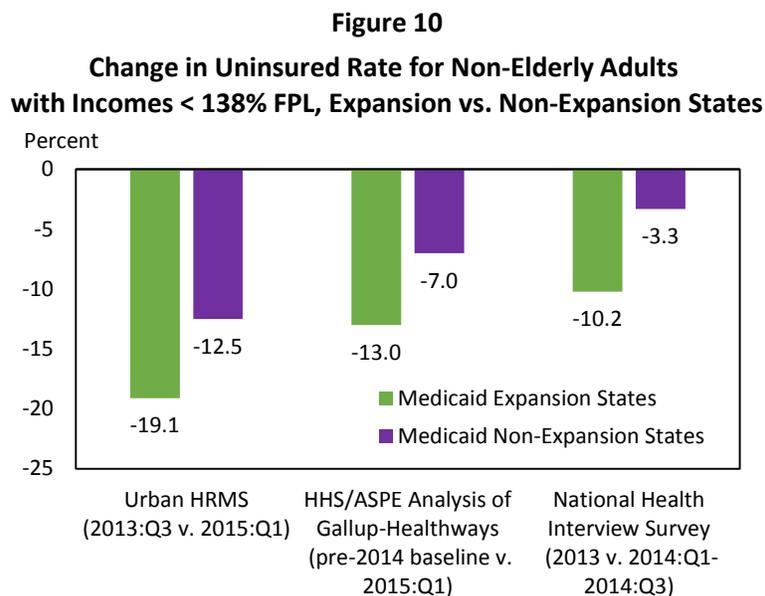
The factors driving these improvements in health care quality are less well-studied than those driving recent trends in costs, but here too aspects of the Affordable Care Act are likely playing a role. Notably, the Affordable Care Act linked hospitals' Medicare payment rates to measures of the quality of care they provide through three programs: the Hospital Value-Based Purchasing Program; the Hospital-Acquired Condition Reduction Program; and the Hospital Readmission Reduction Program, in some cases following the private sector in these initiatives and in other

cases leading it. In addition, the Affordable Care Act supported the creation of the Partnership for Patients through CMS, an initiative that helps hospitals identify and diffuse best practices for improving the quality of care. Hospital industry participants have suggested that this program was highly effective in achieving its goals.⁸

Next Step #1: Expanding Insurance Coverage by Expanding Medicaid in More States

One of the simplest ways the United States can continue the recent progress in expanding insurance coverage is for more States to take advantage of the generous financial support provided by the Affordable Care Act to expand their Medicaid programs. To date, 29 States and the District of Columbia have done so. But another 21 States have not and are thereby missing a major opportunity to improve their residents’ health and financial security, while also improving overall economic well-being in the state. The Administration is willing to work with any interested State to find an approach to Medicaid expansion that achieves its major potential benefits while meeting the state’s needs.

Researchers at the Urban Institute estimate that if all states that have not yet expanded Medicaid did so, another 4.3 million people would gain coverage when those expansions were fully in effect. The data we have received since State Medicaid expansions began to take effect have demonstrated that expanding Medicaid is indeed a highly effective strategy for increasing insurance coverage. While public and private surveys of insurance coverage have shown substantial coverage gains in both expansion and non-expansion states, these surveys have consistently found larger coverage gains in Medicaid expansion states, particularly among low-income adults, the group directly affected by the Medicaid expansion.



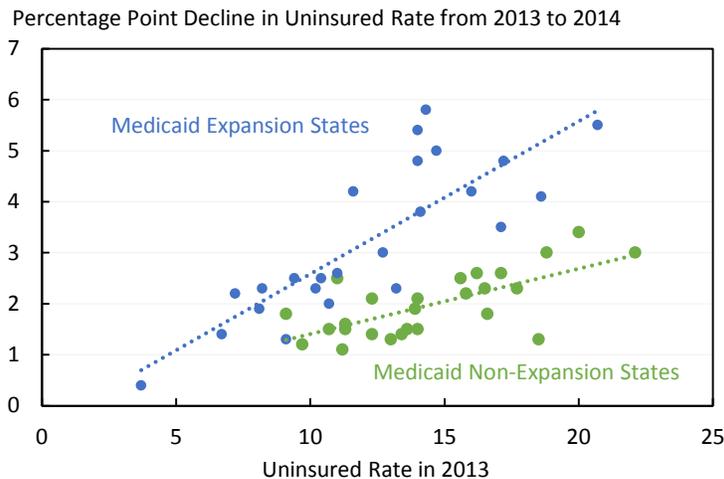
Comparing raw coverage trends between expansion and non-expansion states actually understates the effects of Medicaid expansion on insurance coverage. As shown in the figure,

⁸ The American Hospital Association/Health Research & Educational Trust Hospital Engagement Network. December 2014. *Partnership for Patients Hospital Engagement Network: Final Report.*

Medicaid expansion states typically had lower uninsured rates prior to 2014, and, holding expansion status fixed, states with lower uninsured rates tended to see smaller coverage gains during 2014. Controlling for these differences in pre-2014 insurance prevalence would thus magnify the difference in trends between expansion and non-expansion States. For the State with median 2013 uninsured rate, the 2014 decline in the uninsured rate conditional on expanding Medicaid was 3.5 percentage points, as compared to a 2.0 percentage point reduction conditional on not expanding Medicaid; the raw difference in trends between expansion and non-expansion States was smaller: just 1.1 percentage points.

Figure 11

Fall in Uninsured Rate from 2013 to 2014 vs. Level of Uninsured Rate in 2013, by State



The benefits of further expanding access to insurance coverage through Medicaid would be substantial.⁹ The most obvious benefits of Medicaid expansions accrue to the newly insured themselves. Our best evidence in this area comes from the Oregon Health Insurance Experiment (OHIE), a randomized controlled trial in which some low-income adults were offered Medicaid coverage, while others were not. The OHIE generated compelling evidence that having Medicaid coverage increases access to care, including preventive care; bolsters financial security; and dramatically improves mental health.¹⁰ For example, based on the OHIE’s estimates of the effects of Medicaid along these dimensions, CEA estimates that if all states that have not yet expanded Medicaid did so, another 490,000 people would report receiving all needed care each year, 609,000 fewer people would have trouble paying other bills due to health costs, and 392,000 fewer people would experience symptoms of depression.

Other recent quasi-experimental research, which lacks the OHIE’s randomized research design, but can draw upon a much larger sample size in order to study outcomes that could not be studied in the OHIE, concludes that prior coverage expansions to low-income adults also reduced

⁹ I encourage those interested in longer discussion of the major benefits that Medicaid expansion generates for the newly insured and for State economies to seek out CEA’s recent report on the topic: Council of Economic Advisers. 2015. “Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid” (https://www.whitehouse.gov/sites/default/files/docs/medicaidmissedopportunities2015_final_v3.pdf).

¹⁰ Katherine Baicker et al. 2013. “The Oregon Experiment – Effects of Medicaid on Clinical Outcomes.” *New England Journal of Medicine* 368:1713-1722.

mortality.¹¹ Applying these estimates to the coverage gains projected under Medicaid expansion implies that if all states that have not yet expanded Medicaid did so, these States would avoid more than 5,000 deaths annually. Some recent work also suggests that access to Medicaid coverage improves long-term labor market outcomes, likely by improving health. While this work has focused primarily on children, it is conceivable that similar effects could be present for adults.¹²

Medicaid expansions also have benefits to state economies that go beyond these direct benefits for the newly insured. First, while much of the additional Federal dollars that flow into a State's economy when it expands its Medicaid program goes to finance additional care or reduce out-of-pocket costs for the newly insured, a portion will defray the cost of care that was previously provided without payment. Since those costs would otherwise be borne by some combination of health care providers, government programs, or other entities to which those costs may have been shifted, this reduction in uncompensated care increases overall living standards in the State. While estimates vary regarding the magnitude of the reduction in uncompensated care attributable to Medicaid expansions, they are clearly substantial.¹³

Second, Medicaid expansions strengthen our system of “automatic stabilizers,” increasing the resilience of State economies and the overall U.S. economy in the face of future economic shocks. In particular, expanded eligibility for Medicaid coverage will help safeguard access to health care and cushion household budgets in the face of the job and income losses that occur during economic downturns. Expanding Medicaid thereby not only helps protect families from the consequences of future economic downturns, but also increases aggregate demand when demand would otherwise be impaired, helping to directly mitigate the severity of economic downturns. Strengthening automatic stabilizers could be particularly important if changes in the U.S. economy have increased the likelihood that monetary policy will be constrained by the zero lower bound in future recessions, in which case fiscal policy will have a larger role to play in combatting those recessions.¹⁴

Next Step #2: Realizing the Full Potential of Payment Reform

Turning to costs, the next item I want to discuss is the Administration's ongoing efforts to shift toward payment models that reward efficient, high-quality care. Despite major progress facilitated by the Affordable Care Act, our health care system remains dominated by “fee-for-service” payment systems. Economists agree that traditional fee-for-service payment systems

¹¹ Benjamin D. Sommers, Katherine Baicker, and Arnold M. Epstein. 2012. “Mortality and Access to Care among Adults after State Medicaid Expansions.” *The New England Journal of Medicine* 367, no. 11: 1025-1034; Benjamin D. Sommers, Sharon K. Long, and Katherine Baicker. 2014. “Changes in Mortality after Massachusetts Health Care Reform: A Quasi-Experimental Study.” *Annals of Internal Medicine* 160, no. 9: 585-593.

¹² David Brown, Amanda Kowalski, and Ithai Lurie. 2015. “Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?” NBER Working Paper 20835; Sarah Cohodes, Daniel Grossman, Samuel Kleiner, and Michael F. Lovenheim. May 2014. “The Effect of Child Health Insurance Access on Schooling: Evidence from Public Health Insurance Expansions.” NBER Working Paper 20178.

¹³ Amy Finkelstein, Nathaniel Hendren, and Erzo Luttmer. 2015. “The Value of Medicaid: Interpreting Results from the Oregon Health Insurance Experiment.” <http://economics.mit.edu/files/10580>.

¹⁴ Jason Furman. March 2015. “Questions and Answers: The Economic Recovery and the Path Forward” (https://www.whitehouse.gov/sites/default/files/docs/20150310_questions_and_answers_nabe.pdf).

have at least three problematic consequences for the care patients receive.¹⁵ First, fee-for-service payment leads to excessive use of low-value services since health care providers' incomes are tied directly to the number of services they provide, irrespective of those services' worth. Second, it provides little or no direct financial incentive to improve quality of care since payments do not vary based on the quality or outcomes of the care patients receive. Third, fee-for-service payment encourages poorly-coordinated care since each provider a patient sees is paid separately and no single provider has a financial incentive to make sure that the overall package of care a patient receives fits together as a coherent whole.

These shortcomings of fee-for-service payment are why the Administration is using the tools created by the Affordable Care Act, which were bolstered by this spring's bipartisan physician payment reform legislation, to widely deploy "alternative payment models"—like bundled payments or Accountable Care Organizations (ACOs)—that orient payment around an episode of care or the patient as a whole, rather than individual services. By structuring payment in this way, these models support care coordination and eliminate the incentive to provide excessive and low-value services. These models also link payment to quality performance in order to encourage the provision of high-quality care. In these models, Medicare plays an essential role in defining how cost and quality performance will be measured, but it is then up to providers to come up with innovative ways of meeting these targets and to share in the benefits that they create.

The Administration's strategy for driving the widespread adoption of alternative payment models has two key components: deploying these models widely in public programs; and facilitating their spread in the private sector. But before discussing each prong of this strategy in greater detail, I want to note that both depend crucially on the work being done by the Center for Medicare and Medicaid Innovation (the "Innovation Center"), which was created by the Affordable Care Act to develop and deploy innovative new payment models that improve the efficiency and quality of care. It was therefore particularly troubling to see the House Appropriations Committee propose to eliminate funding for the Innovation Center earlier this year. CBO recently estimated that eliminating the Innovation Center's funding would increase deficits by \$31 billion over the next ten years by stifling the deployment of new payment models in Medicare, making the House proposal a particularly egregious case of being pennywise and pound foolish; CBO has also estimated that savings generated by the Innovation Center's activities will get larger over time as more new models reach their full potential.¹⁶

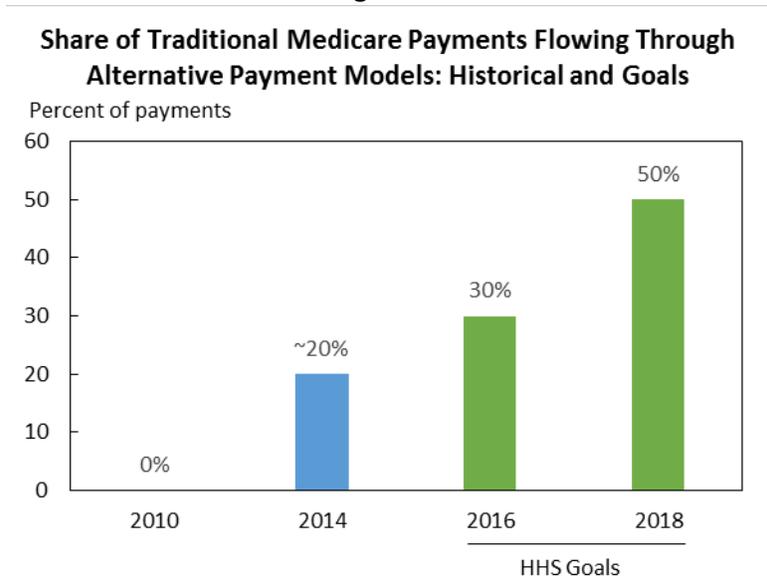
Deploying Alternative Payment Models in Medicare

¹⁵ For a more detailed discussion, see Jason Furman and Matt Fiedler. March 2015. "Continuing the Affordable Care Act's Progress on Delivery System Reform Is an Economic Imperative" (<https://www.whitehouse.gov/blog/2015/03/24/continuing-affordable-care-act-s-progress-delivery-system-reform-economic-imperative>).

¹⁶ Inside Health Policy. June 2015. "CBO Estimates House Plan to Eliminate Innovation Center Would Cost \$31 B." (<https://healthpolicynewsstand.com/content/cbo-estimates-house-plan-eliminate-innovation-center-would-cost-31b>); Congressional Budget Office. July 2015. "Estimating the Budgetary Effects of Legislation Involving the Center for Medicare and Medicaid Innovation" (<https://www.cbo.gov/publication/50692>).¹⁷ Centers for Medicare and Medicaid Services. August 2015. "Medicare ACOs continue to Improve Quality of Care, Generate Shared Savings" (<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-25.html>).

The Administration has already made significant progress in deploying alternative payment models in Medicare. Prior to the Affordable Care Act, such models were virtually non-existent in Medicare, but, by 2014, about 20 percent of traditional Medicare payments flowed through alternative payment models, all of them created or made possible by the law. And HHS has set the ambitious goal of at least 30 percent of traditional Medicare payments flowing through these models by 2016 and 50 percent by 2018.

Figure 12



One pillar of these efforts consists of “bundled payment” models, in which Medicare makes a single payment for all services associated with an episode of care. The Administration’s work in this area reached an important milestone this summer, when the Innovation Center proposed a bundled payment model for hip and knee replacement that will apply on a mandatory basis in 75 randomly-selected markets starting in 2016, the first time the Innovation Center has used its authority to propose a mandatory model. Under the proposed model, Medicare will make a single payment for all care provided to a hip or knee replacement patient starting with the date of the surgery and continuing for 90 days after discharge, and the payment amount will be adjusted based on the quality of the care the hospital provides. This model builds on a voluntary Innovation Center bundled payment initiative that covers a broader array of episode types.

Another pillar consists of “accountable care” models in which providers take on the responsibility for managing the entirety of a patient’s care during the year and can earn “shared savings” if they reduce average per-person spending below a benchmark level while also delivering high-quality care. Across the country, as of January of this year, medical providers had formed 424 ACOs serving 7.8 million Medicare beneficiaries—or around one-fifth of total traditional Medicare enrollment—through the Medicare Shared Savings Program (MSSP) and the Innovation Center’s Pioneer ACO program.¹⁷

¹⁷ Centers for Medicare and Medicaid Services. August 2015. “Medicare ACOs continue to Improve Quality of Care, Generate Shared Savings” (<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-08-25.html>).

Looking ahead, the Administration is using the lessons learned from early experience with accountable care models to expand participation and make the models more effective. This spring, the Pioneer ACO model became the first Innovation Center model to be certified by Medicare's actuary as having saved money for the Medicare program, while improving the quality of patient care. On the basis of that certification, several features of the Pioneer ACO program were incorporated on a permanent basis into the MSSP.¹⁸ At the same time, CMS made other improvements to the MSSP, and committed to making significant improvements in the program's cost "benchmarking" methodology that will strengthen ACOs' incentives to improve efficiency and encourage continued participation in the program. The Innovation Center has also recently solicited applications to join the Next Generation ACO program, a successor to the Pioneer ACO program that will begin in January 2016.

Finally, a third element of the Administration's strategy for widely diffusing alternative payment models in Medicare relies upon the bipartisan physician payment reform legislation passed by Congress this spring. Under the legislation, physicians will be eligible for bonus payments, and, ultimately, for larger annual payment updates, if they participate in alternative payment models that meet specified criteria. Medicare's actuary has estimated that, due in part to these bonuses, physician participation in such models will reach 60 percent by 2019 and will become essentially universal over the long run.¹⁹ By both replacing the flawed sustainable growth rate formula and creating these new incentives, this legislation will finally allow physicians to fully engage in delivery system reform.

Spreading Alternative Payment Models in the Private Sector

Deploying alternative payment models in Medicare is important in its own right, but historical experience and economic evidence implies that doing so will also help accelerate their deployment system-wide. Medicare is the Nation's single largest payer, so it has a unique ability to use both its knowledge and ability to solve coordination problems to engage providers to deploy new models, which other payers can then capitalize on. For example, when Medicare deployed "prospective payment" for hospitals during the 1980s, private payers followed suit. More recently, economic research has found that when Medicare changed the structure of how it paid physicians, private payment patterns followed suit.²⁰ In this vein, it is notable that private payers made around 40 percent of payments through mechanisms other than traditional fee-for-service in 2014, up from an estimated 11 percent in 2013, and have begun entering into ACO-like contracts with providers on a substantial scale.²¹

¹⁸ David Nyweide et al. 2015. "Association of Pioneer Accountable care Organizations vs Traditional Medicare Fee for Service with Spending, Utilization, and Patient Experience." *Journal of the American Medical Association* 313, No. 21.

¹⁹ CMS Office of the Actuary. "Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2)" (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/2015HR2a.pdf>).

²⁰ Jeffrey Clemens and Joshua Gottlieb. October 2013. "In the Shadow of a Giant: Medicare's Influence on Private Physician Payments." NBER Working Paper No. 19503.

²¹ Catalyst for Payment Reform. 2014. National Scorecard on Payment Reform (<http://www.catalyzepaymentreform.org/images/documents/nationalscorecard2014.pdf>); Matthew Petersen, Paul Gardner, Tianna Tu, and David Muhlestein. June 2014. Growth and Dispersion of Accountable Care Organizations: June 2014 Update. Leavitt Partners.

Nevertheless, action by public programs alone may not be sufficient to ensure widespread adoption of new payment models in the private sector. Economic research in a variety of settings has found that when one payer changes its practices in ways that reduce costs or improve quality, other payers in the same market may benefit as well, since medical providers often apply the improved approaches to care delivery with all of their patients.²² For example, research on the ACO-like Alternative Quality Contract (AQC) created by Blue Cross Blue Shield of Massachusetts found that Medicare realized “spillover” cost savings as the AQC came online for privately-insured patients in Massachusetts.²³

The presence of cross-payer “spillovers” means that the deployment of alternative payment models can face a classic collective action problem, in which all payers are better off in a world where alternative payment models are the norm, but many payers would rather let someone else do the hard work of deploying them. Collaborative effort between public and private payers may be able to help solve this problem by helping payers agree to move forward together or by facilitating the spread of information in order to reduce adoption costs. Collaborative efforts may also make it easier for different payers to align their new models, reducing administrative costs for providers and potentially increasing models’ efficacy. Thus, the Administration is also working to facilitate this type of collaborative work across payers by creating a Health Care Payment Learning and Action Network that brings together public- and private-sector stakeholders to work to address these barriers.

Next Step #3: Implementing the Excise Tax on High-Cost Employer Plans

The final item I want to discuss is the Affordable Care Act’s excise tax on high-cost employer-sponsored coverage, sometimes known as the “Cadillac tax.” There is broad consensus among economists across the political spectrum that, by counteracting long-standing distortions in our tax code, the excise tax will reduce health care costs, boost workers’ wages, and improve our fiscal outlook. That consensus was highlighted in a letter published last week by 101 leading economists and health policy experts who highlighted the tax’s benefits and strongly opposed efforts to weaken or repeal the tax.²⁴

Despite this support, the House Ways and Means Committee recently reported out legislation that would repeal this provision, along with a number of other proposals that would reverse much of the progress I have been discussing. In the time remaining, I want to discuss why repealing the tax or delaying its scheduled implementation in 2018 would have serious negative consequences for our health care system, for worker’s wage growth and for our long-term fiscal outlook. Of course, the Administration is always willing to work with Congress to improve the Affordable

²² Katherine Baicker, Michael Chernew, and Jacob Robbins. 2013. “The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization.” *Journal of Health Economics* vol. 32, no. 6, pp. 1289-1300. December; Sherry Glied, and Joshua Graff Zivin. March 2002. “How do Doctors Behave When Some (But Not All) of Their Patients Are in Managed Care?” *Journal of Health Economics*, vol. 21, no. 2, pp. 337-353.

²³ Michael McWilliams, Bruce Landon, and Michael Chernew. August 2013. “Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated with a Commercial ACO Contract.” *Journal of the American Medical Association* vol. 310, no. 8, pp. 829-836.

²⁴ Letter to Senator Orrin G. Hatch, Senator Ron Wyden, Representative Paul D. Ryan, and Representative Sander M. Levin. October 2015 (http://www.cbpp.org/sites/default/files/atoms/files/cadillac_tax_letter.pdf).

Care Act, but any changes to the excise tax—or other provisions of the law—must preserve, not undermine, the law’s major benefits for our health care system, our economy, and the deficit, which is why the Administration opposes legislation that would repeal or delay this provision.

Background on the High-Cost Excise Tax

The basic policy rationale for the excise tax is familiar to most of those in this room. Stretching back to Martin Feldstein’s seminal work in the 1970s, economists have recognized that because employees pay income and payroll taxes on compensation provided in the form of wages and salaries, but not on compensation provided in the form of health care benefits, employers have a strong incentive to skew compensation packages away from wages and salaries and toward health care benefits.²⁵

In concrete terms, this so-called “tax exclusion” gives employers a choice at the margin between giving employees, on average, around 65 cents in after-tax wages or a full dollar in health benefits. Even if the worker and society would be better off with higher wages and a more efficient health plan, the tax system will often tip the balance against that outcome. The result is health care benefits whose cost and generosity are excessive and wages that are correspondingly too low.

The excise tax counters the distortions created by the tax exclusion by placing a 40 percent tax on health plan costs in excess of \$10,200 for self-only coverage and \$27,500 for other-than-self-only coverage, starting in 2018.²⁶ By design, these thresholds were set far above the cost of the plans held by most workers. For comparison, the Kaiser Family Foundation estimated that the average family premium in employer-based coverage was \$17,545 in 2015, and if premium growth matches the most recent National Health Expenditure Projections, the statutory threshold will be nearly 40 percent above than the average premium in 2018.²⁷ These thresholds will be upwardly adjusted for firms that would be expected to have higher costs because of their demographic makeup and for enrollees in certain high-risk industries and occupations.

Lower Health Care Costs

The most direct benefit of the tax will be to give employers an incentive to make their health care plans more efficient, benefits that, as described below, will ultimately accrue to employees. Economists generally agree that the resulting reductions in health costs will be quite large. One reasonable estimate comes from a recent analysis by Jane Gravelle of the Congressional

²⁵ Martin Feldstein. 1970. “The Rising Price of Physician’s Services,” *Review of Economics and Statistics*, 52:2, 121-133; Martin S. Feldstein. 1973. “The Welfare Loss of Excess Health Insurance,” *Journal of Political Economy*, 81:2, 251-80.

²⁶ Some analysts have erroneously argued that the excise tax “overcorrects” the distortion created by the tax exclusion since the 40 percent excise tax rate exceeds the typical marginal tax rate on labor income. However, when making such comparisons, it is crucial to account for the fact that excise tax rates are typically quoted on a “tax exclusive” basis, whereas income taxes are typically quoted on a “tax inclusive” basis. Converting the excise tax rate to be comparable to labor income tax rates generates a tax rate 28.6 percent ($=100*0.4/[1+0.4]$), which is lower than typical marginal tax rates on labor income. While the actual effective rate will be somewhat higher than 28.6 percent in some cases due to interactions with the business tax system, average rates quoted on a “tax inclusive” basis are still likely to be meaningfully below 40 percent.

²⁷ Office of the Actuary, Center for Medicare and Medicaid Services. July 2015. “NHE Projections 2014-2024” (<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html>).

Research Service, who estimated that the tax would reduce national health expenditures by as much as \$60 billion dollars in 2024 (3.6 percent of projected private insurance spending in that year), and these effects will be even larger in later years.²⁸ Few, if any, other health care policies commonly discussed can generate savings of this magnitude.

Higher Wages for Workers

The second main benefit of the excise tax—which follows directly from the reductions in health costs outlined above—will be substantial increases in workers’ wages. Economic theory implies that the money employers save on health benefit costs as a result of the tax will be passed through to workers as higher wages in the long run. The theory that employers will pass on health benefit savings in the form of higher wages has received empirical support,²⁹ and undergirds CBO and Joint Committee on Taxation (JCT) analyses of the budgetary effects of the excise tax.

The magnitude of these increases in workers’ take-home pay will be quite large. Simple calculations based on CBO/JCT estimates imply that the tax will increase take-home pay by \$45 billion per year by 2025,³⁰ and since the extent to which the tax reduces health costs is forecast to grow over time, the wage increases attributable to the tax will grow over time as well. For comparison, that wage gain is about double the CBO’s estimate of the wage increase for low- and middle-income families from increasing the minimum wage from \$7.25 per hour to \$10.10 per hour.³¹

While economic theory and evidence are clear that reductions in employers’ health benefit costs will fully accrue to workers in the long run, they do not offer clear guidance on how quickly that will occur. Compensation packages take time to adjust and labor markets take time to reach equilibrium, so it would not be surprising if savings were passed through to wages only over the course of a few years, particularly during periods when the economy falls short of full employment. Even in this case, however, the reduction in health benefit costs would benefit workers through another channel: by reducing employers’ compensation costs and thereby boosting hiring.

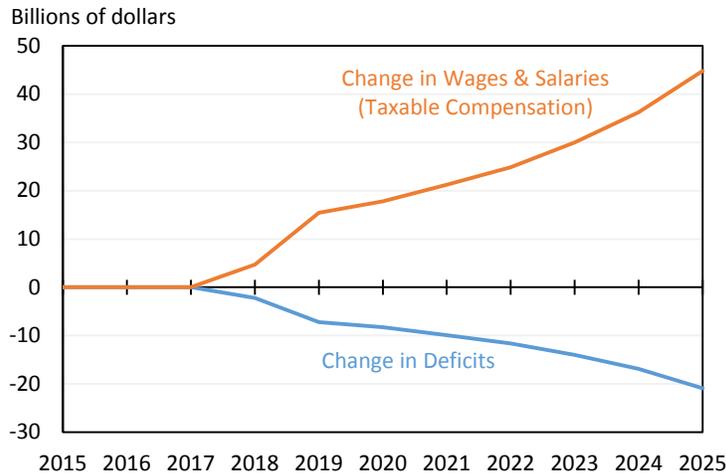
²⁸ Jane Gravelle. 2015. “The Excise Tax on High-Cost Employer-Sponsored Health Insurance: Estimated Economic and Market Effects.” Congressional Research Service (<https://www.fas.org/sgp/crs/misc/R44159.pdf>).

²⁹ See, for example, Baicker and Chandra (2006).

³⁰ Specifically, CBO/JCT estimate that repealing the excise tax would increase the deficit by \$21 billion in 2025, and CBO stated earlier this year that roughly three-quarters of the fiscal effects of the tax arises from the increase in payroll and income tax revenue as workers’ wages rise. Assuming an average marginal tax rate on labor income of around 35 percent, this translates into a wage increase of \$45 billion ($=[\$21 \text{ billion} * 0.75]/0.35$). The 35 percent marginal tax rate used in this calculation is the average marginal labor tax rate that would apply to a proportional reduction in employer health care spending that was paid out as higher wages, as estimated using published tables from the Urban-Brookings Tax Policy Center. For the three-quarters estimate cited above, see Congressional Budget Office. January 2015. “Updated Estimates of the Insurance Coverage Provisions of the Affordable Care Act” (<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/49892/49892-breakout-AppendixB.pdf>).

³¹ CBO estimates that this increase in the minimum wage would increase aggregate earnings by low- and middle-income families by \$19 billion in 2016, measured in 2013 dollars. See Congressional Budget Office. February 2014. “The Effects of a Minimum-Wage Increase on Employment and Family Income” (<https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44995-MinimumWage.pdf>).

Figure 13
Estimated Effects of the High-Cost Excise Tax
on Deficits and Wages & Salaries



Lower Future Deficits

The excise tax’s third major benefit is that it will substantially reduce deficits. CBO and JCT estimate that the tax will reduce deficits by \$91 billion over the ten years ending in 2025, due largely to the increase in income and payroll taxes associated with the increase in wages described above.³² While this is a sizable sum on its own, these savings grow rapidly over time. Extrapolating the CBO/JCT score into a second decade implies that the tax will reduce the deficit by more than \$500 billion over that ten-year period, and the savings are likely to continue to grow thereafter. The excise tax is therefore a major reason that repealing the Affordable Care Act would sharply increase long-run deficits, as well as one of the reasons that the 75-year fiscal gap has diminished substantially in recent years. Repealing the tax would also substantially increase the risk that a future effort to repeal the Affordable Care Act would be scored as reducing, rather than increasing, the deficit.

Lower long-run deficits will have substantial benefits for our economy. By boosting national saving, they will increase capital accumulation and reduce foreign borrowing, thereby raising national income and workers’ wages over time. Alternatively, the deficit savings generated by the excise tax may help us avoid cuts to crucial investments like education or infrastructure that increase the United States’ long-run productive capacity.

How Will the High-Cost Excise Tax Accomplish These Goals?

Since all of these major economic benefits flow from employers’ efforts to make their health care plans more efficient in response to the tax, it is worth delving further into how employers will achieve these savings. Employers can achieve savings in a variety of different ways, and the precise mix of tools they will elect to use is impossible to predict today. Indeed, an important

³² Congressional Budget Office. October 2015. “Reconciliation Recommendations of the House Committee on Ways and Means” (<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/49892/49892-breakout-AppendixB.pdf>).

virtue of the excise tax as a tool for reducing costs is that it gives employers, insurers, and providers an incentive to work together to find innovative new ways to cut costs, like diffusing the Medicare payment reforms I discussed earlier and discovering and deploying novel solutions that policymakers have not considered at all. Nevertheless, we can make some educated guesses about the types of approaches employers are likely to use.

Some public discussion of the excise tax has assumed that employers' primary response will be to increase cost-sharing. For a pair of reasons, however, I suspect that this conventional wisdom will turn out to be overstated. First, while introducing moderate cost-sharing can encourage more efficient use of services, evidence dating back to the RAND Health Insurance Experiment suggests that increasing cost-sharing often runs into diminishing returns.³³ Surely some employers who are currently offering plans with very limited cost-sharing will find scope to achieve savings here, but others may find it to be an ineffective tool. Second, to the extent that increasing cost-sharing has only a limited effect on utilization, it will often be of limited use in avoiding the tax. A substantial fraction of out-of-pocket spending in employer coverage now occurs through tax-preferred vehicles like flexible spending accounts and health savings accounts. The excise tax generally treats all tax-preferred spending—whether on premiums or cost-sharing—equally, so merely shifting dollars between these categories will, in many cases, have a limited effect on employers' exposure to the tax.

As discussed above, to date there is no evidence that the impending onset of the high-cost excise tax is leading to more rapidly growing cost sharing. In fact, I suspect that many employers will respond to the incentives created by the high-cost excise tax by focusing on strategies that directly reduce the prices paid for health care goods and services and that reduce the use of low-value services. With respect to prices, U.S. health care markets—including pharmaceutical markets, physician and hospital markets, and insurance markets—feature sellers that hold significant market power.³⁴ In such markets, a key determinant of prices is health plans' willingness to invest effort in extracting better prices from sellers and steering enrollees toward lower-priced providers. By dulling the extent to which employers are affected by high prices, the tax exclusion has undermined employers' willingness to invest that effort, raising prices in the health care sector.³⁵ The excise tax provides a counterweight that will help to drive that effort up and, therefore, prices down.

With respect to utilization, employers also have access to a variety of tools to reduce the use of low-value care. Traditional tools include sensible utilization management and using cost-sharing in a targeted way to steer enrollees toward more efficient providers. Surely these traditional tools will be part of how employers respond to the incentives created by the tax. But I suspect that the excise tax will also help drive employer engagement in broader payment reform efforts like those I discussed in the last section. While these efforts have considerable potential to drive cost savings and improve the quality of care for their enrollees, they also require real effort from employers to stand them up, and that effort may have been difficult to justify in a world where

³³ Joseph Newhouse and the RAND Health Insurance Experiment Group. 1993. "Free for All? Lessons from the RAND Health Insurance Experiment."

³⁴ Martin Gaynor, Kate Ho, and Robert Town. 2014. "The Industrial Organization of Health Care Markets." NBER Working Paper 19800.

³⁵ Feldstein (1970) and Feldstein (1973).

the Federal government was effectively agreeing to pick up a large portion of the tab for inefficiently high-cost care.

It is important to note that cost-cutting efforts by plans affected by the tax are likely to have substantial “spillover” benefits for other plans in the market, including lower-cost plans. For example, when high-cost plans become more aggressive about negotiating lower prices with providers, this will tend to strengthen the bargaining position of lower-cost plans since it reduces providers’ ability to threaten to “walk away” from the negotiation and simply exclusively serve the high-cost plans. Indeed, recent research has found that markets with more generous plans tend to have higher hospital prices market-wide, at least in markets where hospitals wield significant market power.³⁶ Similarly, as I noted above in discussing the Administration’s strategy for payment reform, economic research demonstrates that when one payer in a market reforms payment in ways that encourage provider to deliver more efficient care, other payers in the same market frequently benefit as well. Over the longer run, greater cost-consciousness among private payers may also help guide medical research and development efforts toward cost-reducing, rather than cost-increasing innovations.³⁷

As a final note, it is obviously possible that employers could use any of the tools discussed above too aggressively. For example, excessive cost-sharing can undermine access to care and the financial protection that insurance is supposed to provide, and negotiating too hard for low provider rates can jeopardize patient access or undermine quality. Employers will, however, have a strong incentive to avoid these outcomes. Health benefits are a key tool that employers use to recruit and retain workers, and that will remain the case after the excise tax is in effect. Employers that cut too deeply along any of these dimensions will find that they lose workers to other employers that have struck a more sensible balance. The risk that employers will go too far in their efforts to cut costs thus seems unlikely to materialize in practice.

Will the “Cadillac Tax” Actually be a “Chevy Tax”?

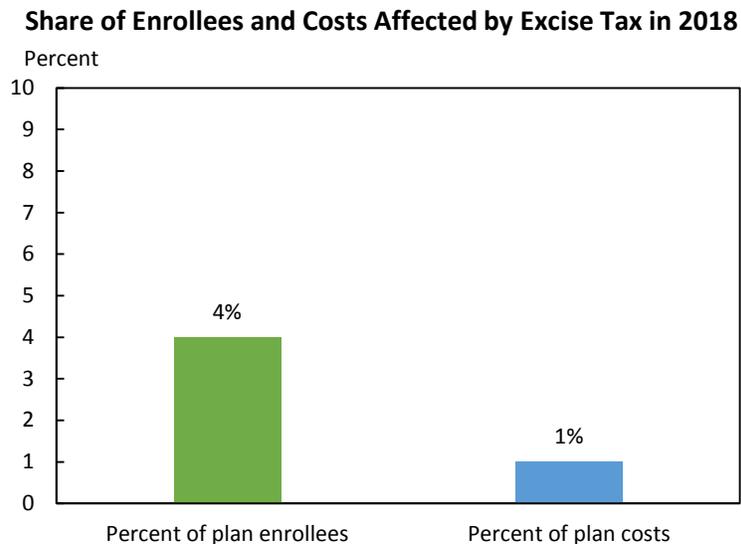
Despite these major benefits for our health care system, the labor market, and the deficit, the excise tax has its share of critics. One prominent criticism of the tax is that, rather than applying only to generous “Cadillac” plans, the excise tax will substantially burden workers with more typical “Chevy” plans. If true, this could raise legitimate policy concerns.

However, the claim that the excise tax will burden “Chevy” plans is at odds with the facts. Due to the very high thresholds above which the excise tax applies, the Department of the Treasury’s Office of Tax Analysis estimates that just 4 percent of people enrolled in employer coverage will be in plans with costs above the excise tax thresholds in 2018, even if employers make no adjustments at all to avoid the tax.

³⁶ Laurence Baker, Kate Bundorf, and Daniel Kessler. 2015. “Does Health Plan Generosity Enhance Hospital Market Power.” NBER Working Paper 21513.

³⁷ Amy Finkelstein. 2007. “The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare.” *Quarterly Journal of Economics* 122 no. 3: 1–37; Clemens, Jeffrey. 2011. “The Effect of U.S. Health Insurance Expansions on Medical Innovation.” SIEPR Discussion Paper No. 11-016, Stanford University.

Figure 14



This estimate is similar to, although somewhat lower than, recent Congressional Research Service (CRS) estimates of the share of plans that will be affected by the tax in 2018.³⁸ While the difference between the Treasury estimate and the CRS estimate reflects a variety of factors, one notable difference is that the CRS analysis did not account for the fact that many employers will qualify for higher thresholds due to the age, gender, or occupational mix of their workforces. This estimate is also substantially lower than a recent estimate published by the Kaiser Family Foundation.³⁹ The Kaiser analysis focused on the share of employers with at least one plan in which a worker who elected to make the maximum contribution to a flexible spending account allowable by law would trigger the tax. In practice, many employees at such employers would be enrolled in lower-cost plans and the overwhelming majority would not max out their FSAs, which means that the metric used in the Kaiser analysis does not provide a particularly useful way of thinking about the breadth of the tax’s impact.

Furthermore, for many purposes, focusing on the share of enrollees or plans that are above the thresholds substantially overstates the tax’s actual impact since the tax applies only to the portion of plan costs that exceeds the thresholds. For example, a family plan with a plan costing \$27,600 would be affected by the tax in 2018 but only on \$100 of that cost—for a total of \$40 in taxes. For many purposes—including evaluating the risk that the tax will have unintended consequences for employer coverage—the more relevant metric is the share of plan costs that are subject to the tax. According to the same Treasury estimates cited above, only around 1 percent of plan costs will be affected by the tax in 2018, even if employers take no steps to avoid the tax.

³⁸ Sean Lowry. 2015. “The Excise Tax on High-Cost Employer Sponsored Health Coverage: Background and Economic Analysis.” Congressional Research Service (<https://www.fas.org/sgp/crs/misc/R44160.pdf>).

³⁹ Gary Claxton and Larry Levitt. 2015. “How Many Employers Could be Affected by the Cadillac Plan Tax.” Kaiser Family Foundation (<http://kff.org/health-costs/issue-brief/how-many-employers-could-be-affected-by-the-cadillac-plan-tax/>).

Now, as many analysts have noted, because the thresholds above which the tax applies are indexed to the Consumer Price Index rather than a measure of health care costs, the tax's impact is likely to grow over time, and these impacts could become too large in the long run. In practice, however, it will be many years before the tax's impact reaches a level that would raise serious concerns. Even by 2025, the end of the current ten-year budget window, Treasury estimates that only about 3 percent of plan costs would be affected by the tax, well below the level that would risk creating unintended consequences for employer coverage.

Conclusion

It is increasingly widely-understood that the Affordable Care Act has changed our health care system for the better by driving the uninsured rate to a historical low, helping to reduce the growth of health care costs, and contributing to recent improvements in health care quality. But what is less well understood is that the law's capacity to drive rapid progress has just begun, provided that we commit ourselves to making the best possible use of the tools the law provided.

But this will not happen on its own. It will require more governors and state legislatures to do the right thing for their States and expand their Medicaid programs. It will require the Administration to continue hard work in collaboration with payers and providers to develop and deploy new ways of paying for care. And it will require the Congress to preserve the high-cost excise tax and its major benefits for our health care system, for workers' paychecks, and our fiscal future. The next several years have the potential to be almost as transformative for our health care system as the last five; the question is whether we will rise to the challenge.

Notes to Figures and Tables

Figure 1

Source: CEA analysis of National Health Interview Survey, Cohen et al. (2009), Klemm (2000), and CMS (2009), and Gallup-Healthways Well-Being Index.

Note: Data are quarterly starting in 2014:Q1. Data for earlier years are generally either annual or bi-annual. Because NHIS data are not currently available after 2015:Q1, Gallup data are used to extrapolate through 2015:Q2.

Figure 2

Source: Bureau of Economic Analysis; CEA calculations.

Figure 3

Source: KFF/HRET Employer Health Benefits Survey.

Figure 4

Source: KFF/HRET Employer Health Benefits Survey; Medical Expenditure Panel Survey, Insurance Component.

Figure 5

Source: Medical Expenditure Panel Survey, Household Component; CEA calculations.

Note: Figure plots trends for individuals enrolled in employer-sponsored coverage for the full year.

Figure 6

Source: Office of the Actuary, Center for Medicare and Medicaid Services, National Health Expenditure Projections.

Note: Medicare spending growth for 2015 is a CMS projection. GDP price index for 2015 is a CBO projection. The Medicare growth rate for 2006 has been adjusted to remove the effect of the introduction of Medicare Part D.

Figure 7

Source: Census Bureau, Quarterly Services Survey (hospital services & ambulatory services); Bureau of Economic Analysis National Income and Product Accounts (prescription drugs, population, GDP price index).

Figure 8

Source: Agency for Health Care Research and Quality; CEA calculations.

Figure 9

Source: Centers for Medicare and Medicaid Services, Office of Enterprise Data and Analytics; CEA calculations.

Figure 10

Source: Urban Institute, Health Reform Monitoring Survey; Assistant Secretary for Planning and Evaluation, Department of Health and Human Services; Centers for Diseases Control, National Health Interview Survey.

Note: Medicaid expansion status reflects the categorization used by the data source.

Figure 11

Source: Census Bureau, American Community Survey.

Note: Following Census, states are categorized by their Medicaid expansion status as of January 1, 2014.

Figure 12

Source: United States Department of Health and Human Services.

Figure 13

Source: Congressional Budget Office; CEA calculations.

Note: Deficit effects are taken directly from the CBO score. Effects on taxable compensation are computed from the CBO score using the methodology in the text.

Figure 14

Source: United States Department of the Treasury, Office of Tax Analysis.